MENTAL HEALTH SERVICES ACT

Annual Update for Programs & Expenditures
Fiscal Year 2025–26

Photo: BHRS Office of Diversity and Equity's 15-Year Celebration

Photo: San Mateo County Mobile Crisis Response Team

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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

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Photo: San Mateo County Health, BHRS program offices

INTRODUCTION

INTRODUCTION TO SAN MATEO COUNTY

Located in the Bay Area, San Mateo County is bordered by the Pacific Ocean to the west and San Francisco Bay to the east. The county was formed in April 1856 out of the southern portion of then-San Francisco County. Within its 455 square miles, the county is known for a mild climate and scenic vistas. Nearly three quarters of the county is open space, and agriculture remains a vital contributor to the economy and culture. The county has long been a center for innovation. Today, San Mateo County's bioscience, computer software, green technology, hospitality, financial management, health care, and transportation companies are industry leaders. Situated in San Mateo County is San Francisco International Airport, the second largest and busiest airport in California, and the Port of Redwood City, which is the only deep-water port in the southern part of the San Francisco Bay. These economic hubs have added to the rapidly growing vitality of the county.

COUNTY OF SAN MATEO MISSION

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

We are committed to

- the highest standards of public service,
- a common vision of responsiveness,
- the highest standards of ethical conduct, and
- treating people with respect and dignity.

The county is committed to building a healthy community. The County of San Mateo Shared Vision 2025 places an emphasis on the interconnectedness of all communities and, specifically, of county policies and programs. Shared Vision 2025 is for a sustainable San Mateo County that is a (a) healthy, (b) prosperous, (c) livable, (d) environmentally conscious, (e) collaborative community.

BEHAVIORAL HEALTH AND RECOVERY SERVICES

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

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

BHRS Vision

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

BHRS Mission

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

BHRS Values

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

SAN MATEO COUNTY DEMOGRAPHICS

The projected 2025 population of San Mateo County is 721,201, a 5.4% decrease from 2020, see Exhibit 1. Daly City remains the most populous city, followed by San Mateo and Redwood City.

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

As the county's population continues to shift, it also continues to grow in diversity; 45.57% of residents speak a language other than English at home, and 35.01% are foreign born. San Mateo County's threshold languages are Spanish, Chinese (Mandarin and Cantonese), Tagalog, and Russian (as identified by Health Plan of San Mateo). San Mateo County Health identified Tongan and Samoan as priority languages on the basis of a growing number of clients served and Arabic, Burmese, Hindi, and Portuguese as emerging languages. Exhibit 2 displays the percentage of race/ethnicity groups in San Mateo County.

Exhibit 1. San Mateo County Population

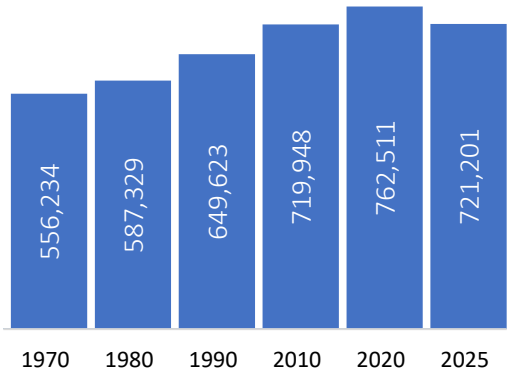
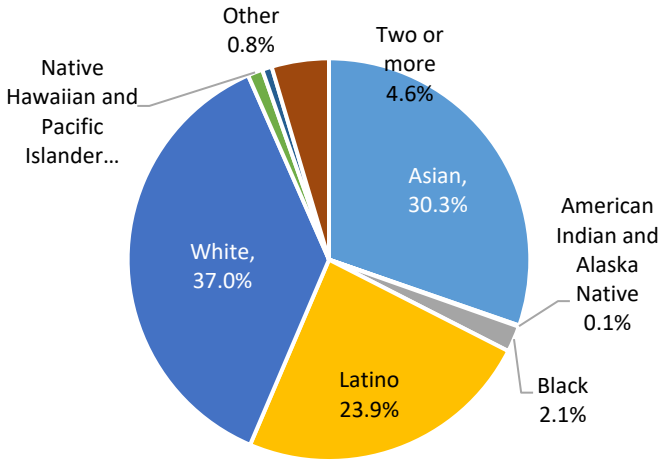
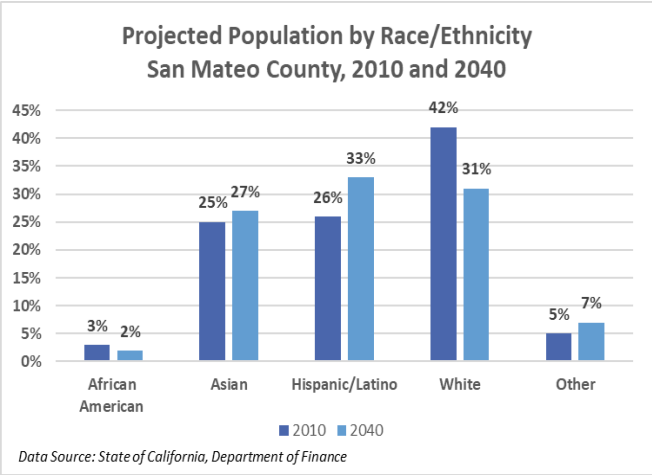


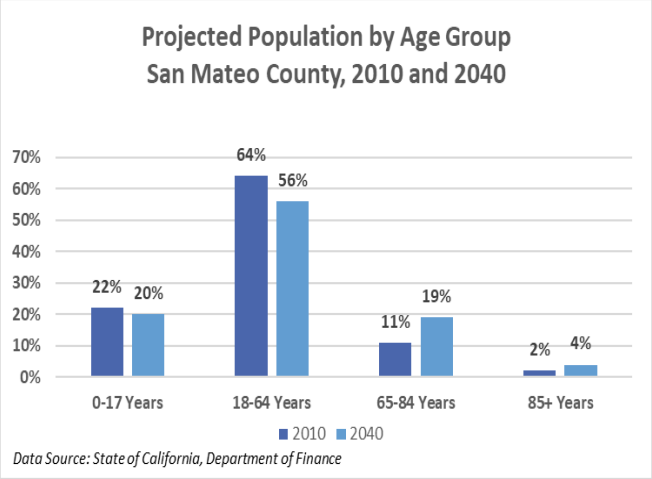
Exhibit 2. San Mateo County Population by Race/Ethnicity



By 2040, as can be seen in Exhibit 3., San Mateo County is projected to have a majority non-White population. The White population is projected to decrease by 11%. The Latino and Asian communities are projected to increase by 7% and 2%, respectively.[1] In addition, the projected population by age group shows that residents 65 years and older are projected to almost double.

Exhibit 3. San Mateo County Projected Population by Race/Ethnicity and Age Group





[1] See sustainablesanmateo.org.

MHSA BACKGROUND

Proposition 63, the Mental Health Services Act (MHSA), was approved by California voters in November 2004 and provided dedicated funding for mental health services by imposing a 1% tax on personal income over $1 million. San Mateo County received an annual average of $50.1 million in the past 5 years through fiscal year (FY) 2023–24.

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

◆ Community collaboration ◆ Cultural competence ◆ Consumer- and family-driven services

◆ Focus on wellness, recovery, and resiliency ◆ Integrated service experience

The MHSA provides funding for community program planning activities, which include stakeholder involvement in planning, implementation, and evaluation. MHSA-funded programs and activities are grouped into "components," each one with its own set of guidelines and rules. Exhibit 4 provides a high-level view of the MHSA components, funding allocation and descriptions.

Exhibit 4. Mental Health Services Act (MHSA) Components

76%

Community Services and Supports (CSS)

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

19%

Prevention and 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)

Education, training, and workforce development to increase capacity and diversity of the workforce

Capital Facilities and Technology Needs (CFTN)

Buildings and technology used for the delivery of MHSA services to individuals and their families.

Photo: BHRS Office of Diversity and Equity 15-Year Celebration

COMMUNITY PROGRAM PLANNING

COMMUNITY PROGRAM PLANNING

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

ASSESSMENT OF MENTAL HEALTH NEEDS

A comprehensive Community Program Planning (CPP) process framework was developed to inform the FY 2023–26 MHSA Three-Year Program and Expenditure Plan (MHSA Three-Year Plan), in collaboration with clients and families, community members, staff, community agencies, and stakeholders. The CPP framework guided decisions and priorities for the plan and included three phases: (a) needs assessment, (b) strategy development, and (c) MHSA Three-Year Plan development. The needs assessment phase begins with a review and analysis of more than 20 local assessments, reports, and data sets, including the BHRS Cultural Competence Plan, which cites data and narrative analysis on population demographics and needs of unserved, underserved, or inappropriately served communities. As per California Code Regulations, Title 9, § 3650(a)(1)(A), counties must identify the number of children, transitional-age youth (TAY), adults, and older adults by gender, race/ethnicity, and primary language spoken at home. The most recent 2024 BHRS Cultural Competence Plan is included as Appendix 1 to support this requirement for MHSA.

MHSA STEERING COMMITTEE

The MHSA Steering Committee continues to play a critical role in the development of MHSA program and expenditure plans in San Mateo County. The MHSA Steering Committee makes recommendations to the planning and services development process and, as a group, ensures 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. Steering committee meetings are open to the public and include time for public comment as well as means for submission of written comments.

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

The MHSA Steering Committee meets four times per year in February, May, September, and December. All MHSA Steering Committee meeting materials, including slides, minutes, and handouts, can be found on the MHSA website (www.smchealth.org/MHSA) under the Steering Committee tab. The following Exhibit 5 lists MHSA Steering Committee members in FY 2024–25.

Exhibit 5. Fiscal Year (FY) 2024–25 MHSA Steering Committee Members

Stakeholder group	Name	Title (if applicable)	Organization/affiliation (if applicable)
Family member	Jean Perry [a]	MHSA co-chairperson	Behavioral Health Commission, Lived Experience Education Workgroup
Public	Leticia Bido [a]	MHSA co-chairperson	Behavioral Health Commission
Client/consumer	Jana Spalding	Program coordinator	Behavioral Health and Recovery Services, Office of Consumer and Family Affairs
Cultural responsiveness	Maria Lorente-Foresti	Director	Behavioral Health and Recovery Services, Office of Diversity and Equity
Cultural responsiveness	Kava Tulua	Executive director	One East Palo Alto
Family member	Chris Rasmussen	Chair	Behavioral Health Commission
Family member	Juliana Fuerbringer	Board member	California Clubhouse
Health care	Jackie Almes	Youth behavioral health programs	Peninsula Health Care District
Health care	Jessica Ho/ Dee Wu	Government and community affairs manager	North East Medical Services
Other—peer support	ShaRon Heath	Executive director	Voices of Recovery San Mateo County
Provider of behavioral health services	Adriana Furuzawa	Division director	Family Service Agency
Provider of behavioral health services	Melissa Platte	Executive director	Mental Health Association
Provider of behavioral health services	Mary Bier	Coordinator	North County Outreach Collaborative
Public	Michael Lim	Commissioner	Behavioral Health Commission, Lived Experience Education Workgroup
Public	Paul Nichols	Commissioner	Behavioral Health Commission

[a] The Behavioral Health Commission's MHSA co-chairpersons termed out as of December 2024. New commissioners will be appointed starting February 2025.

STAKEHOLDER ENGAGEMENT

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

Representation Across Diverse Race/Ethnicity Demographics Groups

When race/ethnicity demographics of MHSA Steering Committee participants are compared with San Mateo County census data, there is a need to increase Hispanic/Latinx community representation. The most notable improvement is in the engagement of Asian/Asian American identifying communities, which were underrepresented by 15% in FY 2020–21 and are now underrepresented by 8%. This improvement has been supported by increased partnerships and contracts with Asian/Asian American serving organizations. Diverse communities are engaged in planning through the BHRS Office of Diversity and Equity (ODE) Health Equity Initiatives (HEIs), which are not represented in these data.

Exhibit 6 includes San Mateo County demographics and MHSA Steering Committee participant demographics for unique participants throughout FY 2023–24.

Exhibit 6. Comparison of San Mateo County and MHSA Steering Committee Demographics

San Mateo County race/ethnicity		MHSA Steering Committee race/ethnicity	
White alone, not Hispanic	37%	White or Caucasian	43%
Asian	30%	Asian Indian/South Asian, Chinese, Filipinx [a]	22%
Hispanic or Latino	24%	Hispanic or Latinx	14%
Black or African American	2%	Black or African American	8%
Native Hawaiian or Pacific Islander	1%	Native Hawaiian or Pacific Islander	4%
American Indian or Alaska Native	0.2%	Native American or Indigenous	0%
Two or more	5%	Two or more [a]	8%
Other	0.8%	Another race/ethnicity	1%

[a] Combined to allow for comparison as per MHSA legislation but represented uniquely in Exhibit 7. below.

MHSA planning continues to engage diverse communities through regional collaboratives—North County Outreach Collaborative (NCOC), the East Palo Alto Community Service Area, and the Coastside Collaborative—and through the ODE's HEIs. HEIs represent diverse cultural and ethnic groups including the African American Community Initiative (AACI), Chinese Health Initiative (CHI), Filipino Mental Health Initiative (FMHI), Latino/a/x Collaborative (LC), Native and Indigenous Peoples Initiative (NIPI), Pacific Islander Initiative (PII), PRIDE Initiative (PI), Spirituality Initiative (SI), and the Diversity and Equity Council (DEC).

MHSA Steering Committee Participant Demographics

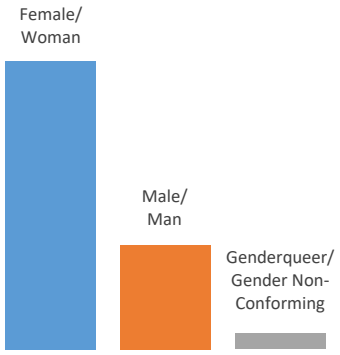
Combined for May 2024, September 2024, and December 2024

Exhibit 7. MHSA Steering Committee Participant Demographics

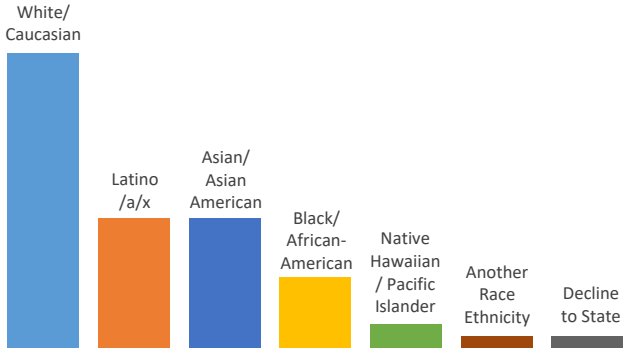
What is your age range?	
16–25 years	6%
26–59 years	75%
60–73 years	19%

What part of the county do you live in or work in?	
Central County	40%
North County	10%
South County	15%
Coastside	6%
Countywide	13%
East Palo Alto/Belle Haven	10%
N/A (outside of county)	6%

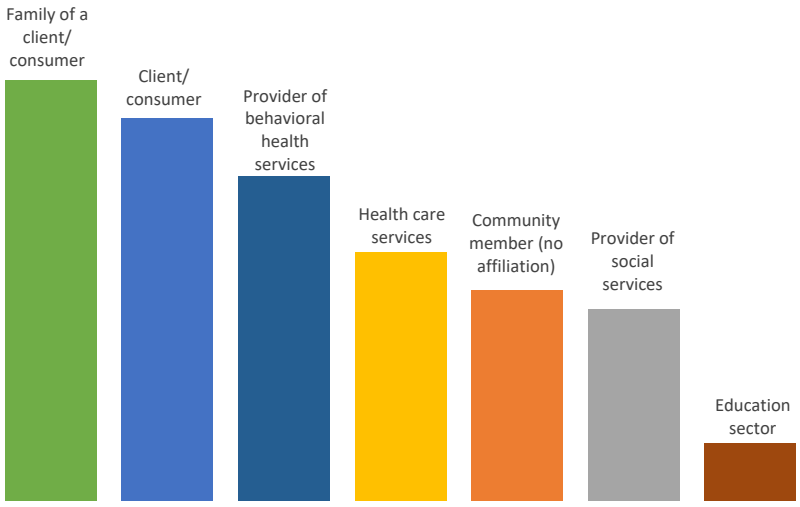
Gender Identity



Race/Ethnicity



Stakeholder Group



Peer, Client/Consumer, and Family Engagement in MHSA

MHSA is committed to engaging individuals with lived experience, clients, family members and peers, in planning, implementation, and evaluation activities. Participation and expertise of individuals with lived experience are promoted and compensated with stipends. During the FY 2023–24, a total of $24,150 or 805 stipends ($30 per stipend for up to 2 hours of participation in any one activity) were provided to clients and family members of clients participating in MHSA-funded activities, see Exhibit 8 below.

Exhibit 8. Stipends Provided to Individuals with Lived Experience

Activity (Fiscal Year 2023–24)	Stipend amount distributed	Number of unique recipients
Health Equity Initiatives	$7,680	51
Access test calls	$540	14
Advocacy Council	$3,600	22
Behavioral Health Commission Older Adult Committee	$120	3
Quality Improvement Committee	$30	1
Canyon Oaks Youth Center (COYC) surveys	$750	15
Lived Experience Education Workgroup	$4,560	54
Mental Health Month planning	$600	10
Health ambassadors focus group	$480	16
MHSA Three-Year Plan workgroup	$540	3
Youth crisis needs	$120	4
MHSA Steering Committee	$330	8
Youth Mental Health Pathways	$450	15
Recovery Happens planning committee	$1,920	14
Suicide Prevention Committee	$1,140	8
Youth Committee Roadmap workgroup	$30	1
Spanish family support group	$300	2
Department of Health Care Services audit	$60	2
Tech Café	$480	16
Housing Heroes	$90	3
Full-service partnership evaluation key informant interview	$330	11
Total	**$24,150**	**273**

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

The MHSA Annual Update for FY 2025–26 with program data from FY 2023–24 was presented to the BHC on March 5, 2025. The BHC voted to open a 30-day public comment period on March 5, 2025 and held a public hearing on April 2, 2025. The BHC reviewed the public comments received and voted to close the public comment period on April 5, 2024, and to submit the MHSA Annual Update to the Board of Supervisors. Please see Appendix 2 for the materials presented to the BHC and all public comments received.

The MHSA Annual Updates are submitted to the San Mateo County local Board of Supervisors for adoption and to the County of San Mateo Controller's Office to certify expenditures before final submission to the State of California Commission for Behavioral Health (CBH) and the Department of Health Care Services (DHCS).

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

- Announcements at internal and external community meetings
- Announcements to programs engaging diverse families and communities (HEIs, Health Ambassador Program [HAP], Lived Experience Academy [LEA], etc.)
- Emails disseminating information to an MHSA distribution list of more than 2,600 subscribers and ODE distribution list of more than 2,300 subscribers
- Word of mouth on the part of committed staff and active stakeholders
- Posting on the MHSA webpage (smchealth.org/MHSA) and the BHRS Blog (smcbhrsblog.org)

MHSA WORKGROUPS

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

MHSA OUTCOMES WORKGROUP

Between October and December 2024, an MHSA Outcomes Workgroup was convened, made up of diverse stakeholders including clients, family members, community members, service providers, and

BHRS staff, as can be seen on Exhibit 9. The workgroup met monthly with the goal of identifying direct treatment program outcomes to inform on the impact of MHSA-funded programs.

Exhibit 9. MHSA Outcomes Workgroup Members (12 were selected and attended)

Participant	Organization and/or affiliation	Stakeholder group
Adriana Furuzawa	Felton Institute, (re)MIND® Early Psychosis Programs	Provider of mental health services
Dan Foley	LifeMoves, San Mateo County Navigation Center	Client/family member; people living with disabilities; veterans organizations; our local unhoused population
Ivy Clark	No affiliation	Client/family member; people living with disabilities; faith-based organization; veterans; trans-parent, 8–10 years in shelters and encampments, housing voucher recipient, 20-year core agency client, St. Vincent de Paul client/safe house resident
Jean Perry	Behavioral Health Commission	Family member; older adult clients, clients with co-occurring intellectual disability
John McMahon	National Alliance on Mental Illness, San Mateo County, HelpLine	Client/family member; people living with disabilities
Jordan Anderson	No affiliation	Client/family member
Juliana Fuerbringer	Clubhouse Coalition California, California Clubhouse, Emerita, MHSA Steering Committee	Family member; provider of mental health services
Lanajean Vecchione	No affiliation	Client/family member; people living with disabilities; MHSA advocate and older adult
Lucianne Latu	Taulama for Tongans Pacific Islander Initiative San Mateo County Community Health Improvement Plan Mental Health Work Group San Mateo County Community Needs Assessment Coalition	Client/family member; people living with disabilities; health care; aging and adult services, Pacific Islander community, access to services, barriers to services related to the availability of linguistically and culturally appropriate services and resources
Melissa Platte	Mental Health Association of San Mateo County	Provider of mental health services; providers of other social services; housing; emergency, transitional, and permanent; housing assistance for people living with HIV/AIDS
Tamara Hamai	Hamai Consulting	Client/family member; have worked many providers, clients/consumers/families, education, and health care; expertise in human development and organizational effectiveness
Tarra Knotts	No affiliation	Client/family member; people living with disabilities; education

The MHSA Outcomes Workgroup was facilitated by an independent consultant, American Institutes for Research, with support from BHRS staff. Specific objectives of the group included the following:

- Develop a standardized framework for reporting on the outcomes of direct treatment programs funded by MHSA.
- Identify and define key indicators that capture behavioral health outcomes of clients in a meaningful and accessible manner.
- Discuss strategies for improving both the data collected and reporting of key indicators.

Participants provided input on the definitions of nine outcome measures: emergency utilization, employment, housing, connection, personal goals met, criminal justice involvement, hospitalization, substance use, and education. Workgroup members' input focused on the need to shift from deficit-based, crisis-focused indicators toward more holistic, person-centered measures of connection, wellness, and resilience, while also understanding the challenges of data collection and system constraints. In addition, facilitated dialogues provided opportunities to discuss data collection and reporting best practices. All MHSA Outcomes Workgroup meeting materials, including slides, minutes, and handouts, can be found on the MHSA website (www.smchealth.org/MHSA) under the Community Program Planning tab.

Key strategies for **improving data collection**:

1. In collaboration with stakeholders (e.g. clients, providers) develop a trauma and culturally informed best practice data collection plan and tools that cover all indicators:
    - Implement strategies to get meaningful feedback from clients, providers and stakeholders throughout the process of data collection, reporting and dissemination.
    - Develop and implement qualitative data collection tools (e.g., patient surveys, interview and focus group protocols) to capture clients' experience and engagement with a program.
    - Provide program staff with tailored implementation and technical assistance support.
    - Establish feedback loops with clients and program staff to get their input on data collection processes.
    - Share and disseminate results of data collection with clients and partner agencies.
2. Review the cadence of data collection processes:
    - Identify the optimal intervals for data collection once the baseline has been established.
    - Assess the optimal frequency of data collection and develop a plan for continuous improvement.
3. Integrate the County's "Inclusive Language Guidelines" into data collection processes.
    - Incorporate "Inclusive Language Guidelines" into all qualitative data collection tools (e.g. patient surveys, interviews and focus groups).

- Check if existing secondary data collection methods include options from the "Inclusive Language Guidelines." If necessary, consider adding new categories or modifying existing ones to better capture diverse identities.

Key strategies for improving **reporting of outcomes**:

1. Include a section in all BHRS reports that provides the purpose of the report and explains how the required performance indicators and goals align with this purpose.
2. Include narrative insights as well as qualitative data on clients' perspectives on engagement and program effectiveness.
3. Provide narrative context with all data tables and charts that include provider and client feedback and the reasons behind the outcomes.
4. Report referral data and goal completion data separately.
5. Incorporate stakeholder input on interpretation of findings before finalizing the report:
   - Ensure appropriate interpretation of the results, develop processes to gather input from providers, clients and other stakeholders on results and conclusions before finalizing the report.
6. Develop best practices around utilization of results for continuous improvement:
   - Consider providing technical assistance (e.g., coaching on how to use results of data analysis) to providers based on results of the report.
   - Use the results of data analysis to improve client engagement.

MHSA INNOVATION PROJECT PLANNING

With the availability of funding for new INN projects through the remainder of the current MHSA Three-Year Plan, BHRS sought to identify potential INN projects that would meet current needs and align with the priorities of Proposition 1 – Behavioral Health Service Act (BHSA).

- BHRS staff reviewed the fourteen ideas that had been pre-screened in 2022 as part of a community participatory process to gather a broad solicitation of innovation ideas. The ideas were reviewed against new Innovation requirements given Prop. 1 – BHSA changes and five projects were identified as meeting the required components of early intervention, treatment, and/or recovery.
- BHRS then conducted an internal feasibility review of the five projects and determined to move forward with two of the five INN proposals based on BHRS capacity and priorities for the Prop. 1 – BHSA transition.

On September 5, 2024, the MHSA Steering Committee met to review the two community-derived INN ideas, and the two multi-county collaborative projects, and provide comment and considerations for the projects through breakout room discussions and online comment forms. The Behavioral Health

Commission (BHC) voted to open the 30-day public comment period on October 2, 2024 and held a public hearing at closing of the public comment period on November 6, 2024.

The projects were approved by the Commission for Behavioral Health (CBH) on February 27, 2025. Request for Proposal process will follow to support an open procurement process for the relevant projects. The 4 INN project plans and all public comments received were submitted to CBH and DHCS as an Amendment to the FY 2024-25 MHSA Program and Expenditure Plan.

1. *Peer Support for Peer Workers.* Total amount proposed: $580,000 for 4 years ($450K service delivery, $55K BHRS administration, $75K evaluation). The project creates a team of trained peers to provide on-demand peer support services for peers and family members in the workforce. The project supports behavioral health workforce development priorities as peer and family support specialists are supported, stable and well, leading to higher job satisfaction and retention rates, better work-life balance, improvement in services provided, and a decrease in burnout, vicarious trauma, and compassion fatigue.

2. *Animal Fostering and Care for Client Housing Stability and Wellness.* Total amount proposed: $990,000 ($870K service delivery for 3 years, $120K evaluation). The project will provide temporary animal foster care, veterinary and pet support services as needed by adult and older adult clients living with serious mental illness (SMI) and/or substance use disorders (SUD) for whom animal care is an urgent and temporary barrier to receiving a higher level of care such as residential treatment or hospitalization or maintaining their housing stability and wellness.

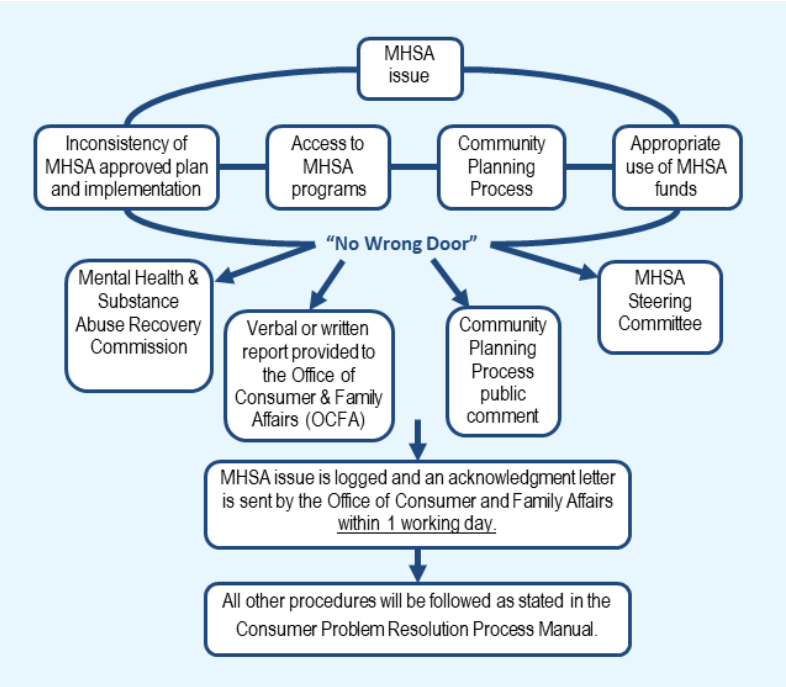
3. *allcove Half Moon Bay.* Total amount proposed: $1,600,000 for 4 years $1.5M service delivery for 3 years, $100K BHRS administration, evaluation to be provided by Stanford as part of the multi-county collaborative). This youth-focused “one-stop-shop” health center for youth ages 12 to 25 living in the coastside region of San Mateo received a grant to support start-up costs. Local INN funding will supplement and support the delivery of mental health support groups, individual therapy and other early intervention treatment services at the center.

4. *Progressive Improvements for Valued Outpatient Treatment (PIVOT) – developing capacity for MediCal billing.* Total amount proposed $5,650,000 for 5 years ($5M service delivery for 5 years, $200K BHRS administration, $450K evaluation). The project will support community-based organizations that are interested become certified providers of specialty mental health services (SMHS) for individuals living with serious mental illness (SMI) or substance use disorders (SUD) and/or bill MediCal for allowable for peer support and early intervention services. The project has the potential to support the sustainability of critical Community-Defined Evidence Practices (CDEPs) by identifying billable components of CDEPs.

MHSA ISSUE RESOLUTION PROCESS

The MHSA Issue Resolution Process resolves process-related issues with (a) the MHSA community program planning process, (b) consistency between approved MHSA plans and program implementation, and (c) the provision of MHSA-funded programs.

Exhibit 10. MHSA Issue Resolution Process



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

For the FY 2023–24 reporting year of this MHSA Annual Update, there were nine quality-of-care-related grievances filed with the BHRS OCFA for MHSA-funded programs, as can be seen in Exhibit 11. There were no MHSA process-related grievances.

Exhibit 11. Types, Number and Outcome of Grievances

Type of grievance (Fiscal Year 2023–24)	Number of grievances	Outcome (from the client's perspective: was the outcome favorable, partially favorable, not favorable?)
Access: services not available	2	1 favorable, 1 partially favorable
Case management: assessment, care, or process concerns	2	1 favorable, 1 unfavorable
Customer service: interactions with plan services concerns	0	Not Applicable
Quality of care: effectiveness, efficiency, acceptability concerns	5	3 partially favorable, 2 unfavorable
Abuse, neglect, exploitation: potential or actual client harm	0	Not Applicable
Other reasons	0	Not Applicable

Photo: BHRS Workforce Education and Training

FISCAL SUMMARY

FISCAL SUMMARY

This Fiscal Summary section includes MHSA funding requirements and locally developed guiding principles, history of revenues and expenditures, available unspent funds, reserve amounts, reversion projections, new funding allocations, and ongoing priorities. See Appendix 3 for the FY 2025–26 Funding Summary by component.

MHSA FUNDING REQUIREMENTS

MHSA-funded programs and activities are grouped into components, each one includes a required funding allocation and reversion period, see Exhibit 12. Reversion period is the length of time a County must spend MHSA revenues received before the funds revert back to the State.

Exhibit 12. MHSA Component and Category Funding Allocation Requirements

Component	Category	Funding allocation	Reversion period
Community Services and Supports (CSS)	Full-service partnerships (FSPs) General systems development Outreach and engagement	76% (51% of CSS must be allocated to FSP)	3 years
Prevention and Early Intervention (PEI)	Early intervention Prevention Recognition of signs of mental illness Stigma and discrimination Access and linkages	19% (51% of PEI must be allocated to program serving ages 0–25 years)	3 years
Innovation		5%	3 years

In addition, counties received one-time allocations in three additional components, listed in the Exhibit 13. Locally, ongoing annual and one-time allocations are prioritized to sustain the work in these components, as per the following guidelines:

- Up to 20% of the average 5-year Community Services and Supports (CSS) component revenue can be allocated to Workforce Education and Training (WET), Capital Facilities and Technology Needs (CFTN), and prudent reserve.
- A maximum of 33% of the average 5-year CSS revenue may fund the prudent reserve.
- Up to 5% of the total MHSA annual revenue may be spent on administration and community planning processes.

Exhibit 13. Other MHSA Components Funding Allocations

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

MHSA FUNDING PRINCIPLES

MHSA Funding Principles build from the San Mateo County Health department budget balancing principles to guide MHSA reduction and allocation decisions when needed. The MHSA Funding Principles were presented to the MHSA Steering Committee in September 2018 for input and comment given a budget reduction planning throughout the county that was expected to have implications for MHSA funding. These Funding Principles continue to lead budget decisions.

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

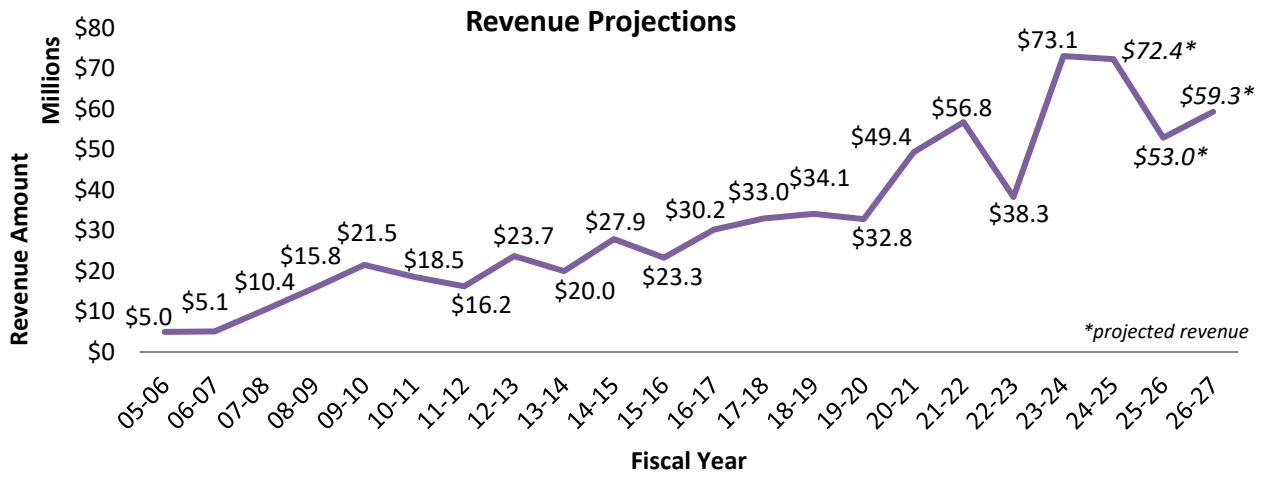
MHSA ANNUAL REVENUE GROWTH

Statewide, MHSA represents slightly less than one third of community mental health funding. In San Mateo County, MHSA represents about 15% of BHRS revenue.

MHSA funding is based on various projections that consider information produced by the State Department of Finance, analyses provided by the California Behavioral Health Directors Association, and ongoing internal analyses of the state's fiscal situation. Exhibit 14 shows annual revenue allocation for San Mateo County since inception. The factors that impacted the decreases and increases in revenues throughout the years are as follows:

- FY 2005–06 and FY 2006–07: CSS funding only.
- FY 2007–08 and FY 2008–09: PEI and INN funding were released in those years, respectively.
- FY 2010–11 and FY 2011–12: Decrease due to California recession of 2009.
- FY 2012–13: Increase due to a one-time allocation as counties shifted to receiving monthly MHSA allocations based on actual accrual of tax revenue (Assembly Bill 100).
- FY 2014–15: Increase due to a one-time adjustment from changes in the tax law that took effect on January 1, 2013 that led to many taxpayers filing in December 2012.
- FY 2019–20: Decrease due to "No Place Like Home" initiative (Assembly Bill 1618) which diverted MHSA revenue growth funds. In addition, there was a tax filling extension to July 2020 due to COVID-19 pandemic.
- FY 2020–21 and FY 2021–22: Increases due to 2020 delayed tax filing and increase in millionaire revenues as a result of the COVID-19 pandemic.
- FY 2023–24: Increase due to unprecedented one-time adjustment from delayed tax filings and reconciliation of actual revenues received from taxpayers during the COVID-19 pandemic.
- FY 2024–25: Higher than anticipated revenue due to a one-time allocation from unspent State MHSA reserves.
- FY 2025–26: Decrease as annual revenue allocations settle.
- FY 2026–29: Counties will receive a baseline revenue amount (to be determined) for three years as a revenue stability strategy.

Exhibit 14. MHSA Revenue Growth



FISCAL CONSIDERATIONS

Proposition 1 (Behavioral Health Transformation) —Local Impact

The recent passage of California's Proposition 1, in March 2024, introduced significant changes to the MHSA funding allocations.

Proposition 1 emphasizes increasing residential treatment facilities and supportive permanent housing for individuals living with serious mental illness and/or substance use disorders, enhanced integration of substance use and mental health services, and robust fiscal accountability and outcome reporting for behavioral health departments and their networks of contracted providers. The proposition was comprised of two legislative measures—Senate Bill 326 (Eggman) and Assembly Bill 531 (Irwin). **Assembly Bill 531** authorizes $6.38 billion in bond funding for behavioral health treatment facilities and supportive housing as described further in Exhibit 15 below.

Exhibit 15. Proposition 1 – Assembly Bill 531 Obligation Bond Funding Allocations

Assembly Bill 531 Obligation Bond Funding	
$2.893 billion	Grants for behavioral health treatment and residential facilities, including acute and subacute facilities, are encompassed under the Behavioral Health Continuum Infrastructure Program. Cities, counties, and tribes may apply for these grants.
$1.5 billion	Grants specifically for counties, cities, and tribal entities for behavioral health treatment and residential facilities including acute and subacute facilities, encompassed under the Behavioral Health Continuum Infrastructure Program.
$1.065 billion	Loans or grants to develop supportive housing for veterans or their households who are homeless, chronically homeless, or at risk of homelessness.
$922 million	Loans or grants to develop supportive housing for persons who are homeless, chronically homeless, or at risk of homelessness and are living with a behavioral health challenge.

Senate Bill 326 renames the MHSA as the Behavioral Health Services Act (BHSA) and reforms funding allocation and accountability requirements as follows:

- Requires funding to be inclusive of substance use without a primary mental health diagnosis and inclusive of involuntary treatment.
- Requires new local funding allocations:

30% housing interventions (e.g., rental and operating subsidies, nonfederal share of rent, housing retention/maintenance, some capital investments)

  - 51% to chronically homeless populations

35% FSPs

35% behavioral health services and supports

  - 51% to early intervention services

Can transfer up to 7% from any one category to another

- Imposes new fiscal and performance outcome reporting requirements for all behavioral health service revenues (i.e., federal, state, and local funding) and broadens the 3-year planning process to include county/regional planning, managed care plans, private insurance, and other sectors.
- Redirects additional funds to the state: 10% of annual revenues (currently 5%) for administration as well as statewide behavioral health workforce initiatives and population-based prevention and $20 million to establish the BHSA Innovation Partnership Fund.

BHSA Policy Manuals are being developed by the Department of Health Care Services (DHCS) to provide counties with guidance necessary to implement BHSA including planning, reporting, fiscal, and program implementation requirements. The policy manual will be updated on a continual basis. As of the publishing of this report, the final policy manuals have not been shared with counties.

BHSA Revenue Stability Workgroup is being convened by the California Health and Human Services (CalHHS) and DHCS jointly to assess year-over-year fluctuations in tax revenues and create a more stable and predictable revenue stream for counties. An annual revenue baseline will be established to build the BHSA Three-Year Integrated Plan and require counties to spend at least the baseline revenue each fiscal year. As of the publishing of this report, this revenue baseline has not been shared with counties.

Given these unknows and final guidance on BHSA revenues and program requirements, the MHSA Three-Year Plan funding priorities remains with no additional expansions and all MHSA-funded programs and services will continue through June 30, 2026. Starting FY 2026–27, funding will be redirected from current MHSA allocations to meet the new funding requirements—as demonstrated in Exhibit 16.

Exhibit 16. Proposition 1 – Categories and Funding Allocations

BHSA funding allocation category [a]	BHSA amount	Current MHSA amount	Amount to meet requirement
Housing interventions (30%)	$18,973,907	$10,012,430	$8,961,477
Full-service partnerships (32%)	$20,238,834	$19,004,082	$1,234,753
Behavioral health services and supports—early intervention (19.4%)	$12,257,144	$10,279,745	$1,977,399
Behavioral health services and supports—other services (18.6%)	$11,776,472	$18,438,259	($6,661,787)
Administrative expansions	$1,655,080	0	$1,655,080

[a] Estimates are subject to change on the basis of further guidance from the Department of Health Care Services on what is allowable and not allowable in the Behavioral Health Services Act (BHSA) funding categories. The amounts in the table are based on the current FY 2025–26 Mental Health Services Act (MHSA) proposed ongoing budget, leveraging transfer allowances between categories; the actual funding amounts will depend on future revenues. [b] Estimated impact to the overall MHSA budget is based on the new 10% of revenue state allocation.

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

- $5.6 million (32%) from outpatient treatment programs.
- $3.0 million (100%) from population-based prevention programs.
- $1.4 million (28%) from innovation projects that do not meet criteria.

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

- Restructuring programs to meet the new funding requirements.
- Identifying alternate funding sources.
- Planning for new positions, capacity development, and/or restructuring of workloads to support the significant expansions to planning, fiscal, and performance outcome reporting requirements.

Decisions related to restructuring programs and/or termination of any services due to the passing of Proposition 1 will be informed through a comprehensive Community Program Planning (CPP) process to launch early in 2025. This process will consider program outcomes, equitable impact, new funding requirements, and guidance from DHCS and engage stakeholders, community-based organizations (CBOs), the Behavioral Health Commission, and the Board of Supervisors.

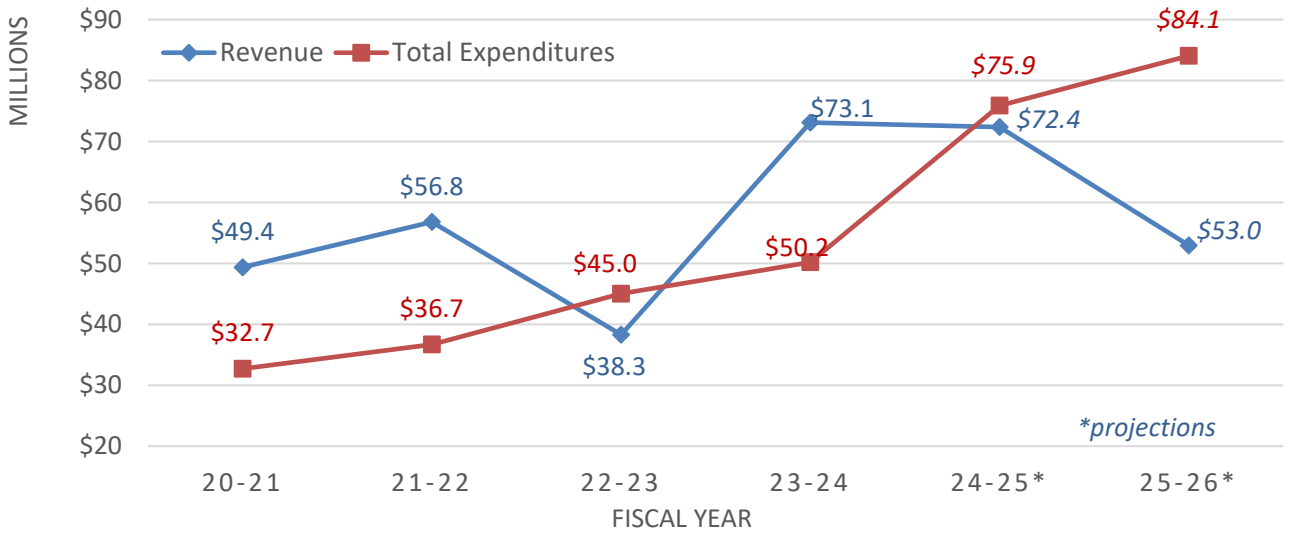
Ongoing Over-Revenue Budget Strategy

San Mateo County's budgeting strategy typically targets the 5-year average revenue, to maintain sufficient expenditures, to avoid reversion, and to not overcommit revenues. Starting FY 2021–22, the strategy shifted to an over-revenue budget. This allows us to spend down unprecedented high revenues received. The proposed ongoing budget for FY 2025–26 is $68.1 million. The projected 5-year average revenue through FY 2025–26 is $58.6 million.

Exhibit 17 below depicts MHSA revenue in blue and total expenditures (including one-time allocations) in red, per FY. Ideally, counties are spending at the same rate as they are receiving

revenues, yet annual MHSA revenue distributions are volatile and often difficult to project. For example, at the start of the COVID-19 pandemic, a recession was projected. Counties across the state immediately shifted their expenditure plans to either reduce programs or keep the ongoing budget status quo for FY 2020–21, as was the case in San Mateo. Actual revenues increased that year, through FY 2021–22, and led to an unprecedented significant one-time adjustment in FY 2023–24, nearly doubling the revenue received. In FY 2024–25 one-time increased revenues will continue due to the reallocation of unspent State MHSA reserves.

Exhibit 17. MHSA Revenue and Expenditures, Fiscal Year (FY) 2020-21 to FY 2025-26



One-Time Spend Plan Strategy

Planning for one-time funding is another strategy used to spend down unanticipated revenue increases and lower than budgeted expenditures. Exhibit 18 displays an analysis of funding availability for one-time spending. Even though we are spending at a high rate, the increase in unallocated funds at end of each fiscal year is due to significant unprecedented one-time adjustments from the state in FY 2023–24 and FY 2024–25. Given the unknowns in revenue stability and program requirements these unallocated funds can help reconcile our high ongoing budget vs. revenue baselines counties will receive as part of the BHSA transition.

Exhibit 18. MHSA Annual Unspent, Fiscal Year (FY) 2023–24 to FY 2025–26

Annual unspent at end of fiscal year			
	FY 2023–24	FY 2024–25[a]	FY 2025–26[a]
Projected revenue	$73,469,859	$72,368,590	$52,950,164
Ongoing budget expenditures	$44,482,117	$59,691,785	$67,483,081
One-time plan expenditures	$5,698,375	$16,203,000	$16,532,900
Trust fund balance	$98,167,162	$94,640,967	$63,575,150

Annual unspent at end of fiscal year			
	FY 2023–24	FY 2024–25[a]	FY 2025–26[a]
Obligated funds:	$69,233,017	**$56,981,270**	**$40,817,171**
Reserve	$28,362,318	$28,362,318	$28,362,318
Innovation encumbered	$11,122,355	$9,685,327	$9,554,128
Workforce Education and Training encumbered	$1,351,719	$1,740,000	$2,240,000
$39 million One-Time Spend Plan	$28,396,625	$17,193,625	$660,725
Available for one-time planning	***$28,934,145***	***$37,659,697***	***$32,267,101***

[a]FY 2024–25 and FY 2025–26 are projections based on the 2025–26 Governor's January Budget.

The FY 2023–26 MHSA Three-Year Plan included a process for identifying "big-ticket" items for a $34 million one-time spend plan. The FY 2024–25 Annual Update increased the one-time spend plan by $5M for the development of supportive housing units and an Amendment to the FY 2024–25 Annual Update reallocated clinic renovation funds for a clinic facility purchase. The "big-ticket" item categories include (a) housing developments, (b) capital facilities, (c) technology, and (d) system transformation projects. Implementation of this $34 million one-time plan will continue through FY 2025–26. Exhibit 19 represents an updated plan based on expenditures to date:

Exhibit 19. MHSA One-Time Spend Plan, FY 2023-24 through FY 2025-26

MHSA One-Time Spend Plan						
Priority	Item	FY 2023–24 Actual	FY 2024–25 Estimated	FY 2025–26 Projected	Total	Description
Housing	Hotel/property acquisition		$2,300,000	$3,700,000	**$6,000,000**	Hotels/properties for transitional and/or supportive housing
	Supportive housing units	$5,000,000	$5,000,000	$5,000,000	**$15,000,000**	25 supported units for Behavioral Health and Recovery Services (BHRS) clients via Department of Housing Affordable Housing Notice of Funding Availability
	Board and care buyout			$1,800,000	**$1,800,000**	Behavioral Health Continuum Infrastructure Grant—10% match required
Capital facilities	Clinic renovations			$1,800,000	**$1,800,000**	Renovations focused on improving safety at BHRS clinical sites.
	South County Clinic			$3,800,000	**$3,800,000**	South County Clinic property purchase
	Methadone clinic			$0	**$0**	Behavioral Health Continuum Infrastructure Grant—10%

MHSA One-Time Spend Plan						
Priority	Item	FY 2023–24 Actual	FY 2024–25 Estimated	FY 2025–26 Projected	Total	Description
						match; on Veterans Administration campus in Menlo Park with Santa Clara County
	Youth crisis stabilization and crisis residential			$0	**$0**	Behavioral Health Continuum Infrastructure Grant—applying until Round 6
	2191-95 El Camino Real property renovations	$145,522	$200,00	$0	**$345,522**	Newly purchased property to be used by California Clubhouse, and security enhancements
Technology needs	Asset refresh	$146,947	$400,000	$540,000	**$1,086,947**	Computer/phone refresh and service coverage for BHRS
System transformation	Trauma-Informed Systems	$4,000	$110,000	$220,900	**$334,900**	Estimated cost for limited-term position services for trauma-informed and employee wellness supports
	Youth Crisis Continuum of Care consultant	$204,040	$100,000		**$304,000**	Estimated cost for consultant services to assist with BHRS Youth Crisis Continuum of Care
	Early Childhood, Children and Youth Collaborative	$64,786		$850,000	**$914,786**	Early Childhood Mental Health Network: expansion of trauma-informed services and San Mateo County Collaborative for Children and Youth: to design countywide plan
	Contractor infrastructure		$600,000	$1,900,000	**$2,500,000**	Infrastructure and training support for contracted providers to advance equity priorities and California Advancing and Innovating Medi-Cal payment reform
	Communications	$133,080	$193,000	$132,000	**$458,080**	Behavioral Health Services public awareness campaigns
Grand totals		**$5,698,375**	**$8,903,000**	**$19,742,900**	**$34,344,275**	

Total Operational Reserve

Counties are required to establish a prudent reserve to ensure that the county programs will be able to serve clients, should MHSA revenues drop. The California Department of Health Care Services Information Notice 19-017, released on March 20, 2019, established an MHSA prudent reserve level that does not exceed 33% of the 5-year average CSS revenue received. For San Mateo County, this corresponds to $8,879,780, of which $4,755,145 was transferred to the prudent reserve in FY 2021–22 and $600,000 in FY 2008–09. The remaining may be transferred in FY 2024–25 pending amount of revenue received and analysis of new prudent reserve requirements from Proposition 1–BHSA. Only 20% of the MHSA 5-year revenue average can be transferred to the prudent reserve, CFTN, and WET in a given year.

In addition, per the FY 2019–20 MHSA Annual Update, the MHSA Steering Committee, the BHC (local mental health board), and the Board of Supervisors reviewed and approved a recommended total operational reserve of 50% (prudent reserve + additional operating reserve) of the highest annual revenue for San Mateo County, which currently equals $28,362,318. The additional operational reserve is maintained with local unspent funds. This allows the flexibility in budgeting for short-term fluctuations in funding without having to go through the state's administrative process to access the prudent reserve, in the event that revenue decline is less than the state's threshold or funding is needed in a timely manner. Given the anomaly projected revenue increase in FY 2023–24, the recommendation is to keep the operational reserve at the $28,362,318 level.

Reversion

MHSA legislation requires that MHSA funding under the key components (CSS, PEI, and INN) be spent within 3 years, or it must be returned to the state for reallocation to county behavioral health statewide. San Mateo County's annual MHSA spending in CSS and PEI targets the 5-year average revenue and more recently is over revenue to avoid reversion. As long as the budget amount is expended as planned, there is no risk of reversion for CSS and PEI. For the INN component, Assembly Bill 114 established that the 3-year reversion time frame for INN funds commence upon approval of the project plans. Whereas this minimized the reversion risk for funds accrued while planning for new INN projects and/or awaiting approval by the Commission for Behavioral Health, San Mateo County estimates $27,116 to revert as of FY 2023–24. This is because of lower expenditures than anticipated for INN projects at start-up, as projects require time to become fully staffed and running.

Housing Funds

DHCS Information Notice 16-025 required counties to complete an *Ongoing Fund Release Authorization* for both existing and future unencumbered San Mateo County MHSA Housing Program funds (e.g., funds that are no longer required by a housing project, accrued interest, and/or other funds received on behalf of the counties). Funds will be released annually to counties with a 3-year reversion term. The MHSA Housing Initiative Taskforce prioritized these funds to support ongoing "housing assistance" in the form of flexible funding for clients for housing-related expenses (moving costs, deposits, first month's rent). These unencumbered housing funds will be used for this flexible fund.

SUMMARY OF FISCAL PRIORITIES

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

- Continue implementing the $39 million one-time spend plan through FY 2025–26.
- Continue implementing the MHSA ongoing budget total of $67.5 million and priorities:

FSPs including Community Assistance, Recovery, and Empowerment (CARE) Court FSP and FSP housing supports.

Behavioral health workforce priorities related to workforce capacity development and recruitment and retention strategies.

PEI priorities related to improving access to services specifically for youth and the Chinese community and implementing crisis continuum priorities and substance use prevention strategies.

See Appendix 3 for the FY 2025–26 Annual Update Funding Summary by component.

Photo: Navigation Center of San Mateo County, Redwood City, CA

ANNUAL UPDATE
FY 2025–26

(Includes highlights and data from FY 2023–24 programs)

MHSA ANNUAL UPDATE FY 2025–26 (DATA FROM FY 2023–24)

Welfare and Institutions Code Section § 5847 states that county mental health programs shall prepare and submit an Annual Update for MHSA programs and expenditures. The Annual Update includes any changes to the plan and expenditures. This Annual Update will focus on presenting the latest set of full FY 2023–24 data, including program and fiscal planning highlights and updates, grievance data, program outcomes, and evaluation reports.

Photo: Individualized Medication-Assisted Treatment

COMMUNITY SERVICES AND SUPPORTS (CSS)

FULL SERVICE PARTNERSHIP (FSP) PROGRAMS

FSP programs do "whatever it takes" to serve medically fragile older adults, adults, transitional-age youth (TAY), and children, youth, and their families who are living with serious mental health challenges and help them on their path to recovery and wellness. FSPs include services that are available 24 hours a day, 7 days a week; peer supports; high staff-to-client ratios for intensive behavioral health treatment including medications; linkage to housing; supported education and employment; treatment for co-occurring disorders; and skills-based interventions.

In San Mateo County, FSP programs are contracted out. Edgewood Center and Fred Finch Youth & Family Services serve children, youth, and TAY using the California Department of Social Services' (CDSS) Wraparound Services Program for Children (Wraparound),[2] and Caminar and Telecare serve adults, older adults, and their families.

Exhibit 20 includes cost per client and cost per slot for FSP programs. These costs 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 or supportive services provided.

Exhibit 20. Full Service Partnership (FSP) Program Costs

FSP Program	FY 2023–24 FSP slots	FY 2023–24 clients served	Cost per client [a]	Cost per slot
Child/youth FSPs				
Out-of-county foster care settings FSP	10	6	$55,766	$18,080
Integrated FSP—Short-Term Adjunctive Youth and Family Engagement	30	53	$25,549	$31,116
Comprehensive FSP—Turning Point	40	53	$64,661	$55,970
Transition-age youth FSPs				
Comprehensive FSP—Turning Point	50	59	$12,829	$54,657
Adult/older adult FSPs				
Adult and older adult/medically fragile FSP	207	238	$3,582	$10,706
Caminar comprehensive FSP	50	30	$23,807	$14,548
Caminar assisted outpatient treatment FSP	30	62	$17,361	$40,873
South County Clinic embedded FSP	15	20	$7,600	$5,018

[a] Calculated on the basis of clients served during the fiscal year (FY) and the MHSA funding contribution only (not including housing); this is not representative of the full cost of providing services. There are also reimbursements and other revenue sources associated with full-service partnerships (FSPs) that may decrease the final MHSA funding contribution.

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

FSP OVERALL DEMOGRAPHICS

The following Exhibits 21-31 include demographic data for all FSP clients and for child/youth, TAY and Adult/Older Adult FSP clients, across all providers.

Exhibit 21. Percentage of All FSP Clients by Age (*n* = 501)

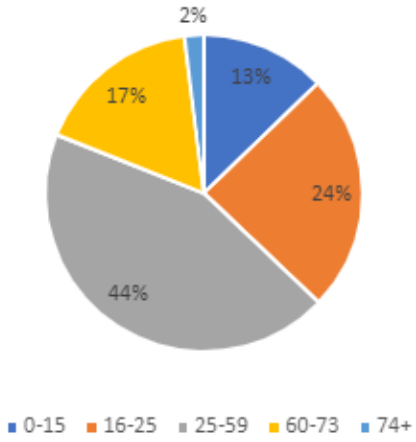


Exhibit 22. Percentage of All FSP Clients by Gender (*n* = 501)

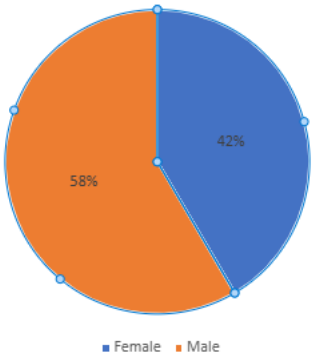


Exhibit 23. Percentage of All FSP Clients by Primary Language (*n* = 501)

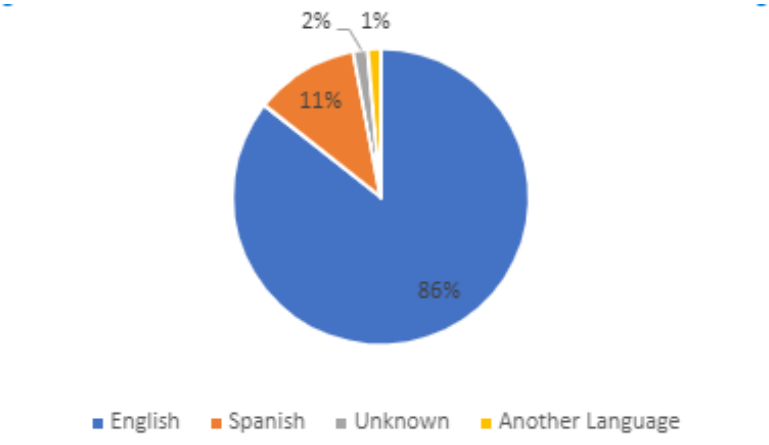


Exhibit 24. All FSP Clients by Race/Ethnicity

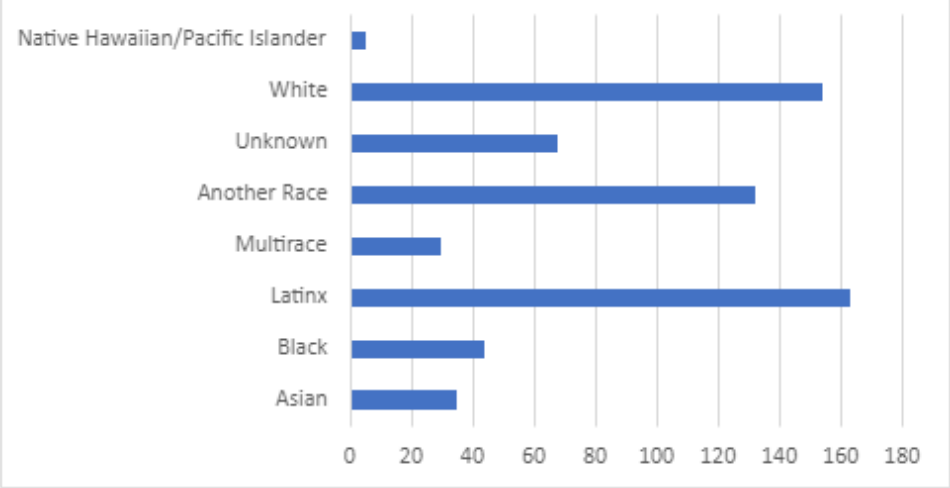


Exhibit 25. Child/Youth and TAY FSP Client Demographics

FY 2023–24 (total clients = 186)

Percentage of FSP clients by ethnicity	
Hispanic or Latino	54
Not Hispanic or Latino	29
Unknown/not reported	17

FY 2023–24 (total child/youth clients = 64)

Percentage of child/youth FSP clients by ethnicity	
Hispanic or Latino	58
Not Hispanic or Latino	26
Unknown/not reported	16

FY 2023–24 (total TAY clients = 122)

Percentage of TAY FSP clients by ethnicity	
Hispanic or Latino	55
Not Hispanic or Latino	27
Unknown/not reported	18

Exhibit 26. Child/Youth (0–15 Years) FSP Clients by Race/Ethnicity

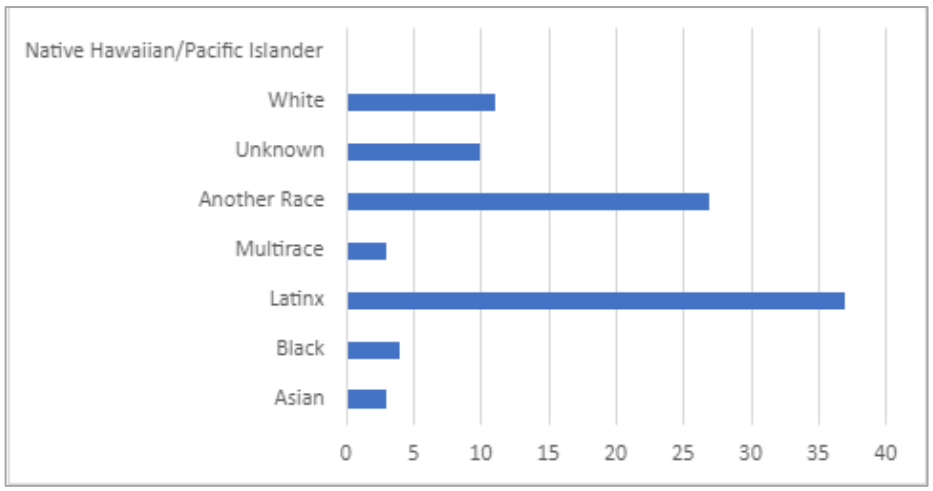


Exhibit 27. TAY (16–25 Years) FSP Clients by Race/Ethnicity

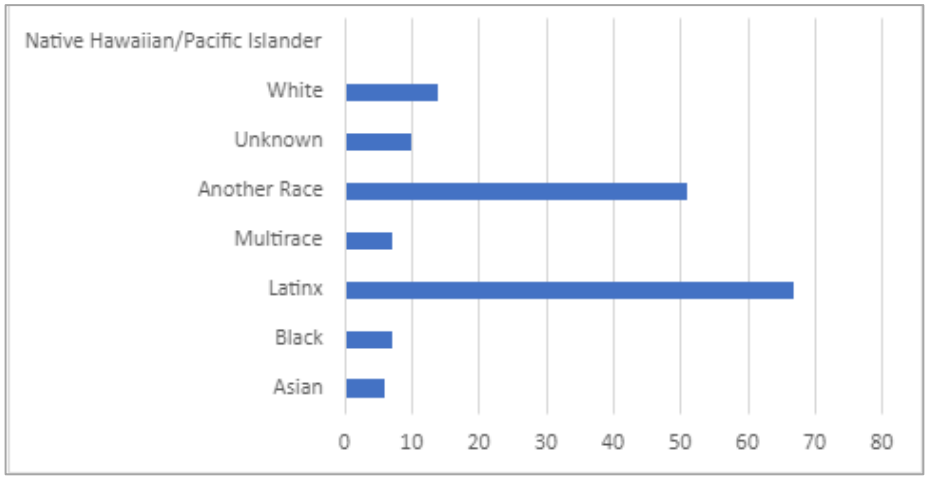


Exhibit 28. Adult and Older Adult FSP Client Demographics

FY 2023–24 (total clients = 315)

Percentage of adult FSP clients by ethnicity	
Hispanic or Latino	33
Not Hispanic or Latino	56
Unknown/not reported	11

FY 2023–24 (total clients ages 26–59 years = 220)

Percentage of FSP clients by ethnicity	
Hispanic or Latino	21
Not Hispanic or Latino	65
Unknown/not reported	14

FY 2023–24 (total clients ages 60–73 years = 85)

Percentage of FSP clients by ethnicity	
Hispanic or Latino	13
Not Hispanic or Latino	82
Unknown/not reported	5

FY 2023–24 (total clients ages 74+ years = 10)

Percentage of FSP clients by ethnicity	
Hispanic or Latino	20
Not Hispanic or Latino	80
Unknown/not reported	0

Exhibit 29. Adult (ages 26–59) FSP Clients by Race/Ethnicity

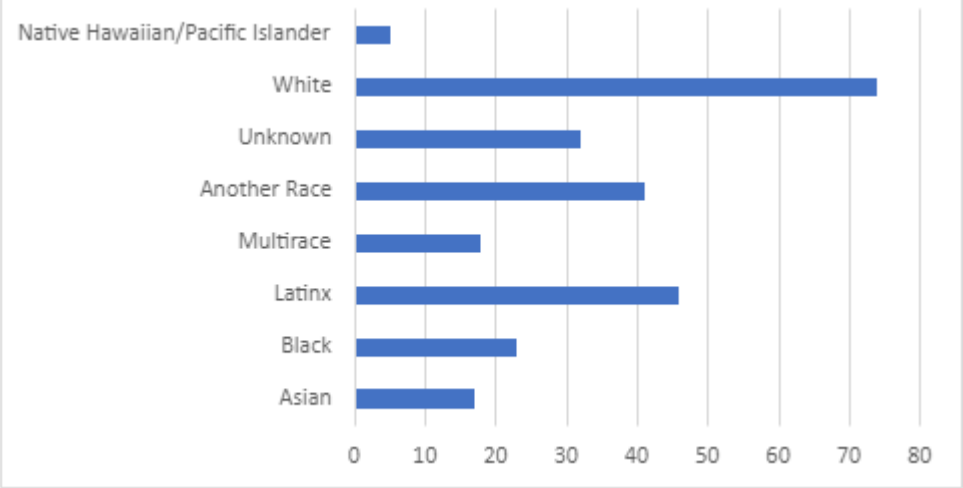


Exhibit 30. Adult (ages 60–73) FSP Clients by Race/Ethnicity

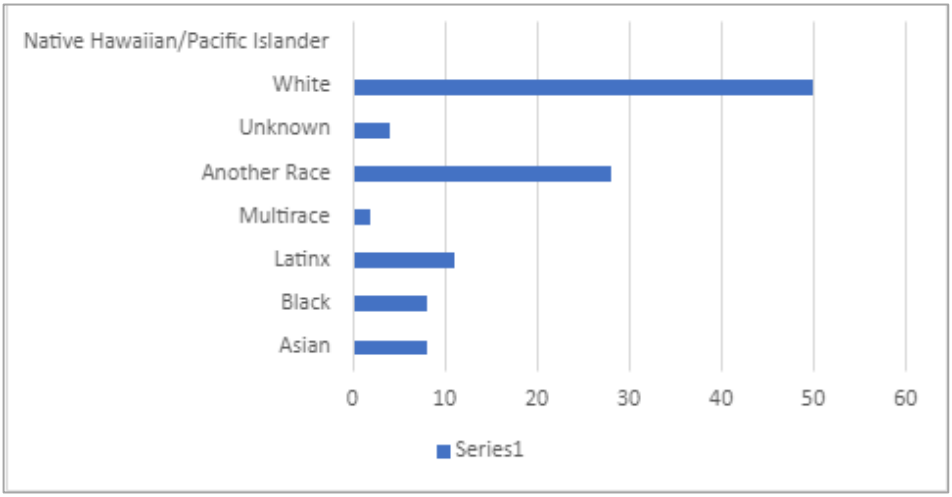
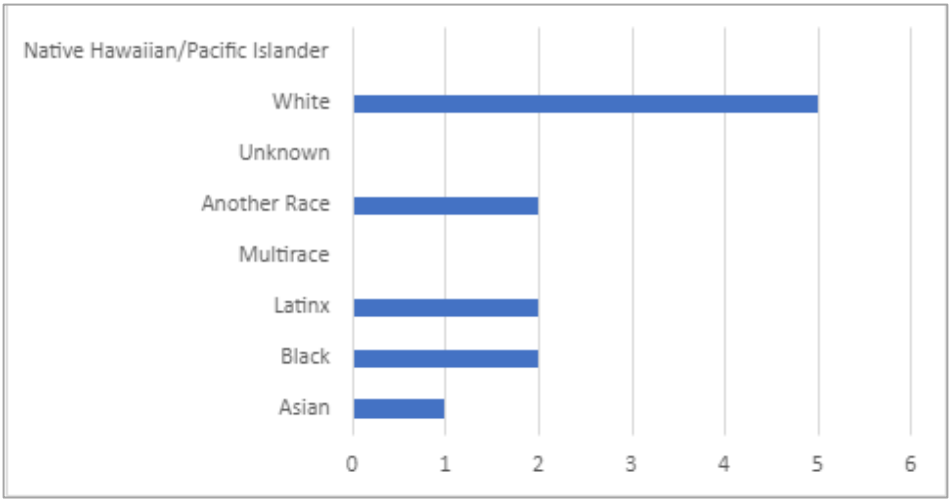


Exhibit 31. Adult (ages 74+) FSP Clients by Race/Ethnicity



FSP OVERALL OUTCOMES

As part of San Mateo County's implementation and evaluation of the FSP programs, an independent consultant analyzes FSP data to understand how enrollment in the FSP is promoting resiliency and improved health outcomes of clients living with a mental illness. Year-to-year outcomes are tracked for individual clients in FSPs. Information collected for FSPs includes data in 10 domains: residential status (e.g., unhoused, emergency shelter, apartment alone), criminal justice involvement (e.g., detention, incarceration), education (e.g., school enrollment and graduation, completion dates, grades, attendance, special education assistance), employment, financial support, legal issues, emergency interventions (e.g., physical health emergencies, psychiatric emergency services [PES], and hospitalizations), health status, substance use, and for older adults, activities of daily living. Data from FSP participants are collected by providers via self-reported intake assessment, key event tracking, and 3-month assessments. See Appendix 4 for the complete FSP Evaluation Report for FY 2023–24. The following Exhibits 34–35 present a highlight of the percentage improvement between the year just prior to FSP and the first year with FSP, by age group. Client stories are shared in the specific program outcome sections.

Exhibit 34. Percentage Change in Outcomes Among FSP Adults and Older Adults

FSP outcome	Adults (25–59 years)			Older adults (60 years and older)		
	Year before	Year after	Change	Year before	Year after	Change
Self-reported outcome	***N* = 118**			***N* = 24**		
Homelessness	48 (41%)	35 (30%)	–27%	5 (21%)	4 (17%)	–20%
Detention or incarceration	35 (30%)	22 (19%)	–37%*	3 (13%)	3 (13%)	0%
Employment	1 (1%)	6 (5%)	500%	0 (0%)	0 (0%)	NA
Arrests	20 (17%)	4 (3%)	–80%*	3 (13%)	1 (4%)	–67%
Mental health emergencies	87 (74%)	33 (28%)	–62%*	13 (54%)	4 (17%)	–69%*
Physical health emergencies	50 (42%)	17 (14%)	–66%*	6 (25%)	4 (17%)	–33%
Active SUD	63 (53%)	60 (51%)	–5%	5 (21%)	5 (21%)	0%
SUD treatment	28 (24%)	33 (28%)	18%	3 (13%)	2 (8%)	–33%
Health care utilization (EHR data)	***N* = 404**			***N* = 85**		
Hospitalization	125 (31%)	59 (15%)	–72%*	22 (26%)	12 (14%)	–45%†
Hospital days per client	11.1	3.7	–67%*	9.3	4.0	–57%†
PES	211 (52%)	153 (38%)	–56%*	34 (40%)	21 (25%)	–38%*
PES event per client	1.6	1.0	–37%*	0.6	0.1	–46%†

Note. Self-reported outcomes do not include Telecare. FSP = full-service partnership; SUD = substance use disorder; EHR = electronic health record; PES = psychiatric emergency services. The percentage difference with employment for older adults is reported as NA because the percentage of older clients with employment was 0% in the prior year and in the year after (from 0% to 0%). Blue font indicates outcomes that significantly improved. Black font indicates outcomes that did not change or changed but the change was not statistically significant.
*Indicates a change significantly different from 0 at .05 significance level. †Indicates a change marginally different from 0 at .08 significance level.

Exhibit 35. Percentage Change in Outcomes Among FSP Children and TAY

FSP outcome	Child (16 years and younger)			TAY (17–25 years)		
	Year before	Year after	Change	Year before	Year after	Change
Self-reported outcome	***N* = 238**			***N* = 284**		
Homelessness	9 (4%)	8 (3%)	–11%	33 (12%)	32 (11%)	–3%
Detention or incarceration	27 (11%)	27 (11%)	0%	38 (13%)	31 (11%)	–18%
Arrests	30 (13%)	10 (4%)	–67%*	63 (22%)	20 (7%)	–68%*
Mental health emergencies	94 (39%)	13 (5%)	–86%*	129 (45%)	29 (10%)	–78%*
Physical health emergencies	19 (8%)	1 (0%)	–95%*	58 (20%)	5 (2%)	–91%*
Suspensions	47 (20%)	21 (8%)	–55%*	27 (10%)	6 (2%)	–78%*
Grade (self-rating)	3.32	2.97	–10%*	3.19	3.11	–3%
Attendance (self-rating)	2.24	1.97	–12%*	2.46	2.49	2%
Health care utilization (EHR data)	***N* = 214**			***N* = 229**		
Hospitalization	10 (5%)	3 (1%)	–91%*	26 (11%)	16 (7%)	–67%
Hospital days per client	1.2	0.1	–91%	4.1	2.0	–51%†
PES	52 (24%)	23 (11%)	–56%*	93 (41%)	58 (25%)	–66%*
PES event per client	0.5	0.2	–54%*	1.1	0.7	–37%*

Note. TAY = transition-age youth; FSP = full-service partnership; EHR = electronic health record; PES = psychiatric emergency services. Red font indicates a statistically significant negative percentage change. Blue font indicates outcomes that significantly improved. Black font indicates outcomes that did not change or changed but the change was not statistically significant from the year before and the first year of enrollment in an FSP.

*Indicates a change significantly different from 0 at .05 significance level. †Indicates a marginally significant different change from 0 at .08 significance level.

CHILDREN AND YOUTH FSP

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

INTEGRATED FSP SHORT-TERM ADJUNCTIVE YOUTH AND FAMILY ENGAGEMENT

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

Youth are primarily referred to the SAYFE program through the Human Services Agency (child welfare), juvenile probation, BHRS regional clinics, and schools (typically with an individualized education plan [IEP] for emotional disturbance in place). The treatment is provided to help stabilize youth in their home environment and prevent (or transition back from) a higher level of care (e.g., psychiatric hospital, residential facility, juvenile hall).

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

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

The Youth FSP Program services are open to all youth meeting the following population criteria. However, the program is specifically targeted to Asian/Pacific Islander, Latino, and African American children and youth. The program serves:

- Children and youth (ages 6–21 years) living with serious emotional disturbance (SED)[3] and dually diagnosed (when it is developmentally appropriate and/or best meets the needs of the client and family) with multiple PES episodes and/or frequent hospitalizations with extended stays.
- SED and dually diagnosed children and youth who are at risk of out-of-home placement or returning from residential placement, with juvenile justice or child welfare involvement.
- SED and dually diagnosed unhoused children, youth, and TAY.
- Children, youth, and TAY exiting school-based or IEP-driven services.

[3] SED includes a diagnosis of one or more mental, behavioral, or emotional disorder(s) in children, youth, and TAY resulting in serious functional impairment that substantially interferes with or limits one or more major life activities.

- Youth who are experiencing a "first break" and have been recently diagnosed with a psychotic disorder. This target population may or may not have had prior involvement with the mental health, juvenile justice, and/or child welfare systems.
- Youth and their families who are willing and able to participate in the treatment process.

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

PROGRAM IMPACT

Short-Term Adjunctive Youth and Family Engagement	FY 2023–24
Total unduplicated clients served	53
Total unduplicated families served	53
Total cost per client	$25,549
Cost per contracted slot	$31,116

The SAYFE program works alongside the BHRS primary clinician and uses Wraparound Services Program for Children (Wraparound). The SAYFE program provides a variety of services to youth and her/his/their families. All treatment is voluntary, individualized, and strengths based and actively engages the youth and family. These services may include the following:

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

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

Improves timely access and linkages for underserved populations: The SAYFE program works in collaboration with county staff and other members of the treatment team to ensure timely access and appropriate linkages to services. The clinical intake coordinator contacts the referring party within 5 business days following the authorization for SAYFE services by a BHRS representative and opens the Administrative Reporting Unit (RU) to track referral progress within 24 hours of receiving the referral from the Interagency Placement Review Committee. The SAYFE program follows the procedure outlined next to ensure that the treatment team is working in collaboration with BHRS staff to maintain continuity of care for clients and families:

1. The clinical intake coordinator opens the Administrative RU when receiving the Wraparound Status Form and Interagency Placement Review Committee Form from the Interagency Placement Review Committee representative.
2. The Youth FSP clinical intake coordinator will contact the referent within 5 business days of receiving notification from the Interagency Placement Review Committee representative.
3. All (nonbillable) services before a complete referral packet is received will be documented in the Administrative RU.
4. The clinical intake coordinator will work with the referring party to obtain the referral packet as quickly as possible.
5. When the required documentation is received in its entirety, the referral is considered complete, the Administrative RU episode is closed, and the Treatment RU episode is opened. If the youth does not open in the Treatment RU, there will be documented efforts of attempts and rationale for not opening. The referring party will be informed throughout the process.
6. The clinical intake coordinator contacts the referring party and BHRS clinician for a provider's meeting before contacting the family no later than 5 business days from receiving the completed packet. An initial intake meeting is scheduled with the family no later than 5 business days from the provider's meeting with assistance from the BHRS clinician. Typically, both meetings are scheduled at the same time to expedite commencement of treatment.
7. The SAYFE treatment team schedules initial appointments with the client and family members during the initial intake meeting within 5 business days of commencement of treatment.

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

The SAYFE program has integrated family conferencing in the treatment process to increase engagement and review progress with the family. The family conference is family driven and strengths based and promotes self-reliance. It is a process that brings together the youth, the family, and their natural resources to explore decision making and problem solving for multiple needs and to develop an integrated and comprehensive plan to support youth and their families.

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

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

The SAYFE family partners provide peer support and encouragement to the parents/caregivers to enhance the family's community and natural supports as well as other supports identified in the individualized service plan. The SAYFE family partners also provide educational and parenting support to the parents/caregivers focusing on mental illness and/or substance use disorders, and accessing community parenting resources.

Edgewood operates the only program in San Mateo County focused on kinship families—those in which youth are being raised by a relative caregiver independent of the foster care system. Kinship families present additional unique strengths and challenges. When the SAYFE program serves kinship families, we also connect them to the Kinship Support Network to enhance the Wraparound services to include caregiver counseling, couples counseling, community health nursing and case management, support groups, and respite care.

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

Financial support is provided to the families when necessary to aid in their access to community resources to promote their recovery. For example, SAYFE will provide financial support for food,

clothing, shelter, or recreational activities while the family is waiting to receive their benefits. The case managers and family partners work with the caregivers to identify resources and learn the skills to access them independently for financial support so that these services are sustainable long term after the family graduates from the program. During the past year, SAYFE provided three youth scholarships to engage in community activities of their choice to learn new coping and social skills to support their treatment goals. In addition, SAYFE provided financial support for rent and emergency housing to six families.

Implements recovery principles: The SAYFE program uses the Wraparound model of care, which engages children, youth, and their families through four phases of treatment:

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

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

SUCCESSES

The following qualitative FY 2023–24 success stories highlight the support that the SAYFE team provides to each youth and family during their time in the program:

Client Success Story #1: A 14-year-old youth was referred to the SAYFE program because of severe symptoms of depression including active suicidal ideation, self-harm, and frequent suicide attempts. When this youth entered the SAYFE program, she had just been discharged from a long psychiatric hospitalization and her parents were concerned they couldn't care for her and keep her safe. The parents were in the process of a contentious separation and struggling to agree on custody and visitation arrangements with the youth and her younger sibling.

During the first months of services, family therapy sessions were hostile arguments between parents while the family therapist worked to reflect on the parental relationship's impact on the children based on the youth's symptoms. The youth would frequently leave session, refuse to participate, or shut down and cry. She would make statements pleading to get her parents to stop fighting and focus on co-parenting. The father would argue with the case manager, family partner, and behavior coach

and accuse the staff of "trying to focus too much on her depression" and struggled to understand why the team suggested that he make changes as a parent, when it was his daughter who was struggling.

The youth was in and out of the hospital almost every week for serious suicide attempts and self-harm. The family used Edgewood's crisis response team every night when the youth became dysregulated, and the parents used the detailed coaching and guidance from the crisis team to support their daughter late into the evening or early in the morning. The father called the crisis line in the middle of one of the youth's suicide attempts, and the team helped to save her life by contacting emergency medical services and coaching the parents to use de-escalation skills and techniques while waiting for the fire department to arrive. After the youth was on her way to the hospital, the crisis response team debriefed with the parents and allowed them space to process the traumatic events that just occurred. The family has expressed appreciation and gratitude to the team for their support during this situation.

The family partner worked with the father on parenting skills, crisis intervention and de-escalation techniques, communication, and psychoeducation regarding his daughter's diagnoses and mental health needs. With this support, the father was able to learn how to identify a crisis and intervene before one occurs as well as how to debrief when the youth is ready to do so. In addition, he worked with the case manager to identify parenting classes and attend groups to support his understanding of mental health. After the father completed his parenting course, he was asked to be a "parent ambassador" for the other parents attending the class. He was proud of this moment and talked about how much he learned in these classes with the team.

The youth's last hospitalization was almost a year ago. She participated in a volleyball camp last spring with the agency's financial support, made friends, and enjoyed the sport. The father was extremely thankful for the agency's support and said that it made him happy to see his daughter enjoying her life again. The case manager also worked to help the father with special education services for the youth to receive mental health support and services at school.

Currently, the younger sister is experiencing similar mental health issues. The father has expressed that "this time is different" because now he feels equipped to support her with the skills he learned from the SAYFE team. The father is proud of how much his daughter's mental health has improved since beginning in SAYFE. Family therapy sessions are no longer hostile and instead focus on a space in which the youth can ask for support from her father and improve communication.

Client Success Story #2: A 14-year-old foster youth was referred to SAYFE Wraparound services because of significant symptoms related to her trauma history that impacted her ability to form relational attachment with her foster parents. The youth had eight different placements before her current home and never stayed longer than a year at any home. In addition to struggling with relationships, the youth had difficulty managing her anger, identifying triggers, and respecting boundaries. The foster parents had never been parents before the youth came into their lives and were overwhelmed by her explosive and inappropriate behaviors. They often reported to the team that they felt like she was "the worst of the worst" and "unlike any other foster youth" and were often ready to end the placement.

The parents struggled to understand the youth's symptoms, made unfair demands, and threatened her home if she failed to stop using. Because of her trauma history, the youth pushed back against boundaries and limits and tried to sabotage the relationship and end the placement. The parents had difficulty understanding this dynamic and would challenge the service providers and assure them that they "don't understand that she is unlike any other kid." The family therapist provided psychoeducation on trauma; discussed the importance of consistency, predictability, and trust; and focused on the family's relationships. The therapist explained the importance of the parents' commitment to the youth if they wanted to continue to have her in their lives.

The mother has opened up in family therapy and shared that it is difficult for her to be vulnerable and subject herself to the hurtful comments that the youth makes during times of distress. The parents built a strong attachment to this youth with the team's help. When she becomes angry and tries to sabotage their relationship, the parents use the crisis response team for support and emphasize their commitment and care for the youth. The case manager has worked with the youth to identify her interests and develop healthy coping skills instead of drugs. They spend time together in the community taking walks, learning how to cook, and celebrating the youth's sobriety with her favorite meal. The youth comes to her case management sessions prepared with interests and activities she wants to explore and goals she wants to accomplish and asks for sessions when she needs a break from her home. The parents are not open to using the support of the family partner yet, but the team is hopeful that they will access the support when they are ready.

The SAYFE team has worked in collaboration with BHRS and child welfare to support the family and make treatment decisions together as the youth becomes comfortable with her providers; she has disclosed severe substance use and suicidal ideation and has begun to process her trauma history. The team has monthly Child and Family Team meetings in which the family's progress is highlighted.

CHALLENGES

During FY 2023–24, the SAYFE program continued to assess and address ongoing challenges concerning the increasing cost of living and lack of qualified applicants to retain staff and fill open positions. The high cost of living in San Mateo County and surrounding areas continues to present a challenge for our families and staff who are unable to obtain affordable and suitable housing for their families' needs. Because of this challenge, more San Mateo County residents are relocating out of the area, which has led to increased job openings and a smaller pool of qualified applicants countywide. This has made it more difficult to hire and retain staff who receive competitive salary offers. Edgewood's current salary rates do not match the astronomical cost of living and do not match county salaries and benefits. This is not unique to Edgewood.

Furthermore, SAYFE is an adjunct program that requires the involvement of a San Mateo County clinician, who maintains involvement with the family simultaneously while SAYFE is involved. SAYFE has historically received fewer referrals because of the increased coordination and collaboration required by the county staff who are experiencing burnout because of issues with retention and higher caseloads. The services included in the Wraparound model require a team approach to support the family.

Whereas the SAYFE program received more referrals, many of the clients and families referred in the past year have been in dire financial situations because of the high cost of living, which has had a significant impact on mental health and the ability to access basic needs. These families are not equipped or prepared for the level of commitment and availability required to participate in the program because of financial and/or mental health challenges.

This has led to lower client engagement, lower productivity, and increased workload for staff as they work to tailor their interventions and approaches to make services more manageable and supportive for youth and families. For example, a family may begin services with focusing on case management to help address basic needs and meet with the other members of the Wraparound team once or twice a month until the family can focus on the clinical aspect of the program. Conversely, other families have requested to focus on family therapy to address significant mental health or safety needs before focusing on parenting or case management. The significant needs of the families referred, combined with the increased workloads, have contributed to burnout and difficulty with staff retention.

The SAYFE program leadership has implemented strategies to increase client engagement, staff retention, and hiring. Program staff have increased flexibility for morning and evening appointments to accommodate families' availability, and the program offers telehealth appointments when appropriate to allow greater access to services. SAYFE also offers financial support for families to decrease financial burden so they can engage in services to support their youth. As a Trauma-Informed Systems Agency, Edgewood strives to encourage staff and families to incorporate self-care regularly to avoid burnout.

DEMOGRAPHICS

SAYFE Program Client Demographics (N = 53)

	Number of clients	Percentage of total
Age		
0–15 years	29	55.0
16–25 years	24	45.0
26–59 years	0	0.0
60–73 years	0	0.0
74 years and older	0	0.0
Prefer not to answer/unknown	0	0.0
Primary language		
English	34	64.0
Spanish	17	32.0
Another language	2	4.0
Prefer not to answer/unknown	0	0.0
Race/ethnicity		
Asian or Asian American	3	6.0

	Number of clients	Percentage of total
Black or African American	4	8.0
Native Hawaiian or Pacific Islander	0	0.0
White or Caucasian	5	9.0
Latino/a/x or Hispanic	32	60.0
Multiple races/ethnicities	3	5.0
Another race, ethnicity, or tribe	27	51.0
Prefer not to answer/unknown	12	23.0
Gender identity		
Female/woman/cisgender woman	34	64.0
Male/man/cisgender man	19	36.0
Transgender woman/trans woman/trans-feminine/woman	0	0
Transgender man/trans man/trans-masculine/man	0	0
Questioning or unsure of gender identity	0	0
Prefer not to answer/unknown	0	0

COMPREHENSIVE FSP TURNING POINT

Part of the Youth FSP Turning Point Child and Youth (TPCY) program is designed to support the county's most vulnerable youth and their families to maintain and improve the youth' 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 the context of their unique family system, culture, and community.

The 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. Youth are primarily referred to the TPCY program through the Human Services Agency (child welfare), juvenile probation, BHRS regional clinics, and schools (typically with an Individual Education Plan for emotional disturbance in place). The 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).

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

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

The Youth FSP Program services are open to all youth meeting the following population criteria. However, the program is specifically targeted to Asian/Pacific Islander, Latino, and African American

children and youth. Identified San Mateo County resident populations to be served by the program are

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

In addition, all enrollees in the TPCY

- Are ages 6–21 years,
- Are at risk for placement in a Level 10–14 residential facility or "stepping down" from a Level 10–14 residential facility, and
- Must be currently involved in Child and Family Services (child welfare) or probation.

Edgewood's TPCY program works with children, youth, and emerging adults as well as their families to provide services, including the following:

- 24/7 crisis support
- Case management
- Individual and family therapy
- Psychiatric assessments and medication support
- Peer support for youth and parents
- Therapeutic after-school programming
- Housing support
- Independent living skills development

These services ensure that youth are successful in their transition from higher levels of care back into the community. The TPCY program uses the Wraparound model of care for children, youth, and families engaged in its program. In the Youth FSP, the TPCY program provides various services to youth and their families. All treatment is voluntary, individualized, and strengths based and actively engages the youth and family. These services may include individual therapy with the client's goals

that focus primarily on symptom reduction as a means to improve functional impairments; group therapy with the client's goals for two or more family members that focus mainly on symptom reduction as a means to improve functional impairments; family therapy that focuses on the care and management of the client's mental health condition within the family system; collateral services that provide support to one or more significant persons in the life of the client, which may include consultation and training to assist in better utilization of services and understanding of mental illness; and rehabilitation services that assist in improving, maintaining, or restoring functional skills, daily living skills, medication compliance, and access to support resources.

Also, the families and youth have access to the Crisis Response Services provided by the Youth FSP team, which is available 24) hours on weekends and evenings. Families and youth also have access to behavior coaching services and psychiatry services.

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

PROGRAM IMPACT

Comprehensive FSP	FY 2023–24
Total clients served	53
Total cost per client	$64,661
Cost per contracted slot	$55,970

Improves timely access and linkages for underserved populations: The Youth FSP TPCY program works in collaboration with the other BHRS staff and other providers to ensure implementation of each enrollee's care plan. The Youth FSP clinical intake coordinator contacts the referring party no later than 5 business days following authorization by the BHRS designated representative and opens the RU within 24 hours of receiving the referral from the Interagency Placement Review Committee team.

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

In addition, TPCY provides family conferencing in the care planning process. The family conference is family driven and strengths based and promotes self-reliance. The family conference is a process that brings together the youth, the family/caregiver, and their natural resources. The focus of the family

conference is to explore decision making and problem solving for multineeds families and to develop an integrated and comprehensive plan for youth and their families/caregivers.

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

Increases number of individuals receiving public health services: The Youth FSP Program addresses the whole family and provides support to parents/caregivers when they have mental health or substance abuse needs. The TPCY family partners and case managers facilitate access to services, interfacing with Adult Mental Health Services or AOD services of the BHRS Division. The TPCY team will provide crisis/brief intervention services to those not meeting the criteria and refer them to primary care or community resources, as needed.

The TPCY's treatment team provides support and encouragement to the parents/caregivers to enhance the family's community and natural support, transportation services, and support as identified in the individualized care plan. The TPCY family partners provide educational support and linkage focusing on mental illness and/or substance use disorders, and finding resources.

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

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

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

Implements recovery principles: The Youth FSP TPCY program uses the Wraparound model of care, which engages children, youth, and their families through four phases of treatment:

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

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

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

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

SUCCESSES

Success Story #1: A young male client was referred to the TPCY program as he was struggling with posttraumatic stress disorder after years of witnessing and at times being a target of domestic violence. His mother was struggling to support him and his siblings by herself after entering the workforce for the first time.

This client spent many days sleeping and avoiding school. When awake, he was often tearful, and his low mood and irritability led to frequent conflicts with peers and physical violence toward siblings. Through the team-based Wellness Recovery Action Plan (WRAP) approach, the clinician and youth specialist worked with the client on building his self-confidence, teaching tools for emotional regulation, and supporting school reintegration. The family partner worked with the client's mother on strategies for encouraging the client to go to school through a strengths-based approach, and the case manager linked her to resources to support her son's medical needs and transportation to school. The case manager also attended IEP meetings and helped the client's mother learn how to navigate the school system. In addition, the team used flex funds to help make their apartment safer and more livable and supported the client's mother with organizing and developing healthy routines.

A year later, the client was going to school most of the time, with minimal conflict at home and at school. He loves playing with his friends and even goes to their houses sometimes after school. Overall, he has had significant improvement academically, but in the classes in which he's struggling, his mom is actively involved in getting him the support he needs. The client is now transitioning to a lower level of care based on his growth and how well he is doing.

Success Story #2: This client was referred to Wraparound services by Children and Family Services (CFS), who was involved because of physical punishment by the father. The client had a history of hospitalization due to self-harm, ongoing conflict with the father, aggressive behaviors impacting home and school, and occasional substance use. After services were initiated, the youth and her father were active participants in individual therapy, case management, behavioral coaching, and family partner support. The clinician and the behavior coach worked with the youth on emotional regulation, anger management, self-esteem, and healthy relationship skills, whereas the family partner, case manager, and clinician provided her dad with ongoing coaching of healthy communication skills. The team also worked to connect the client and father to their natural supports for respite and maintained an ongoing collaboration with the client's school-based therapist to ensure that there were no gaps in mental health support and academic support.

A year later, the youth and father have both made significant progress. The severity of the client's symptoms significantly decreased. The client no longer self-harms and is now able to communicate with her father regarding her feelings as well as the need for space so as to not escalate situations. She no longer uses substances and uses coping skills to regulate herself (arts and crafts, journaling, listening to music). The father has also learned communication and de-escalation skills, which have improved his relationship with his daughter, and he is now an active advocate for his daughter's needs. CFS is no longer involved, and the youth's father no longer uses physical punishment.

The client will soon be transitioning to a lower level of care based on how well she is doing as well as progress made in the home and family dynamics.

CHALLENGES

Although the TPCY program has had success in the past year in hiring and filling positions within the program, the majority of the team are now new to the program and the Wraparound model. Given the complexity of the Wraparound service model, it is often a significant learning curve for new providers. This, combined with the acuity and severity of incoming clients, can often feel like a steep climb for those joining the program. In addition, the requirements for documentation and agency protocols to become familiar with, paired with a new set of providers fresh and ready to support families, leave the program often overwhelmed.

To address this, program leadership has and will continue to develop a robust onboarding and training process for incoming team members, often using resources across the agency to support staff on the basis of identified needs and expertise. When possible, caseloads are scaled for individuals to ensure sustainability. Each provider coming into the program attends a recurring team meeting, individual supervision, and group supervision weekly. Internal and external trainings provide

support in areas specific to the service model, diagnosis and treatment, vicarious trauma, self-care, and more.

DEMOGRAPHICS

TPCY Program Client Demographics (N = 53)

	Number of clients	Percentage of total
Age		
0–15 years	31	58.0
16–25 years	22	42.0
26–59 years	NA	NA
60–73 years	NA	NA
74 years and older	NA	NA
Prefer not to answer/unknown	0	0.0
Primary language		
English	34	64.0
Spanish	19	360
Another language	0	0.0
Prefer not to answer/unknown	0	0.0
Race/ethnicity		
Asian or Asian American	3	6.0
Black or African American	2	4.0
Native Hawaiian or Pacific Islander	0	0.0
White or Caucasian	3	6.0
Latino/a/x or Hispanic	31	58.0
Multiple races/ethnicities	2	4.0
Another race, ethnicity, or tribe	23	43.0
Prefer not to answer/unknown	13	25.0
Gender identity		
Female/woman/cisgender woman	35	66.0
Male/man/cisgender man	18	34.0
Transgender woman/trans woman/trans-feminine/woman	NA	NA
Transgender man/trans man/trans-masculine/man	NA	NA
Questioning or unsure of gender	NA	NA

	Number of clients	Percentage of total
identity		
Prefer not to answer/unknown	NA	NA

OUT-OF-COUNTY FOSTER CARE FSP

Through the collaborative relationship between San Mateo County and Fred Finch Youth & Family Services, East Bay Wraparound (EBW) formed an FSP in 2010. EBW provides an array of comprehensive and holistic clinical, crisis, and case management services to youth and families served within this department. Fred Finch's delivery of Wraparound services strives to promote wellness, self-sufficiency, and self-care/healing to youth. Every episode of care is divided into four phases guided by 10 principles. The Wraparound team consists of many community partners, the family, the youth, social workers, child welfare providers, court appointed special advocates, and EBW staff. The team works together to develop an individualized service plan to meet a youth and family's identified needs, culture, and preferences. Services are available to participants and their families 24 hours a day and provided in the least restrictive environment (home and community with the goal of keeping families together). All youth and families are given agency, voice, and choice in their care. Natural and community support is encouraged and sought out during and after the duration of services. Service duration is up to the age of 21 years.

Youth in this program meet the following criteria:

- Ages 6–21 years old
- Have Medi-Cal
- Reside in foster care placements outside of San Mateo County and are at risk of losing their current residence and/or at risk for placement in a higher level of care
- Experienced some crisis or safety issue in their home or had a history of multiple placements
- Level of impairment falls in the range of moderate to severe

Wraparound services remove many of the barriers to families receiving therapeutic services. EBW services are designed to provide comprehensive, individualized care by coordinating various support systems around the needs of individuals and families. Multiple aspects of a person's life, including health, education, housing, relationships, and social services, are simultaneously addressed in service delivery. Each individual or family receives a customized care plan tailored to their specific needs. All services are provided in the safest, most accessible, and least restrictive environment to decrease financial, time, and distance barriers often associated with receiving care. EBW staff often have sessions in a participant's home and/or community locations (grocery stores, medical offices, parks, schools, libraries, and other community spaces).

EBW creates a more inclusive and supportive environment to reduce mental health stigma and discrimination for underserved populations. The team is staffed with youth and parent partners who

have lived experience. Families have reported that having a staff team member who has navigated similar struggles helps them to feel less judged and "able to be themselves," thus creating a more therapeutic environment for permanent change to occur. All participants of the program are given agency, voice, and choice in their care. Throughout the Wraparound process, each participant is given the tools to become self-managers of their life. EBW staff empowers every participant and family to build on their strengths through improved self-efficacy and to use principles of self-advocacy.

EBW also provides advocacy and psychosocial education about the three stigmas of mental health (public, self, and systemic) to families, participants, and natural supports to reduce stigma and shame concerning accessing mental health services. EBW staff are encouraged to use each participant's preferred language of person-first versus identity-first language in reference to their mental health challenges and disabilities. Using a participant's preferred identity language actively empowers EBW participants and their families to realize that their mental health challenges and disabilities are important parts of their identity that should be held without shame while also acknowledging the intersectionality of their many identities.

Measuring outcomes for Wraparound services involves a combination of qualitative and quantitative methods to ensure a comprehensive evaluation of every participant. Families and participants give feedback via surveys, in session, and informally, which helps us understand the impact on the families receiving EBW services. The Child and Adolescent Needs and Strengths (CANS) assessment is a multipurpose tool used to assist the Wraparound team with service delivery and planning for care. CANS is also used to monitor various outcomes such as improvements in mental health, school performance, and family stability over time. During regular Child and Family Team meetings, the team discusses the child's strengths, needs, and progress. A team-based approach to planning, strategizing, and problem solving helps to identify any barriers to success for the participant and family. All service outcomes are continuously reviewed and adjustments are made as needed, to ensure that participants receive the highest standard of care.

PROGRAM IMPACT

Out-of-county FSP	FY 2023–24
Total clients served	6
Total cost per client	$55,766
Cost per contracted slot	$18,080

Timely access and linkage: The EBW program has a "do what it takes" motto. EBW is committed to opening all new referrals within a 10-day period. Linking families to needed services occurs at the initial case opening and throughout every episode of care. EBW staff frequently partner with many CBOs, nonprofits, and social service foundations to decrease many remnants of social and economic disruptions caused by COVID-19 for Wraparound families.

Reducing stigma and discrimination: There are many ways in which EBW is striving to reduce mental health stigma. The team is staffed with youth and parent partners who have lived experience. Families have reported that having a staff team member who has navigated similar struggles helps them to feel less judged and "able to be themselves," thus creating a more therapeutic environment for permanent change to occur. EBW also provides advocacy and psychosocial education about the three stigmas of mental health (public, self, and systemic) to families, participants, and natural

supports to reduce stigma and shame concerning accessing mental health services. EBW staff are encouraged to use each participant's preferred identity language in reference to their mental health challenges and disabilities. Using a participant's preferred identity language actively empowers EBW participants and their families to realize that their mental health challenges and disabilities are important parts of their identity that should be held without shame while also acknowledging the intersectionality of their many identities. The program is also improving organizational and individual cultural humility through education, training, workforce development, hiring strategies, and policy changes.

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

Reduced disparities in access to care: Individuals from vulnerable populations—the Bay Area's unserved, underserved, underresourced, and ineffectively served individuals and families—often face barriers to accessing care in the Bay Area. Program staff participate in community outreach efforts and fundraising events to increase access to care.

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

SUCCESSES

Client Success Story: The participant is a 13-year-old, Latinx individual with anxiety, disengagement, poor impulse control, frequent episodes of inappropriate sexual conduct within the community, and neurodivergence. The youth also presented with sporadic suicidal and homicidal thoughts without plan, mean, or intent. During his second placement, the youth's foster parent felt overwhelmed by the youth's high support needs and lack of available services.

The foster parent was very reluctant to start Wraparound services at the initial start of care. The team created a warm environment for the foster parent and youth to "interview" the team as a method of building trust and shared alliance. By the end of the first meeting, both agreed to services, and coordination of care started immediately.

The assigned care coordinator began intensive coordination for services for the youth per the foster parent's request. The EBW care coordinator developed a therapeutic relationship with the youth and was able to implement interventions to decrease the youth's anxiety and impulse control. Notable changes in risk and safety were also present. The foster parent was able to be an active partner in keeping the youth safe. As the youth's anxiety decreased, the youth's engagement in their community and the world around them also increased.

In a few months, the youth will be successfully returning home to his biological parent after two foster care placements. The youth has had a significant decrease in risk and safety concerns as well as inappropriate sexual conduct within the community. The youth is also connected to community supports for neurodivergence, educational supports, and activities to keep the youth connected to community. The foster parent reported that she felt "empowered and less overwhelmed. Youth is getting the help that youth needed after all of this time. I feel supported. The team knows what they are doing."

CHALLENGES

Wraparound programs often provide services to individuals with very high support needs. Providing care to an individual with very high acuity and complex childhood trauma has been a challenge for staff. Providers often feel compassion fatigue and burned out after interactions with this individual because of the participant reenacting trauma on their service providers. The individual often has extremely intense emotional reactions toward others. EBW staff receives ongoing consultation and support. Staff is receiving training in providing services to individuals with complex trauma, maintaining professional boundaries, navigating compassion fatigue, and building trust and emotional safety with participants and families.

DEMOGRAPHICS

Demographic information was not provided because of the small sample size (N = 6) to protect client privacy.

TRANSITIONAL-AGE YOUTH (TAY) FSP

TAY FSPs provide intensive community-based supports and services to youth identified as having the "highest needs" and can include TAY between the ages of 16 and 25 years. Specialized services to TAY with serious emotional disorders are provided to assist them to remain in or return to their communities, support positive emancipation including transition from foster care and juvenile justice, secure safe and stable housing, and achieve education and employment goals. TAY FSPs help reduce involuntary hospitalizations, homelessness, and involvement in the juvenile justice system and improve the quality of life for youth clients.

COMPREHENSIVE TAY FSP AND DROP-IN CENTER

Edgewood's TAY FSP program is a specialized mental health program designed to meet the unique needs of high-risk and highly acute TAY between the ages of 17 and 25 years in San Mateo County; 16-year-olds and those up to age 18 years who are still enrolled in high school will continue to be served by the TPCY FSP. Considered the last treatment option prior to a residential placement, the TAY FSP program provides intensive, around-the-clock support to help youth reach and maintain stability in the community and transition into adulthood.

The TAY FSP program works to address youth' identified needs while also building awareness around the choices and behaviors that oftentimes lead to isolation, hospitalization, incarceration,

homelessness, and increasingly risky substance use. BHRS refers youth who are residents of San Mateo County, are between the ages of 17 and 25 years, and meet at least one of the following eligibility criteria:

- Individual living with SED or SMI and/or dually diagnosed with multiple PES episodes and/or frequent hospitalizations with extended stays in the past 2 years.
- Exiting school-based mental health (SBMH) or IEP-driven services and meeting criteria for SED, SMI, or dually diagnosed.
- Diagnosed with SED or SMI and experiencing homelessness or at risk of homelessness.
- Diagnosed with SED and/or dually diagnosed and at risk of out-of-home placement or returning from residential placement.
- Newly identified and experiencing a "first break" and has been recently diagnosed with a psychotic disorder. This target population may or may not have had prior involvement with the mental health, juvenile justice, and/or child welfare systems.

The TAY FSP engages as much of the youth's biological family, chosen family, and other permanent, supportive adults as possible to support the youth's treatment but also, most important, to be the network of support after the youth has graduated from the program.

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

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

- Age-specific groups and activities
- Independent living skill acquisition
- Crisis response
- Educational/vocational support
- Financial and housing support
- Linkage to resources
- Career and education guidance
- Peer-to-peer support
- Family conferencing
- Individual and family therapy
- Case management and care coordination
- Psychiatry

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

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

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

Peer partners facilitate a safe and welcoming environment using empathy, validation, constructive feedback, and unconditional support. Peer partners are trained in youth development, harm reduction, and peer counseling techniques. Peer partners offer support and peer mentorship; give resources; and plan, implement, and co-facilitate groups and activities. Primary program activities/interventions provided include the following:

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

PROGRAM IMPACT

Comprehensive TAY FSP	FY 2023–24
Total clients served in FSP	59
Total clients served in drop-in center	200
Total cost per client	$12,829
Cost per contracted slot	$54,657

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

The Drop-in Centers address the basic and higher level needs of any TAY in the community, at no expense to the participant. Basic needs include food, hygiene products, and clothing. The Drop-in Centers facilitate in-person activities such as group meals and food distributions and provide access to hygiene and clothing, laundry access, as well as free computer and printer access. Higher level needs addressed by the Drop-in Centers include referrals for mental health treatment, linkage to community health clinics and other health-related resources, support in understanding their benefits, and peer support experienced in problem solving and discussion facilitation.

Peer partners help participants in identifying resources and services that will best fit their needs. Peer partners model how to make calls to health care providers, locate resources via the internet, and serve as direct links to community providers. When a participant or group of participants has a need that is not currently being met by one of the Drop-in Center sites, the staff will reach out to community partners, identify resources, and ensure that participants' needs are met.

Reduces stigma and discrimination: TAY program staff are engaged in ongoing training and coaching to address issues of inherent stigma and discrimination faced by themselves and clients. Team members are strong advocates for clients when they face these issues during their treatment. Given the nature of the population served by the Drop-in Centers—TAY who are marginalized or living outside of the normative young adult experience—it is fair to say that most of the participants are impacted by stigma and/or discrimination.

Recent undocumented immigrants face discrimination daily and view the Drop-in Centers as one of the few safe places providing access to resources for their physical and psychological well-being. TAY of color have reported the comfort they felt upon learning that many peer partners share a similar background, ethnicity, or language; these same individuals reported that a sense of shame and discomfort held them back from asking for support in other settings. Participants also reported feeling that peer partners accept them for who they are, empathizing with their experiences and not judging their past or current behaviors (i.e., harmful to self or others) or who/what they represent (i.e., lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, and two-spirit [LGBTQQIA2S+]; foster; immigrant).

The Drop-in Centers are intentional in hiring peer partners from different backgrounds, experiences, and communities, as they firmly believe that the diverse TAY community they serve should also be reflected in their staff.

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

The Drop-in Centers maintain updated information on available health-related resources in San Mateo County, and this information is made available to any TAY accessing the sites. A resource hub is conveniently located at each center, and peer partners are able to assist TAY in identifying and locating the resources they need. The Drop-in Centers also have access to Edgewood Center's community health nurse, who can provide one-on-one consultation to any TAY with specific health concerns. In addition, the Drop-in Centers are receiving funding through the Sequoia Healthcare District to provide additional health resources to the TAY community using the Drop-in Centers, including providing two health fairs per year. The Drop-in Centers' Stay Healthy events include the distribution of health-related equipment such as yoga mats, stress balls, fidgets, art therapy supplies, educational books, and resources. The Drop-in Centers also host and invite local health agencies such as Planned Parenthood, HealthRight 360, San Mateo County Public Health Clinic, Peninsula Family Services, San Mateo Public Health Nurses, and the Art of Yoga to these events along with the San Mateo County Mobile Health Clinic; this clinic is able to perform on-the-spot sexually transmitted infection screenings and other health-related testing.

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

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

The Drop-in Centers use a harm reduction approach to engage the TAY in meaningful discussion about their substance use. The overarching goal is to have a judgment free space, allowing for

conversations that reduce the stigma of substance use and avoid alienating the TAY who otherwise would feel unwelcomed. The peer partners receive harm reduction training as part of their new hire orientation, and ongoing training and support are available through Edgewood Center's Litmos training platform and through agencies and community partners who are experts in the field. The Drop-in Centers also partnered with the San Mateo Mobile Health Clinic to have Narcan on site and will train peer partner staff on how to administer it to TAY.

SUCCESSES

Success Story #1: Alfred is both a TAY FSP client and a participant at the Drop-in Center. Since joining the Drop-in Center at the beginning of 2024, they have quickly developed a strong sense of community within the center. Alfred faces significant challenges, including severe anxiety, depression, substance abuse, and an eating disorder, and has shared that they lack a healthy support system at home or among friends.

Over time, Alfred's attendance at the Drop-in Center has increased from weekly to daily. They have openly expressed that the Drop-in Centers has saved their life. The center has provided Alfred with harm reduction education and access to essential county resources such as Narcan and fentanyl testing strips, which they obtained during the Drop-in Center's Stay Healthy event. In addition, Alfred has found the Drop-in Center to be a safe space where they can comfortably eat, noting that the sense of connection to the community and the availability of food have played a crucial role in helping them manage their eating disorder behaviors. Alfred has also built strong relationships with the Drop-in Center peer partners, who have been instrumental in helping them navigate multiple instances of suicidal ideation. As a result, Alfred now considers the Drop-in Center their true home.

Success Story #2: Phillis is a young woman referred to the Drop-in Center by court appointed special advocates (CASA) and initially visited the center with her CASA volunteer. She has been struggling to secure employment that meets her financial needs, which has led to recurring difficulties in paying rent. With limited income, Phillis has been unable to afford food and lacks family support for food or shelter because of her gender expression.

The Drop-in Center provided a safe and welcoming space for Phillis to openly discuss her gender identity, something she had not experienced before. The center connected her to a transitional housing program and provided her with monthly access to groceries and hygiene items. Phillis expressed that the housing support and access to necessities were crucial in helping her regain stability and move toward greater independence.

Success Story #3: Client Megan has been enrolled in TAY FSP services since September 2020. The client was referred to the program with a history of trauma, polysubstance use, housing instability, and very limited engagement with mental health services. At the time of referral, the client engaged in aggressive and threatening behaviors toward self and others, specifically her mother, leading the client to a number of psychiatric hospitalizations. The client's polysubstance use impacted her in a number of life domains, including her ability to maintain employment and follow through with school goals, among other things.

After several attempts at rehab, in January 2024, Megan completed an inpatient program through the Latino Commission that supported her through her Alcohol and other Drugs (AOD) rehabilitation. Now, the client has highly improved her engagement and communication with treatment providers, including therapists, case manager, psychiatrist, and behavioral coach. In addition, the client is currently working toward developing employment skills through the Vocational Rehabilitation Services program, where she is currently employed, and is planning to enroll at Skyline Community College this fall. Last, the client is now engaged in family conference meetings, where she and her mother meet with the treatment team to continue working toward her treatment goals.

Success Story #4: Ryan was referred to the TAY FSP after moving to the Bay Area from New York with a history of hospitalizations for unmanageable symptoms of bipolar disorder and anxiety as well as struggling with impulsive substance abuse. Ryan was reserved and never left the house, often expressing that his home life was all he knew. From the beginning, Ryan's goal for himself was to enroll in college, get a driver's license, and eventually live independently, all while hoping to develop socialization skills and healthy coping mechanisms for negative symptoms and impulses. Over the past year, Ryan has been able to stay free of hospitalizations and stop abusing substances all together. Ryan now uses coping skills developed with the clinician and behavior coach and actively engages in healthy activities of daily living such as exercising, meditating, and regularly attending the Drop-in Center for socialization and connecting with peers.

Not letting his diagnosis of autism limit his potential, Ryan was also able to begin college courses, studying psychology, and is now in his third semester at Skyline Community College. Ryan has also been able to pass his written permit test and is currently completing driving courses with flying colors, on his way to obtaining his license. Ryan continues to work with a full Wraparound team to learn how to use public transportation for school and stay consistent with psychiatric medications. Next on Ryan's list of goals is working part time at a gym with the goal of living independently still in sight.

CHALLENGES

TAY FSP Program

Clients referred to the TAY FSP program face barriers including acute symptoms, unstable housing, distrust of county systems, substance use, and transportation issues. To address these challenges, program staff prioritize rapport building, timely resource connections, and targeted interventions to stabilize mental health symptoms. The program emphasizes "warm handoffs" and extended crossover periods between referring programs and TAY FSP to improve client engagement during transitions.

Drop-In Centers

Staffing and resources remain a primary challenge for Edgewood Center's Drop-in Centers. The centers' various projects and activities require adequate staff support, but filling positions and maintaining training have proven difficult, especially with predominantly part-time staff. High participant needs during open hours leave minimal time for staff development within budgeted hours.

Rising operating expenses also impact the centers. Now open 5 days weekly, both centers provide dinner and maintain food pantries. Although partnerships with Second Harvest help provide fresh produce, increasing food costs significantly affect monthly expenses and the centers' ability to maintain their supportive environment.

Transportation Access

Peer partners have identified transportation as a common barrier for participants. The Drop-in Centers can provide only limited free bus vouchers because of funding limitations. To address this, the centers use their program van to transport services and resources to locations where the target population has low access to services.

DEMOGRAPHICS

TAY FSP Program Client Demographics (N = 59)

	Number of clients	Percentage of total
Age		
0–15 years	0	0.0
16–25 years	59	100.0
26–59 years	NA	NA
60–73 years	NA	NA
74 years and older	NA	NA
Prefer not to answer/unknown	0	0.0
Primary language		
English	46	78.0
Spanish	11	19.0
Another language	1	2.5
Prefer not to answer/unknown	1	2.5
Race/ethnicity		
Asian or Asian American	3	5.0
Black or African American	3	5.0
Native Hawaiian or Pacific Islander	0	0.0
White or Caucasian	5	8.0
Latino/a/x or Hispanic	32	54.0
Multiple races/ethnicities	3	5.0
Another race, ethnicity, or tribe	27	46.0
Prefer not to answer/unknown	12	20.0
Gender identity		

	Number of clients	Percentage of total
Female/woman/cisgender woman	33	56.0
Male/man/cisgender man	26	44.0
Transgender woman/trans woman/trans-feminine/woman	NA	NA
Transgender man/trans man/trans-masculine/man	NA	NA
Questioning or unsure of gender identity	NA	NA
Prefer not to answer/unknown	NA	NA

ENHANCED SUPPORTED EDUCATION

Caminar's Supported Education program 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 spring 1991 from a 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.

The Supported Education program maintains both a campus presence and an extensive community footprint, offering regular weekly groups across Caminar's residential programs. These include skills development, self-care workshops, activities, and processing sessions. Clients can access both in-person and virtual support for educational guidance, resource navigation, and career development. The program actively participates in Half Moon Bay adult and TAY subcommittees and maintains a presence at Edgewood's TAY Drop-in Center.

Central to the program's mission is proactive community engagement. Throughout the fiscal year, the team has established connections with numerous community organizations to identify and support individuals who could benefit from educational services. This outreach creates pathways for recovery, support, and personal empowerment. As clients engage with the program, they begin to recognize their potential and discover new opportunities.

The program's curriculum incorporates essential recovery principles including WRAP, personal and professional skill development, resource education and connectivity, educational and career empowerment, leadership development, peer support networks, and engagement through active listening, motivational interviewing, and supportive interaction.

By helping clients embrace new identities as students, peer counselors, or other professionals, the program enhances self-esteem and helps transform the traditional "client" narrative, reducing stigma often associated with receiving mental health support and services.

Caminar's Supported Education program represents a vital pathway to opportunity, making it essential that all San Mateo County clients receive information about and access to these educational support services.

PROGRAM IMPACT

Supported Education	FY 2023–24
Total clients served	107
Total cost per client	$2,045

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

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

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

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

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

The Supported Education program focuses on connecting individuals with educational/vocational services and providing individualized supports. With these supports, the cohort grade point average and retention rates are as follows:

Students attending fall and spring semesters of the Peer Counseling Program

- Achieved an overall grade point average of 3.2.
- Attained a retention rate of 81%.

In addition, 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 and self-care and, in turn, decreases the isolation and stresses that often precipitate an increase in symptoms or a decrease in functioning.

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

Curriculum Summary:

- Peer Counseling 1 class, fall: orientation, digital literacy, academic skills and resources, Health Insurance Portability and Accountability Act (HIPAA), boundaries, Carl Rogers active listening, hierarchy of needs, humanistic psychology, overview of academic programs, group facilitation, communication essentials, roles of families and consumers, WRAP, American Counseling Association Code of Ethics, self-care, diversity and equity programs, and the models of recovery.
- Peer Counseling 2 class, spring: review of digital literacy, review of active listening, motivational interviewing/stages of change, harm reduction/AOD/integrated mental healtha and substance use models, trauma-informed care, classical/operant conditioning, cognitive behavioral theory, problem solving/conflict resolution, the role of advocacy, assessment concepts, developing a treatment plan, writing progress notes/BHRS documentation guidelines, and a career project.
- Fall semester: 23 students completed the Peer Counseling 1 class (Introduction to Peer Counseling).
- Spring semester: 22 students completed the Peer Counseling 2 class (Advanced Peer Counseling).
- Wellness and recovery centers joined from out of county.
- The program served 107 unduplicated clients, with 35 TAYs.
- 207 hours of service were provided (12,440 minutes).
- 30 engagement activities for TAY were offered (classes, groups, outings, one-on-one activities).

SUCCESSES

In FY 2023–24, the Peer Counseling class continued with a hybrid option—both in person at the program's Redwood City location and using the RingCentral Zoom online format. This Zoom format increased accessibility for those students who otherwise have challenges attending in person. In addition, this has enabled participants to check in weekly and become more fluent in alternate methods of communication (the program covers use of phones/tablets in the beginning of class). The students were inspiring in their perseverance, adaptability, engagement, and support of each other.

CHALLENGES

1. **Technology:** Clients can often need extra assistance and, in some cases, upgraded devices to be able to join Zoom activities. Programs are increasingly assisting their clients with grant-sourced devices to aid in their connectivity. To this need, the 2024–25 classes will be offered online and in person.
2. **Client engagement difficulties:** This year, the program had difficulty engaging and supporting TAY in life and career goals. In addition, there has been an ongoing housing crisis that has a direct impact on their stability and overall health and well-being. TAY often prefer doing activities with other TAY, as age appropriate, and often do not want to identify as needing "specialized mental health" programs or activities. Although this is important for connection and self-esteem, it represents challenges for helping professionals in engaging, guiding, and supporting. Nonetheless, this is a critical area of focus, as helping to guide and support TAY in their growth, exploration, and development is both essential and highly rewarding. Program staff have found that engaging with TAY on a personal as opposed to a professional level has aided in connecting and building a relationship that can lead to accepting support for goals and needs. The staff can then introduce their expertise in certain areas with a more natural and relatable setting.

DEMOGRAPHICS

Supported Education Program Client Demographics (N = 107)

	Number of clients	Percentage of total
Age		
0–15 years	0	0.0
16–25 years	4	3.0
26–59 years	84	79.0
60–73 years	19	18.0
74 years and older	0	0.0
Prefer not to answer/unknown	0	0.0
Primary language		
English	106	99.0
Spanish	0	0.0
Another language	1	1.0
Prefer not to answer/unknown	0	0.0
Race		
Asian or Asian American	0	0.0
Black or African American	8	7.0
Native American/American Indian or Indigenous	1	1.0
Pacific Islander	3	3.0
White or Caucasian	55	50.0

	Number of clients	Percentage of total
Another race	37	35.0
Multiple	3	3.0
Prefer not to answer/unknown	0	
Ethnicity		
Latino/a/x or Hispanic	20	19
Caribbean	0	0.0
Central American	0	0.0
Mexican/Mexican American/Chicano	0	0.0
South American	0	0.0
Another identity or tribe	20	19.0
Prefer not to answer/unknown	0	0.0
Not Latino/a/x or Hispanic	87	81
African	8	7.0
Asian Indian/South Asian	0	0.0
Chamorro	0	0.0
Chinese	6	6.0
Eastern European	0	0.0
European	0	0.0
Fijian	0	0.0
Filipino/a/x	5	5.0
Japanese	1	1.0
Korean	0	0.0
Middle Eastern or North African	0	0.0
Samoan	1	1.0
Tongan	0	0.0
Another ethnicity or tribe	66	62.0
Prefer not to answer/unknown	0	0.0
Sex assigned at birth		
Male	NA	NA
Female	NA	NA
Prefer not to answer/unknown	NA	NA
Intersex		
Yes	NA	NA
No	NA	NA
Prefer not to answer/unknown	NA	NA
Gender identity		

	Number of clients	Percentage of total
Female/woman/cisgender woman	57	53.0
Male/man/cisgender man	48	45.0
Transgender woman/trans woman/trans-feminine/woman	0	0.0
Transgender man/trans man/trans-masculine/man	0	0.0
Questioning or unsure of gender identity	0	0.0
Genderqueer/gender non-conforming/gender non-binary/neither exclusively female nor male	0	0.0
Indigenous gender identity	1	1.0
Another gender identity	0	0.0
Prefer not to answer/unknown	1	1.0
Sexual orientation		
Gay or lesbian	2	2.0
Straight or heterosexual	93	88.0
Bisexual	4	4.0
Queer	1	1.0
Pansexual	0	0.0
Asexual	1	1.0
Questioning or unsure of sexual orientation	0	0.0
Indigenous sexual orientation	0	0.0
Another sexual orientation	0	0.0
Prefer not to answer/unknown	4	4.0
Disability status		
Yes	106	99.0
No	0	0.0
Prefer not to answer/unknown	1	1.0
Veteran status		
Yes	2	2.0
No	116	96.0
Prefer not to answer/unknown	2	2.0

ADULT AND OLDER ADULT FSP

ADULT AND OLDER ADULT/MEDICALLY FRAGILE FSP

The FSP program, overseen by Telecare, Inc., provides services to the highest risk adults and 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, when enrolled, to achieve independence, stability, and wellness within the context of their cultures and communities. Program staff are available 24/7 and provide services that include 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/medically fragile adults include maximizing social and daily living skills and facilitating use of in-home supportive services (IHSS).

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. The teams proactively identify needs and gaps in service and provide, broker, or advocate for those necessary services or resources, including benefits acquisition, psychiatric appointments and medication, case management and evidence-based rehabilitation, and other promising practices. The concentrated effort of each team affords the opportunity to engage in continual improvement for clients' lives by circling back on progress made in all the areas identified.

Telecare delivers excellent and effective behavioral health services that engage individuals with complex needs in recovering their health, hopes, and dreams. Clients have 24/7 access to a team member who has working knowledge of their hopes and dreams, treatment plan goals, and interventions that have worked and those that do not, using a team-based approach. Furthermore, each team incorporates titrated services ranging from the most intensive (FSP level) through case management and into wellness. These levels allow members to progress in their recovery journey while keeping their support team intact and allow for aging members to move back into higher levels of support, keeping their support team intact. All service recipients are adults or older adults who are on their recovery journey from complex behavioral health challenges including serious and persistent mental illness, co-occurring medical issues, substance use, criminogenic profiles, and more.

Activities, services, and interventions include but are not limited to assessment and treatment planning, psychiatry, case management, medication support, vocational development/brokerage, supported education brokerage, and numerous evidence-based and promising practices such as motivational interviewing; WRAP; Seeking Safety; Recovery Centered Clinical Systems; and Screening, Brief Intervention, and Referral to Treatment.

PROGRAM IMPACT

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

Telecare adult/older adult FSP	FY 2023–24
Total clients served	238
Total cost per client	$3,582
Cost per contracted slot	$10,706

Reduces stigma and discrimination: The multidisciplinary teams comprise varying professions (case managers, licensed clinicians, nurses, and a prescriber). Still, they also comprise a high number of individuals with lived experience. Approximately 75% of the Telecare teams are individuals on their recovery journey. This normalizes the process, establishes rapport, and reduces stigma.

Increases number of individuals receiving public health services: The program takes almost all client referrals, with few exceptions. They refer, link, and connect clients with various public health providers. Within the first 2 weeks of working with a new member, the team searches for benefits to which the member is entitled and helps establish those benefits for the member.

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

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

SUCCESSES

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

Client Success Story #1: In J.C.'s words, "The team has been really helpful. I really like working with them."

J.C. is a client who came to San Mateo Transitions FSP while at Redwood House following a series of hospitalizations. She successfully completed the crisis residential program, established a therapeutic relationship with her psychiatrist and case management team, and began a medication regimen that assisted her stability. Prior to her completion of the crisis residential program, the FSP staff completed a referral so J.C. could transition to a social-rehab program. J.C. was accepted to Hawthorne House, where she began to thrive because of the program's structure and support as well as the additional support that the FSP staff provided. J.C. was referred to Jobs Plus by the FSP staff and was encouraged by case managers to participate in different community events and outings. Her relationship with her provider persisted, and J.C.'s medication compliance continued. Today, she lives independently and maintains her medication compliance and psychiatric and primary care appointments with the help of her FSP team. She visits her parents weekly and has meaningful and rewarding friendships in the community. She likes to engage in puzzle activities around San Mateo. She is thriving in our community and continues to receive FSP services.

Client Success Story #2: In B.C.'s words, "I'm grateful, and truly thankful and blessed. Thank you, Telecare!!"

B.C. has been a client of the program since 2019. She came to us on conservatorship after being in a locked inpatient facility for nearly a decade. Over the years, she has partnered closely with San Mateo Transitions and Telecare FSP. Services provided to her have included weekly psychiatry appointments, individual psychotherapy, psychosocial rehabilitative services, case management, medication management, and various groups, in addition to other services. With support from the FSP staff, she has learned to partner with numerous agencies and natural support systems in the community. Over the course of time, she has increased her independence and has a more meaningful and rewarding life. She has been able to meet new friends and function more and more independently in the community. B.C. is a kind, compassionate, and determined client of the program and has shown tremendous growth; because of this, she has been able to terminate conservatorship as of July 2024.

CHALLENGES

It has been challenging at times to provide services and interventions to individuals in need who don't want any services or don't feel that they have an illness. The program has been able to find ways to connect with its clients and to link them to best care practices and interactions that foster independence in the community. This includes a number of groups such as art therapy, processing group, co-occurring mental health and substance use disorders support, cooking safety, and life skills.

The program actively pursues measures to continue improving services to its clients. Staff use a variety of tools, including in-person and virtual appointments, technology that allows documentation in the field with the client served, increased response times, and flexibility. Telecare's ability to act proactively, swiftly, and competently within the community is noteworthy. The program is deeply committed to the mission of excellence in San Mateo County.

DEMOGRAPHICS

Telecare Adult and Older Adult FSP Program Client Demographics (N=238)

	Number of clients	Percentage of total
Age		
0–15 years	0	0.0
16–25 years	9	4.0
26–59 years	154	64.0
60–73 years	66	28.0
74 years and older	9	4.0
Prefer not to answer/unknown	0	0.0
Primary language		
English	229	96.0
Spanish	6	3.0
Another language	1	0.02

	Number of clients	Percentage of total
Prefer not to answer/unknown	2	0.08
Race/ethnicity		
Asian or Asian American	16	6.0
Black or African American	23	10.0
Native Hawaiian or Pacific Islander	5	2.0
White or Caucasian	102	43.0
Latino/a/x or Hispanic	53	22.0
Multiple races/ethnicities	17	7.0
Another race, ethnicity, or tribe	45	19.0
Prefer not to answer/unknown	20	8.0
Gender identity		
Female/woman/cisgender woman	71	30.0
Male/man/cisgender man	167	70.0
Transgender woman/trans woman/trans-feminine/woman	NA	NA
Transgender man/trans man/trans-masculine/man	NA	NA
Questioning or unsure of gender identity	NA	NA
Prefer not to answer/unknown	NA	NA

COMPREHENSIVE FSP FOR ADULTS AND OLDER ADULTS

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

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

Caminar FSP has a staffing ratio of 10 staff to one consumer. FSP has the capacity to serve 30 clients. There are frequent team meetings to discuss clients in crisis, hospitalizations, incarcerations, medication noncompliance, and homelessness. A psychiatrist is assigned to the client to provide medication evaluation and psychoeducation. Case managers assist clients with needs related to mental health services, rehabilitation, housing, employment, education, social and recreational activities, and health care. Consumer treatment includes a variety of modalities based on consumer needs, including case management; individual, group, or family therapy; psychiatric medication prescription; and general medication support and monitoring. Consumer self-help and peer support

services include money management, assisting with employment opportunities, social rehab, and assistance with referrals and housing. Caminar also provides community-based nursing to assist clients with improving medication compliance. FSP services are delivered by a multidisciplinary team, which provides 24/7 crisis response support, including IHSS 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 strengthening the client's ability to access health care services and ensuring follow up with detailed care plans.

PROGRAM IMPACT

Caminar adult/older adult FSP	FY 2023–24
Total clients served	30
Total cost per client	$23,807
Cost per contracted slot	$14,548

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

When a client is referred to Caminar services, staff attempt to initiate contact for case management within 2 business days and psychiatry within 5 business days. Clients are assessed rapidly and comprehensively by case managers, a psychiatrist, and a clinic manager/registered nurse (RN). The clinic manager/RN completes a nursing assessment for all clients admitted to the program. Furthermore, FSP also uses a Medication Assistance Program to increase medication compliance and to reduce the risk of clients overtaking or undertaking their medications.

By using the social rehabilitation model, which provides for a nonjudgmental, normalized environment that emphasizes the client as the lead in their care, Caminar works to reduce the stigma and discrimination that the population often faces. The team ensures linkage to outside community providers for primary care and ongoing collaboration with said providers; this helps ensure that Caminar's clients are receiving public health services. By partnering with other nonprofit agencies, Caminar helps reduce the disparities in access to care. Finally, Caminar uses interventions such as harm reduction, motivational interviewing, dialectical behavior therapy (DBT), and WRAP to help strengthen the gains made by clients and implement the principles of recovery throughout all its programs.

SUCCESSES

The FSP program focuses on meeting the client where they are. Currently, FSP has clients who have been facing challenging situations such as homelessness, AOD, housing challenges, and

reengagement with psychiatry. Having a client-centered approach, meeting them where they are, and providing incentives has helped us to be able to reengage, guide, support, and link clients to resources that they can benefit from.

Client Success Story #1: "John" was unhoused and was incarcerated at Maguire Jail for 4 months. When he was released, he relapsed on alcohol a few times, which caused him to be evicted from shelters and unhoused on the streets. Caminar was able to get John into Safe Harbor, where his case manager worked closely with Safe Harbor Shelter staff to secure a housing voucher and ensure that John obtained permanent housing. The Caminar case manager went to multiple collaborative meetings, supported the client in viewing multiple apartments, and worked closely with the Housing Authority, and finally, the client was able to move into his own apartment. John's presentation when he arrived at his new apartment was full of joy and excitement, and he was thankful to his treatment team for this huge accomplishment.

Client Success Story #2: "Jacob" came to FSP after dangerous erratic behavior in the community, including danger to himself and others. During his time in FSP, he completed his time at Eucalyptus House and was able to come off of conservatorship and return home to his family. He started attending a DBT group weekly. He became and remained medication compliant. He was engaged in treatment with his case manager while his family received collateral support. Jacob was able to step down to the New Ventures program, remains engaged in treatment, and is doing well.

CHALLENGES

Housing levels: Not having enough Board and Care (B&C) facilities for clients has been a challenge. B&Cs are not one size fits all, and therefore, not all clients are a fit for a specific B&C. Many times, streamlining communication with B&C operators can be challenging because of all the demands they face and expectations that clients have when communicating with their operator.

Another challenge is that many FSP clients are medically fragile. They may not meet a Skilled Nursing Facility level of care but are too medically fragile to meet Community Care Licensing for B&C. This in-between physical status for clients limits their placements and keeps them in the hospital longer or in a placement that is not appropriate to meet their needs.

Clients experiencing homelessness because of symptoms: Although there has been a small decrease, currently FSP has clients who are unhoused and not able to keep housing because of their symptoms. The program's case managers have worked collaboratively with other providers to ensure that clients get an apartment. However, it has been challenging for some clients to keep an apartment, because of their symptoms and other criteria, and they end up unhoused.

Personnel: It is hard for staff to live on their staff wages in the Bay Area because of inflation. In FY 2023–24, some staff have resigned because of housing costs and needing to move out of the county or state for more affordable housing.

DEMOGRAPHICS

Caminar Adult and Older Adult FSP Program Client Demographics* (N = 92)

	Number of clients	Percentage of total
Age		
0–15 years	0	0.0
16–25 years	6	6.0
26–59 years	66	72.0
60–73 years	19	21.0
74 years and older	1	1.0
Prefer not to answer/unknown	0	0.0
Primary language		
English	80	88.0
Spanish	4	4.0
Another language	3	3.0
Prefer not to answer/unknown	5	5.0
Race/ethnicity		
Asian or Asian American	11	12.0
Black or African American	11	12.0
Native Hawaiian or Pacific Islander	0	0.0
White or Caucasian	30	33.0
Latino/a/x or Hispanic	11	12.0
Multiple races/ethnicities	4	4.0
Another race, ethnicity, or tribe	15	16.0
Prefer not to answer/unknown	19	21.0
Gender identity		
Female/woman/cisgender woman	33	36.0
Male/man/cisgender man	59	64.0
Transgender woman/trans woman/trans-feminine/woman	NA	NA
Transgender man/trans man/trans-masculine/man	NA	NA
Questioning or unsure of gender identity	NA	NA
Prefer not to answer/unknown	NA	NA

*Demographics include Caminar's adult/older adult FSP and AOT FSP combined

AOT OR "LAURA'S LAW" FSP

The purpose of an AOT FSP is to provide services to individuals living with SMI who currently are not receiving treatment and may or may not require court intervention to receive treatment. AOT FSP services are based on the Assertive Community Treatment model.

The AOT target population is adult San Mateo County residents living with SMI who meet the following eligibility criteria as specified in Assembly Bill 1421: clients unable to "survive safely" in the community without "supervision"; clients with a 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 past 36 months because of a mental illness or (b) violent behavior toward self or others in the past 48 months; and clients who were previously offered treatment on a voluntary basis and refused it or are considered "deteriorating."

Program activities include engaging individuals who have not had a successful and lasting connection to treatment and recovery services, have had diversion from the criminal justice system and/or acute and long-term institutional levels of care (locked facilities), or have been diagnosed with SMI as well as complex individuals with multiple comorbid conditions who can succeed in the community with sufficient structure and support.

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

Caminar provides interventions and evidence-based practices such as Assertive Community Treatment, motivational interviewing, feedback-informed treatment, Outcome Questionnaire, cognitive behavioral therapy (CBT), harm reduction, Seeking Safety, trauma-informed services, stages of change, crisis intervention and management, Medication Assistance Program, WRAP, and recovery-based treatment.

PROGRAM IMPACT

Caminar reduces risk by rapid and consistent engagement with clients and their collateral providers, case conferences, increasing contact with clients who may be decompensating, 24/7 availability, and its implementation of the Pro-ACT training. All

AOT (Laura's Law) FSP	FY 2023–24
Total clients served	62
Total cost per client	$17,361
Cost per contracted slot	$40,873

management staff are trained and certified to initiate involuntary hospitalization, when indicated. The program limits school failure and drop out through its Supported Education program and helps lower unemployment by using its Jobs Plus program, which provides skills training and referrals to employers looking for workers. Homelessness is a pervasive problem in the Bay Area and in San Mateo County, in particular. Through its Supported Housing program, Caminar provides housing options to clients in need of independent apartments and shared apartments. In collaboration with BHRS, FSP links clients to multiple housing options: licensed board and cares, single-room-occupancy rooms, shelters, and unlicensed room and boards.

When a client is referred to Caminar services, staff attempt to initiate contact for case management within 2 business days and psychiatry within 5 business days. Clients are assessed rapidly and comprehensively by case managers, a psychiatrist, and a clinic manager/RN. The clinic manager/RN completes a nursing assessment for all clients admitted to the program. Furthermore, FSP also uses a Medication Assistance Program to increase medication compliance and to reduce the risk of clients overtaking or undertaking their medications.

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

SUCCESSES

Client Success Story #1: "Jane" came to Caminar with very little information except for a prior hospitalization and nonengagement with county services. She was a 67-year-old widowed woman. In addition, she was unhoused and came with diagnoses of psychotic disorder not otherwise specified and alcohol use disorder. Caminar's psychiatrist provided for the continuation of a prescription for a medication to manage the symptoms consistent with a psychotic disorder: gross disorganization, delusions, and hallucinations. Caminar was able to secure housing for Jane with a voucher, but these symptoms continued to imperil her housing. She went out into the street several times with no pants on, once with chocolate cake all over her head and face, and she was taken in for 5150s during these incidents.

The management of the apartment complex was very distressed by this and urged that she "find another place to live." During one of the hospitalizations, she was found to have a urinary tract infection. Knowing the connection between urinary tract infections and symptoms of psychosis for the elderly, Caminar staff insisted on medical staff ruling out urinary tract infections in future 5150s, of which there were about half a dozen. Also concerned about the client's housing as well as lack of feeling of belonging at her apartment complex, staff moved her to a Supported Housing unit where

she could be much more closely monitored by caring Caminar staff. Unfortunately, she continued to have psychiatric crises that led to 5150s.

The 5150s ended when she was hospitalized, and the medical staff did additional imaging only to find a fragment of a catheter that had broken off and remained in her bladder. It is unknown how long it had been in her bladder. It took Caminar and hospital staff about a month or so to effectively make the case to her to allow the doctors to remove the fragment, but Jane did eventually agree. After the fragment was removed and she had healed, she was moved to a local Board and Care (B&C) facility.

It is now approaching a year of stability for Jane. She spends most of her days at a local senior center, socializing, developing friendships, playing games with others, and enjoying herself.

Client Success Story #2: "John" was referred because he experienced symptoms of schizophrenia, becoming very aggressive (punching holes in walls, making threatening statements, experiencing delusions). He pushed his father to the ground, so his parents called 911 and the client was brought to the local PES. For the 9 years prior to his admission to AOT, he had 13 episodes with mental health services, most reporting that he had schizophrenia or a similar diagnosis. He wanted to be left alone but did not or could not take medication as prescribed and would therefore get hospitalized. When experiencing symptoms, he could be argumentative, catatonic, paranoid, impulsive, or irritable; have auditory hallucinations; or get physical with his family.

Initially, he did not want to interact at all with Caminar case managers and expressed anger toward them. Slowly, he began to tolerate brief communications with Caminar case managers as he developed some measure of trust, but it was typically not more than 5 minutes at a time. At one point, he went to the hospital complaining of a physical concern and was put on a 5150 hold. John was then temporarily conserved and went to a Mental Health Rehabilitation Center for about 3 months.

When John stepped down to the community again, AOT case management was there to support the client in maintaining regular psychiatry appointments as well as taking medications consistently. Case management has also supported him in pursuing his educational, employment, and recreational goals in addition to improving his relationship with his parents. Not only is John happier with his life, but his whole family is happier as well. He reports never wanting to go back to that "old time."

Client groups: Client groups have been growing in topics and participation this past year. There is a range of staff facilitating these groups, including clinicians, case managers, and peer partners. The program offers the following groups to our case management clients on a weekly basis: DBT skills groups, men's group, women's group, Anti-Defamation League group, and art group.

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

Cultural responsiveness trainings: Caminar values the importance of training its staff to be culturally informed in the care they provide to the program's diverse clients. The following trainings were provided to our staff in FY 2023–24:

- **Cultural Diversity:** This introductory course on cultural diversity provides an overview of cultural diversity and discusses various dimensions and issues of diversity. This course is not exhaustive; however, it provides staff with the fundamental tools that will enable them to interact with others of diverse cultures and effectively perform their job responsibilities.
- **Becoming Visible—Using Cultural Humility in Asking Sexual Orientation Gender Identity (SOGI) Questions:** One of San Mateo County BHRS's strategic initiatives is to reduce health care disparities in the LGBTQ+ populations. To achieve this goal, we will start collecting data on the sexual orientation and gender identity of all our patients/clients. This will require extensive staff training in LGBTQ+ health and psychosocial issues faced by LGBTQ+ populations.
- **Cultural Humility 101: Building Bridges to Diversity and Inclusion:** Cultural humility offers one approach to engage with the ever-changing dynamics of culture and difference, power and privilege, as we go through our day-to-day work. This collaborative and interactive training provides attendees with an opportunity to engage and explore these concepts as we all continue to work toward fostering inclusion in the workplace.

Trainings and evidence-based practices:

- **Harm reduction training:** This involves incorporating a spectrum of strategies including safer techniques, managed use, and abstinence; reviewing a framework for understanding structural inequalities (poverty, racism, homophobia, etc.); and meeting people where they are but not leaving them there.
- **Motivational interviewing:** Caminar has trained all staff in motivational interviewing with follow-up monthly labs to continue practicing the interventions to use with their clients. Monthly labs continue to be offered to staff to increase their skill set, ultimately leading to more successful interventions with clients.
- **Professional Assault Crisis Training (Pro-ACT):** All staff have been trained in Pro-ACT, based on a set of principles that focus on maintaining client dignity while keeping clients and staff safe. Employee in-service training is designed to respect client rights, build a noncoercive treatment environment, minimize the risks associated with emergency response to assaultive behavior, emphasize the role of supervision of employee behavior, support continuous upgrading of skills and knowledge, be free of gender bias, emphasize team skills, and provide experience in problem solving.
- **Violence prevention:** The AOT program staff were also trained in violence prevention to support them in learning safety and de-escalation techniques to keep them and their clients safe. The course emphasis is placed on exercising self-control and systematically using the least-restrictive measures versus attempts to externally control others. Limits

are viewed as informative and helpful to the other party rather than punitive or judgmental.

- **Dialectical Behavior Therapy (DBT):** Case management programs have been trained in DBT skills that mirror the DBT skills group that is being taught to clients weekly by clinicians.
- **Outcome Questionnaire:** Caminar has continued to use Outcome Questionnaire. These measures are the most researched and validated outcome measurement tools available. The first administration captures a baseline level of distress. Routine administrations allow a provider to quickly assess any changes in symptoms and problematic behavior and accurately measure change. Using predictive algorithms that have been proven to be accurate, the system serves as an early warning system, alerting the provider if a client is moving away from expected progress in treatment. Responses provided by the client can assist in treatment planning and help guide the therapeutic direction by identifying strengths and areas of concern.

Succession and retention planning: Caminar is committed to fostering the growth and development of its staff while prioritizing retention to ensure consistency and quality in client care. The program engages in ongoing discussions about succession planning and staff retention strategies. It supports case managers by providing opportunities to complete their trainee hours within the organization. Recently, Caminar implemented regular staff surveys to gather feedback on departmental operations and leadership. The organization has also responded to staff requests by offering specific benefits tailored to employee needs. Flexible work schedules and hybrid work-from-home options have been introduced, which staff report have significantly improved their work-life balance.

AOD use: As a result of intensive case management (ICM) involving rehabilitative interventions, the program has observed a decrease in clients' alcohol and drug use. By providing staff with ongoing training in motivational interviewing and harm reduction techniques, the program has seen a positive impact on clients with co-occurring mental health and substance use disorders.

CHALLENGES

Unhoused clients: Placing clients experiencing homelessness in housing is still a significant difficulty. There are several factors that make this difficult. Clients placed in an AOT are often treatment resistant. Even with the most skillful and/or evidence-based modalities such as motivational interviewing, a portion of clients are unable or unwilling to take psychiatric medications that effectively reduce symptoms or refrain from using substances such as amphetamine/stimulant street drugs, fentanyl, cannabis, or alcohol, which exacerbates the psychiatric symptoms that they have. Placing a client in a Supported Housing program when they are actively using and not taking medications to mitigate psychiatric symptoms can cause the client to burn bridges and be evicted by landlords. These clients tend to make their living environment uninhabited and refuse IHSS and other cleaning services to make their units habitable.

These clients would benefit from units built to be more indestructible or at least much more difficult to damage, along with on-site support services such as case management, medical care, groups, and SUD treatment for those who become ready.

Violent clients: A significant challenge for the program is providing care safely to clients who may exhibit aggressive or assaultive behavior because of their symptoms. A substantial portion of AOT clients have a documented history of assaults against others. Some of these clients are known to carry weapons, including knives, guns, box cutters, and BB guns. To mitigate the risk of harm, staff often arrange to meet these clients at safer locations such as courthouses or probation officers' offices, where clients are less likely to bring weapons.

DEMOGRAPHICS

Caminar Adult and Older Adult FSP Program Client Demographics* (N = 92)

	Number of clients	Percentage of total
Age		
0–15 years	0	0.0
16–25 years	6	6.0
26–59 years	66	72.0
60–73 years	19	21.0
74 years and older	1	1.0
Prefer not to answer/unknown	0	0.0
Primary language		
English	80	88.0
Spanish	4	4.0
Another language	3	3.0
Prefer not to answer/unknown	5	5.0
Race/ethnicity		
Asian or Asian American	11	12.0
Black or African American	11	12.0
Native Hawaiian or Pacific Islander	0	0.0
White or Caucasian	30	33.0
Latino/a/x or Hispanic	11	12.0
Multiple races/ethnicities	4	4.0
Another race, ethnicity, or tribe	15	16.0
Prefer not to answer/unknown	19	21.0
Gender identity		
Female/woman/cisgender woman	33	36.0
Male/man/cisgender man	59	64.0

	Number of clients	Percentage of total
Transgender woman/trans woman/trans-feminine/woman	NA	NA
Transgender man/trans man/trans-masculine/man	NA	NA
Questioning or unsure of gender identity	NA	NA
Prefer not to answer/unknown	NA	NA

*Demographics include Caminar's adult/older adult FSP and AOT FSP combined

SOUTH COUNTY EMBEDDED FSP

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

During FY 2023–24, Mateo Lodge was contracted to provide 50 hours of embedded case management (ECM) services per week for three different levels of intensity for BHRS South County Clinic clients (A—task-oriented case management, 1–2 months duration; B—supplemental case management, 4–6 months duration; and C—FSP clinical case management, 6 –12 months duration). The program was staffed by one staff member 4 days a week for 40 hours/week for this reporting cycle.

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

Each ECM client meets with their embedded case manager and completes a needs assessment to facilitate client goals. The engagement process is critical in building trust and reducing stigma and is highly client centered.

ECM staff are bilingual (Spanish and English) and have participated in professional development opportunities/training including cultural competency, SOGI, assaultive behavior, motivational interviewing, BHRS-required documentation, and compliance trainings. In addition, ECM attend

quarterly meetings with Mateo Lodge, weekly supervision, and bi-weekly staff meetings at South County Clinic. Staff development is targeted to further strengthen ECM awareness of community services, improve culturally appropriate services, and deepen clinical knowledge of the population of clients served to employ best strategies/practice.

PROGRAM IMPACT

This section provides a comparison of health care use data from periods that extended to 3 months before and after clients were admitted to the Mateo Lodge program. The program does not collect any other outcome data that can be used to display its impact.

Integrated FSP—South County	FY 2023–24
Total clients served	20
Total cost per client	$7,600
Cost per contracted slot	$5,018

The following table summarizes the health care use information for the 20 clients who were admitted and actively a part of the Mateo Lodge program during FY 2023–24. Among the Mateo Lodge clients, during the 3 months before program admission, there were 29 PES episodes and two inpatient/residential episodes with 16 total days of inpatient residential stays. During the 3 months following their admission, none of the Mateo Lodge clients had a record of using the same health care services. Please note that these results are as of early October 2024 and may not reflect all health care utilization during the 3 months after admission for those clients admitted late in the fiscal year.

Mateo Lodge Clients' Health Care Use (*N* = 20; FY 2023–24)

	3 months before Mateo Lodgeadmission	3 months after Mateo Lodge admission
Number of PES episodes	29 [a]	0
Number of inpatient/residential episodes	2	0
Total inpatient residential stays (in days)	16	0

[a] Some clients had multiple psychiatric emergency services (PES) episodes.

South County Clinic has complex impaired clients living with SMI because the catchment area services the county jails, Redwood House crisis residential, Cordilleras, three social rehabilitation B&C placements, three inpatient SUD treatment programs, and two homeless shelters. The main barriers for clients served through ECM are limited housing, communication by telephone due to homelessness, co-occurring mental health and substance use disorder, trust issues stemming from mental health diagnoses, and limited resources for undocumented clients. Because the ECM is an adjunct provider, consultation and updates with the treatment team are paramount for client care.

Most of the referrals for the ECM program are to improve clients' engagement with their treatment teams (not making it to appointments) and/or because clients are not psychiatrically stable. In this reporting, all new client referrals were to reduce hospital and PES encounters. The difficult-to-engage client is typically medication noncompliant and/or unhoused with limited family/social support. Use of culturally appropriate community agencies (faith based, Club House, Pride Center) has helped

support recovery when limited financial and family support exists. Assisting clients with task activities such as obtaining a cell phone, assistance to coordinated entry, and other community resources improves client outcomes through building a working rapport and trust with the case manager.

The case manager makes every attempt to meet clients in the community and assess for food insecurity, linkage to mental health services/primary care, referrals to in-home services, and support for housing goals/needs. Engagement strategies used are home visits (both scheduled and unscheduled), use of natural family support, case conference with outpatient community partners, and joint home visits with a member of the treatment team. The best outcomes for ECM clients exist when there is a warm handoff from their clinical treatment team and collaboration with valued community partners.

SUCCESSES

One example of the program's success in FY 2023–24 is the program staff's ability to meet clients in their homes or in community settings. The COVID-19 pandemic previously contributed to increased feelings of isolation among clients, but being able to meet with on-site case managers has lessened their feelings of loneliness and isolation. In addition, the program works with on-site case managers to tailor interventions and forms of support on the basis of the client's needs. For example, a supervisor at a residential facility was concerned that one client was not receiving the support they needed. Mateo Lodge staff then met with the client, who shared needing a different form of support from the on-site case managers. Program staff talked to the on-site case managers and worked with them to adapt to the client's preferences. This collaboration between case managers and other program staff allowed them to adjust their strategies to support clients' needs.

CHALLENGES

In FY 2023–24, the program continued to face challenges connecting with clients who are hard to engage or reach. When a case manager finds it difficult to engage a client in program services, they consult with program staff and treatment team members to identify strategies for improving engagement with the client. Specifically, not being able to physically locate clients continues to be a barrier for the program. The program's intensive case manager has access to other support services within Mateo Lodge, including a mobile support team, and can engage them to help locate clients. The program has also used support from social workers who accompany sheriffs to locate clients. In FY 2023–24, a client with dementia and a history of falling left the center where she was hospitalized. Her case manager put up a bulletin board message identifying her as a missing person and visited her house to check potential leads on her whereabouts. Ultimately, the Mateo Lodge intensive case manager found this client at a different location. When the client was located, one staff member helped build a rapport with the client and created a calm, safe environment for them.

DEMOGRAPHICS

The following table summarizes the demographic information of the 20 clients who were admitted and already actively a part of the Mateo Lodge program during FY 2023–24. Clients were between the ages of 26 and 59 years (55.0%) or 60 years or older (45.0%). English was the only reported primary language (15.0%). Clients who identified as White or Caucasian made up the largest group (55.0%),

and the second- and third-largest groups identified as other (10.0%) and Vietnamese (5.0%), respectively. Most clients did not identify as Hispanic or Latino (55.0%) and did identify as female (70.0%). It is important to note, however, that 85.0% of clients did not report information on their primary language, 20.0% of clients did not report information on their race, 20.0% did not report information on their ethnicity, and 75.0% did not report information on their sexual orientation.

Mateo Lodge Program Client Demographics (N = 20)

	Number of clients	Percentage of total
Age		
0–15 years	0	0.0
16–25 years	0	0.0
26–59 years	11	55.0
60 years and older	9	45.0
Primary language		
English	3	15.0
Spanish	0	0.0
Unknown/not reported	17	85.0
Race		
White or Caucasian	11	55.0
Other	2	10.0
Vietnamese	1	5.0
Black or African American	1	5.0
Multiple	1	5.0
Unknown/not reported	4	20.0
Ethnicity		
Not Hispanic or Latino	11	55.0
Hispanic or Latino	5	25.0
Unknown/not reported	4	20.0
Sex assigned at birth		
Male	14	70.0
Female	6	30.0
Unknown/not reported	0	0.0
Sexual orientation		
Straight or heterosexual	5	25.0
Lesbian, gay, or homosexual	0	0.0
Unknown/not reported	15	75.0

HOUSING SUPPORTS

Housing supports can include various strategies such as scattered site housing, augmented B&Cs, room and boards, temporary shelter beds, transitional housing, and permanent supportive housing. In addition, a comprehensive continuum of services can include pre-housing engagement strategies such as drop in centers, field services targeting unhoused populations, and linkages and peer support after psychiatric emergency, hospitalization, and incarceration.

TAY FSP HOUSING

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

- Locate and obtain needed units of housing.
- Ensure that leased housing remains in clean, safe, and habitable condition.
- Collaborate on a regular basis with the FSP provider.
- Use creative, harm-reduction-based techniques beyond standard property management practices and activities.
- Manage relationship with property owners including timely payment of rent, monitoring and enforcement of lease provisions, and problem solving.
- Support the TAY resident with occupational therapist services.

PROGRAM IMPACT

TAY Supported Housing	FY 2023–24
Total clients served	12
Total cost per client	$36,188

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

ADULT/OLDER ADULT SUPPORTED HOUSING

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

SUCCESSES

Belmont Apartments: Of the 24 resident units, five formerly unhoused adults living with SMI and SUD are original tenants, having moved in when the project opened more than 17 years ago. Three of the current tenants have been in residence for more than 13 years, and 11 have been in residence for more than 1 year. The eligibility for Belmont Apartments did not and does not include an MHSA eligibility designation; however, at least 75% of current residents would be so designated if needed.

Cedar Street Apartments: Of the 14 resident units, five formerly unhoused adults living with SMI and SUD are original tenants, having moved in when the project opened more than 11 years ago. Two of the original tenants have passed away, seven residents have been tenants for 5 years or more, and two residents have been tenants for at least 3 years. Of the 14 units, five are designated MHSA units. However, 10 current tenants were officially designated as MHSA eligible.

Since opening, there are a number of residents with complex medical conditions, including a resident who was told she had fewer than 6 months to live. The program's RN and nursing staff worked closely with her, she was provided a fully disability accessible unit, and she was connected to other support services both inside and outside the apartment, including food delivery. As a result, her lifespan was extended by 5 years, during which time we were able to connect her to her family; at the end of her life, her family was making regular visits. There is currently a resident who is close to end-stage Parkinson's disease. He is an original tenant who resided on the second floor. Upon diagnosis, staff were able to move him to a handicap adaptable/accessible first floor unit, trading with another resident. He has done well for a long period of time. However, at the end of 2023, he required skilled nursing care, which was expected to be temporary. It has now been determined that he will not be able to return to Cedar Street Apartments because he requires a much higher level of care than can be provided.

Finally, as a Housing and Urban Development (HUD) 811 project, the program is not required to use the Coordinated Entry System for referrals to the program, which has allowed it to accept some tenants who, by virtue of their illness, would never have agreed to a Coordinated Entry System assessment, much less to the other requirements to remain on the Coordinated Entry System list as vulnerable. Staff have been able to rapidly house some individuals and quickly provide them with the stability and services that have contributed greatly to their success in remaining housed.

Waverly Place Apartments: Of the 15 resident units, nine formerly chronically unhoused adults living with SMI and SUD are original tenants, having moved in when the project opened more than 5 years ago. All units are designated as MHSA units. Several residents have already successfully lived at Waverly Place Apartments longer than they have lived anywhere else as adults. Two residents have fairly significant medical conditions and are working with the Mental Health Association's RN and occupational therapists to ensure that they receive the care they need as well as to provide assistance in making and keeping medical appointments.

CHALLENGES

Belmont Apartments: The COVID-19 pandemic created the greatest challenge for both staff and residents. For those clients who had been employed, their work ended and this resulted in a long period of inactivity. For the better part of 2 years, Mental Health Association staff were the only in-person people residents were seeing, and safety protocols made even that more difficult. Staff continued working to repair some of the interpersonal damage that resulted. Many of the tenants' treatment team staff moved to remote work, retired, or simply moved away. As a result, tenants found it much easier to disconnect from services, which resulted in not taking medications, not seeing a professional for treatment, and for a number of individuals, having their episode with county BHRS closed because of not being seen or attending appointments. It is a major lift to try to repair those relationships as well.

As a result of the subsidies for the units coming through HUD as permanent supportive housing subsidies, the program is now required to use the Coordinated Entry System for referrals. This system has proven challenging as the information provided is all self-reported, and securing documentation to meet eligibility requirements is time consuming. In addition, the support services funded for the project do not necessarily meet the complex needs of residents, which has created some very real challenges not only for on-site staff but also for some of the residents. Many of the individuals referred through the Coordinated Entry System process do not have an interest in participating in BHRS, which means that Mental Health Association staff are often the only providers they see, regardless of their personal challenges or issues. Moreover, the program is seeing an increasing number of individuals who are early in their recovery from SUD and are hoping for a clean and sober living situation, which, as a result of Housing First requirements, the program cannot provide. While acknowledging that SUD relapse is fairly common, staff are seeing it happen more rapidly now and continuing longer than ever before.

Cedar Street Apartments: Whereas the COVID-19 pandemic created challenges similar to those at Belmont Apartments, Cedar Street Apartments faced some unique issues. Staff were advised not to enter tenant units unless absolutely necessary and to meet one-on-one in the community room,

rather than in apartments. Community rooms were closed for most community building activities, further limiting social interactions.

In addition, the program is grappling with the fact that many of the residents are aging and are starting to present with physical and medical challenges that the program was not originally designed to address. To address this, the program has raised funds to have an RN working on site part-time as well as occupational therapy services available for residents. This additional staffing has helped to keep residents out of the emergency room and/or hospital.

Waverly Place Apartments: Although Waverly Place opened 2 years prior to the COVID-19 shutdowns, many of the residents, all of whom were chronically unhoused, were still in the early stages of treatment and recovery. When the shutdown occurred, many completely disconnected from services and increased their usage of substances. This situation, combined with a moratorium on evictions, resulted in significant challenges for individuals that impacted the Waverly Place community as a whole.

AUGMENTED BOARD AND CARES

Augmented Board and Cares (B&C) provide a supported living environment for individuals living with SMI and/or SUD in San Mateo County. The program's 10 contracted facilities offer supported living environments that allow clients to remain in their community.

The program's target population is adults living with SMI who have completed a social rehabilitation program, were previously receiving treatment in a locked Institution for Mental Diseases, or self-referred. Clients are members of the HPSM and have either Social Security Administration or General Assistance benefits. They can demonstrate the ability to maintain mental stability, are compliant with medications, and are in need of housing in a supported living environment.

The program is managed by one designated B&C liaison and multiple B&C facility operators who implement program activities on site at each of the 10 B&C facilities contracted by BHRS. The B&C liaison oversees admissions and referrals to the facilities, completes client assessments, coordinates care with clients' treatment teams, and manages discharges from the facilities. These processes require daily collaboration with the B&C operators to ensure that any potential impacts to placement are promptly addressed. BHRS uses some of its MHSA funds to support the mental health groups offered at B&C facilities and finance incentives that reward B&C operators for providing clients with timely care.

Activities for clients include the following:

- B&C operators provide clients with three meals a day and medication management services, which include storing and administering medications. The operators regularly

collaborate with the client's treatment team and conservator,[4] as applicable, to track the client's progress and address any issues that could affect the client's placement.

- B&C operators work in close collaboration with the B&C liaison. The role of the liaison is to support the client's transition into the B&C facility, oversee and coordinate client care, and ensure that the B&C addresses issues that impact placement.
- BHRS facilitates a series of mental health groups for clients at the B&C facilities. Curricula for these groups have included Seeking Safety, Illness and Recovery Management, Dual Diagnosis, and WRAP.
- The program supports clients in achieving stable housing placements by referring them to external organizations—such as the Helping Our Peers Emerge (HOPE) peer mentor program and Serenity House—that provide clients with emotional support and advocacy services. HOPE helps clients living with SMI reintegrate into the community following their discharge from a psychiatric hospital,[5] whereas Serenity House is a crisis residential program that offers an alternative to hospitalization for individuals living with mental illness who are experiencing increasing distress and require short-term, 24/7 treatment and support services.

Activities for facility operators are as follows:

- The B&C liaison develops and coordinates a training schedule for the B&C operators to increase their capacity to address client needs and fulfill their Continuing Education Unit requirements.
- The program incentivizes B&C operators to facilitate timely referrals and maximize the use of available beds. If the B&C operator can keep their occupancy at 95% before the end of the fiscal year, they earn an incentive based on how many beds are in the facility.

PROGRAM IMPACT

Board and cares	FY 2023–24
Total clients served	78
Total cost per client	$34,485

Improves timely access and linkages for underserved populations: Over the past year, the B&C program continued to follow existing protocols that ensure efficient referral, screening, and admissions processes. The B&C liaison promptly reviews referrals using a standardized 15-item checklist to determine the appropriate level of care. If the client is eligible, the B&C liaison searches for available placements and swiftly prepares them for transition to a B&C facility. The B&C liaison regularly reassesses referred clients and develops process improvements when issues with

[4] A conservator is a court-appointed individual who is responsible for managing the financial and personal affairs of an incapacitated individual, or conservatee. Their responsibilities may include arranging housing, education, health care, transportation, and more for the conservatee. More information about conservatorship can be found at https://www.metlife.com/stories/legal/conservatorship/.

[5] More information about the HOPE peer mentor program can be found at https://www.smchealth.org/article/helping-our-peers-emerge-program.

placement are identified. The B&C liaison coordinates daily with the B&C operators, treatment team, and conservator, if applicable, to meet the needs of clients. There is a strong focus on coordinating client care in the facilities and promptly addressing issues.

During FY 2023–24, the B&C program introduced process modifications to improve care linkages. To mitigate delays that often occurred while providers gathered documentation for admissions, the B&C liaison implemented a documentation submission deadline for health care providers. To increase program capacity and decrease placement delays for older adult clients, the B&C program opened a second Residential Care Facility for the Elderly. In addition, the program instituted intake case conferences to simplify the care plan development process. Providers, conservator(s), and the client collaborate during these meetings to ensure that the client receives the appropriate level of care and services from the program.

Reduces stigma and discrimination: B&C operators are taught that clients' disruptive behaviors often stem from mental health challenges, dispelling the notion that clients are "bad." B&C operators receive training on related diversity, equity, and inclusion topics, such as cultural humility, implicit bias, sexual orientation, gender identity, the Neurosequential Model of Therapeutics (NMT), trauma and trauma-informed care, and the recovery model. During FY 2023–24, the program continued to exhibit their commitment to reducing stigma and discrimination by adhering to the following procedures. B&C operators are trained and required to submit incident reports documenting any potentially discriminatory behavior, which in turn triggers a mandatory review of the situation by the B&C liaison and treatment team. In addition, B&C operators seek to expedite resolution of any concerns expressed by clients. The B&C liaison conducts monthly on-site visits to each B&C facility to evaluate clients' care and maintains regular contact with facility operators. If needed, the B&C liaison will organize a case conference with the treatment team, case managers, and conservators to discuss measures required to address any forms of stigma and discrimination brought to their attention.

Reduces disparities in access to care: All clients placed at a B&C facility are connected to BHRS regional clinics or an FSP program to meet their psychiatric and medical needs. If clinicians determine that a client needs a higher level of mental health services, the care team takes steps to provide timely access to such services. The B&C liaison's role is critical in supporting this objective. Their monthly site visits to each B&C facility and regular communication with B&C operators and treatment teams provide plenty of opportunity for B&C liaisons to assess whether clients are receiving the appropriate level of care.

Increases number of individuals receiving public health services: Because clients are already enrolled in services from the Division of Public Health prior to arriving at a B&C facility, the program is not directly involved in meeting this MHSA objective. However, the program does refer clients to additional organizations that provide field-based case management services, including Bridges to Wellness,[6] Caminar New Ventures,[7] and Adult Resource Management (ARM).

[6] More information about the Bridges to Wellness program can be found at https://www.hpsm.org/about-us/community-impact/community-partners.

Implements recovery principles: The B&C program fulfills MHSA objectives through its commitment to implementing recovery principles, described as follows:

- **Providing trauma-informed care:** B&C operators refer clients experiencing challenges with substance use to SUD treatment programs and to one B&C facility that specializes in serving clients with SUD. B&C operators are trained to recognize relapse symptoms and coordinate with the client's treatment team and the B&C liaison to develop a support plan grounded in recovery principles. The recovery model guides consideration and implementation of trauma-informed interventions at B&C facilities.
- **Promoting care coordination:** Historically, the B&C program used complex case conferences, in which providers at various levels gather to discuss emerging placement issues and brainstorm solutions for supporting clients using recovery principles. Starting in FY 2023–24, B&C began conducting intake case conferences as part of each client's admission into the program. Intake case conferences ensure that new clients' goals and perspectives are incorporated into their care plans from the beginning, setting a better foundation to elevate clients' quality of life. As a result, the program has connected more clients to recovery-oriented resources, such as the HOPE peer mentor program, that host community events and forums.
- **Building social networks:** BHRS clinicians offer recovery-oriented groups at different B&C facilities. Topics addressed through these groups have included seeking safety, illness management and recovery, and managing symptoms for individuals with dual diagnoses.
- **Delivering culturally sensitive care:** The B&C program continues to make progress toward their goal of increasing linguistic access at their facilities. The program now employs bilingual staff who speak Spanish at two of their facilities, enabling the program to provide more internal resources to clients who speak Spanish. In addition, B&C operators coordinate with external bilingual support staff from other county teams to further improve services for Spanish-speaking clients.
- **Maintaining current housing placements:** The program promptly addresses potential behavioral concerns to avoid escalations to larger issues that would risk clients' current housing placements. B&C operators practice harm reduction techniques and connect clients to resources such as Serenity House, HOPE, Bridges to Wellness, ARM, and providers of ICM services.

This section provides a comparison of health care use data, including engagement with other projects, PES episodes, and inpatient/residential episodes, from periods that extended to 3 months before and after clients were admitted to the B&C program. It also displays a breakdown of the B&C episodes that were open at any time during FY 2023–24. The open episodes did not have a discharge date, or the discharge date was within FY 2023–24.

[7] More information about Caminar New Ventures can be found at https://www.smchealth.org/sites/main/files/bhrs_housing_information__november_2020_mrocha_final_0.pdf.

The program served 78 clients in FY 2023–24. The following table summarizes the engagement of B&C clients with other San Mateo County BHRS programs by displaying the total number of opened episodes (see definition earlier) and the average number of episodes per client. For clients who were admitted and actively part of the B&C program during FY 2023–24, there were 11 total episodes opened with an average of 0.14 episodes during the 3 months before program admission. During the 3 months following admission, the total and average number of episodes increased to 28 and 0.36, respectively.

Engagement of Board and Care Clients With Other Programs (*N* = 78; FY 2023–24)

	3 months before admission	3 months after admission
Number of total episodes opened with other programs	11	28
Average number of episodes opened per client with other programs	0.14	0.36

The following table summarizes the health care use information for the 78 clients who were admitted and actively part of the B&C program during FY 2023–24. Three months before program admission, there were 19 PES episodes, and there were no PES admissions 3 months after enrollment in the program. There were no inpatient/residential episodes or days of stay among B&C clients before and after enrollment in the program.

Board and Care Clients' Health Care Use (*N* = 78; FY 2023–24)

	3 months before admission	3 months after admission
Number of psychiatric emergency services episodes	19 [a]	0
Number of inpatient/residential episodes	0	0
Total inpatient/residential stays (in days)	0	0

[a] 19 episodes among 19 clients, or one episode per client.

SUCCESSES

In FY 2023–24, the B&C program celebrated substantial improvements in communication and care coordination with the implementation of intake case conferences. Proactively holding these case conferences enhanced the program's ability to provide client-centered, high-quality care. In addition, program leadership has received positive feedback from both clients and B&C operators on this new operating process. Operators reported that the intake case conferences have helped to clearly delineate treatment team roles and responsibilities, making them feel better prepared to handle any complex client challenges that may arise. Clients have expressed appreciation for the opportunity to share their care preferences during their intake case conference, remarking that this activity makes them feel welcomed, among other positive reactions. In one instance, a client's ability to state their food preferences during this meeting allowed their B&C operator to quickly create and execute a plan for making those food choices available to the client at the facility. During another intake case conference, attendees learned that one client's snoring disrupted the sleep of other residents at night. The B&C operators devised a solution that involved modifying room assignments to eliminate

the disturbance for nearby residents. In both situations, clients stated that they felt heard and supported through this process.

The following client story further highlights the positive client outcomes that the program has derived from implementation of intake case conferences.

Client Success Story #1: A client who had been living independently at Humboldt House recently experienced a significant decline in mental health and physical abilities that prompted their referral to the B&C program. Following the client's transition to a B&C facility (Ismaela's Care Home in San Bruno, California), they heavily grieved the loss of their independence. The client stated that they were upset about the increased level of care that they now required and felt uncomfortable asking for support from the program. However, the B&C program allowed the client's family member to attend the client's intake case conference and contribute to the care plan development process. The client shared that they were grateful to have the support of their family member while initiating their care at the B&C facility. Although the client had been scared and nervous at the beginning of the conference, they felt supported and comforted by the end. Now, after residing at Ismaela's Care Home for 3 months, the client earnestly participates in their recovery and self-care. They regularly attend self-help support groups, meet with their treatment team and Bridges to Wellness case manager, and are an active member of the National Alliance on Mental Illness (NAMI).[8]

Client Success Story #2: A client with an extensive history of hospitalizations and placements in locked facilities located outside of San Mateo County was referred to the B&C program. They completed a 1-year transition period at Hawthorne House, a social rehabilitation facility, where they developed necessary skills for reintegration into the community. After this transition period, the client relocated to Bianca's Place, a B&C facility in San Mateo County, where they have remained for the past 6 months. The client has expressed numerous positive sentiments about residing at this facility, stating that they have made friends with other residents and enjoy attending outings with their HOPE peer mentor. The client is pleased with the food served at the facility, likes to take walks, and appreciates the way they are treated by their community and treatment team at Bianca's Place.

CHALLENGES

Although there were several vacancies in FY 2023–24, the program experienced an overall reduction in licensed facility[9] beds over the past year. Specifically, there was high demand for and low supply of licensed beds within Residential Care Facilities for the Elderly and adult residential facilities for older adults who have ambulation needs, which has forced the B&C liaison to place some clients in care facilities outside of the county. Although B&C has a team of B&C operators trained to manage out-of-county placements, this solution is not ideal for clients, who generally prefer the comfort and familiarity of San Mateo. Even when there are openings in the county, clients with complex care

[8] For more information about NAMI, see https://namisanmateo.org/.

[9] Licensed facilities provide a higher level of care to clients who often need assistance with medication management, meals, and additional therapeutic support compared with clients who live more independently in Supported Housing facilities.

needs sometimes experience referral and intake processing delays. The B&C liaison and operators have expressed frustration over the lack of available resources to quickly resolve these issues.

In an attempt to mitigate bed availability challenges in FY 2023–24, the program initiated a project to expand the Hopkins Manor facility's bed capacity. The program aims to complete this project, which will create more licensed Residential Care Facility for the Elderly beds for clients, in FY 2024–25. Further, the program was recently awarded a preservation grant that will provide funding for other B&C operators to renovate and increase the number of beds in existing facilities. The B&C liaison has also continued efforts to identify motels and other properties available for purchase in San Mateo County that BHRS can acquire to develop new Supported Housing and licensed facilities.

As in previous years, hiring and retaining qualified staff at the B&C facilities continue to be a challenge. Some B&C operators retired because medical concerns limited their ability to fulfill job duties, and the program has experienced difficulty with filling the vacant job openings. High turnover and lack of new job candidates are attributed to limited program funding for paying wages that are competitive with the prevailing market rate. Last year, staffing challenges nearly forced the program to close a facility. In addition, admissions to one facility were halted while the program resolved language barriers between caregiver staff who spoke Spanish and resident clients who spoke English. Program leadership is actively developing potential solutions in FY 2023–24 to mitigate this risk. For example, they are planning innovative ways to market job openings to recruit new operators who are passionate about working with eligible clients. Additional state or federal funding for wages would also enhance recruiting efforts. The program has applied for a state grant that would enable improvements to facilities and client experience. In the event of a facility closure, the program has processes in place to identify alternative facilities to which they can relocate existing clients.

DEMOGRAPHICS

The following table summarizes the demographic information of the 78 clients who were admitted or already actively a part of the B&C program during FY 2023–24. Most clients were between the ages of 26 and 59 years (56.4%) or 60 years or older (42.3%). A majority spoke English as their primary language (75.6%), and the remaining spoke Spanish (7.7%), Arabic (1.3%), or Tagalog (1.3%). Clients who identified as White or Caucasian made up the largest group (41.0%), and the second- and third-largest groups identified as other (15.4%) and Filipino (10.3%), respectively. Most clients did not identify as Hispanic or Latino (53.8%) and did identify as male (70.5%). It is important to note, however, that 12.8% of clients did not report information on their race, 24.4% did not report information on their ethnicity, and 89.7% did not report information on their sexual orientation.

Board and Care Program Client Demographics (N = 78)

	Number of clients	Percentage of total
Age		
0–15 years	0	0.0
16–25 years	1	1.3
26–59 years	44	56.4
60 years and older	33	42.3

	Number of clients	Percentage of total
Primary language		
English	59	75.6
Spanish	6	7.7
Arabic	1	1.3
Tagalog	1	1.3
Unknown/not reported	11	14.1
Race		
White or Caucasian	32	41.0
Other	12	15.4
Filipino	8	10.3
Black or African American	6	7.7
Other Pacific Islander	2	2.6
Chinese	2	2.6
Multiple	2	2.6
Japanese	2	2.6
Laotian	1	1.3
Samoan	1	1.3
Unknown/not reported	10	12.8
Ethnicity		
Not Hispanic or Latino	42	53.8
Hispanic or Latino	15	19.2
Unknown/not reported	19	24.4
Sex assigned at birth		
Male	55	70.5
Female	23	29.5
Unknown/not reported	0	0.0
Sexual orientation		
Straight or heterosexual	7	9.0
Lesbian, gay, or homosexual	1	1.3
Unknown/not reported	70	89.7

GENERAL SYSTEMS DEVELOPMENT (GSD) PROGRAMS

In San Mateo County, GSD programs have been primarily focused on supportive services for individuals with mental illness through integration of peer and family partners throughout the behavioral health system of care, and community peer run and peer focused wellness centers; system transformation strategies that support integration of services across various sectors impacting

individuals with mental illness' lives including co-occurring mental health and substance use disorders, dual diagnosis intellectual disability, criminal justice, child welfare, aging; and integrating evidence-base practice clinicians throughout the system.

SUBSTANCE USE INTEGRATION

SUBSTANCE USE INTEGRATION PROVIDERS AND STAFF

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

PROGRAM IMPACT

The clients served include data from BHRS staff providing co-occurring mental health and substance use disorder services. The clinical contracted providers that support co-occurring mental health and substance use disorder capacity development to BHRS staff and contracts accomplished the following in FY 2023–24:

Clients served by staff	FY 2023–24
Total clients served	192
Total cost per client	$4,672

Quarter 1, July 2023—September 2023

- Training/Technical Assistance:
  - California Advancing and Innovating Medi-Cal (CalAIM) tools review and feedback, annual review
  - StarVista consultation and training
  - Free at Last staff training, coordination support
  - Community reinvestment grant program review
  - El Centro clients living SMI and crisis intervention training
  - Avatar support training for documentation
  - Standards of Care review and prep
  - Human trafficking training for treatment providers
- Strengthening San Mateo County BHRS partnerships:
  - Recovery provider engagement with the system of care (memoranda of understanding with collaborative meetings)
  - Voices of Recovery San Mateo County support/planning
  - Critical incident report review/training
  - University of California, San Francisco thought leader collaborations in development of BHRS Standards of Care

- Care coordination:
  - American Society of Addiction Medicine (ASAM) authorization form and summary—residential providers

Quarter 2, October 2023—December 2023

- Training/Technical Assistance:
  - BHRS Quality Management: CalAIM implementation and policy updates
  - Therapeutic Lifestle Change (TLC) recovery services training and updates for staff
  - StarVista—first chance training on medication and procedure development
  - In-person trainings: professionalism and ethics, boundaries, crisis de-escalation
  - Sitike staff focus group—Standards of Care
  - BHRS analyst support for Avatar documentation and data entry
  - Standards of Care focus groups: TLC, Our Common Ground (OCG)
  - Medication assisted treatment (MAT)—medication education/information dissemination with analysts
- Strengthening San Mateo County BHRS partnerships:
  - Client feedback initiative work plan development
  - Substance use services at county jail
  - Prevention—high schools and waste water monitoring for prevention efforts
- Care coordination:
  - CalAIM overview and linkage presentation for treatment provider collaboration
  - Incident report review and follow-up chain analysis for improved coordination

Quarter 3, January 2024—March 2024

- Training/Technical Assistance:
  - CalAIM preparation and implementation support, three presentations to treatment providers
  - BHRS AOD Standards of Care development and review
  - Coordination of training offerings for FAL
  - StarVista—leadership support following critical incident
  - Human trafficking training for providers at OCG
  - Tuberculosis testing and residential admissions
  - TLC—recovery services support and education
  - Review the Substance Abuse and Mental Health Services Administration's Screening, Brief Intervention, and Referral to Treatment initiative funding opportunity
  - Training on serving unhoused populations
  - Detox training—as-needed and over-the-counter medications—in Level 3.2

- Strengthening San Mateo County BHRS partnerships:
  - Collaboration with Correctional Health Services—SUD services under CalAIM
  - Coordination for "the culture of homelessness"—serving unhoused populations
- Care coordination:
  - Recovery services step down, transfer, and new admit problem solving for providers
  - CalAIM workflow for change in Level of Care (LOC)

Quarter 4, April 2024—June 2024

- Training/Technical Assistance:
  - American Society of Addiction Medicine (ASAM) Level 0.5 training for AOD providers
  - Standards of Care finalization and partner review
  - Narrative regarding 12 Step Fellowship and CalAIM group requirements, documentation
  - CalAIM narrative for "urgent referrals"
  - Slide deck—bundled residential progress notes
  - Clarification for providers on nuances of confidentiality and mandated reporting
  - StarVista trainings—medication protocols
  - BHRS Quality Management copresentation on CalAIM documentation requirements
  - Continued attempts to coordinate trainings for FAL
  - Draft communication for audit "thresholds"
  - El Centro audit—Avatar
  - Diagnosis documentation support for providers/analysts
  - Service League documentation consultation support
  - Fee-for-service shift—recommendations on planning, requirements, and implementation
- Strengthening San Mateo County BHRS partnerships:
  - Analyst consultation on CalAIM progress notes and billing practices
  - BHRS analyst support for modification to California MHSA (CalMHSA) audit tool—site visit support
  - Fee-for-service shift—discussion with partners and preparation for system change
  - Participate in BHRS analyst bi-weekly staff meetings—CalAIM, audit tools, and process
- Care coordination:
  - California Peer Certification regulations and implications for Medi-Cal billing
  - Detox referral process and coordination

YOUTH RESIDENTIALS

During the reporting period, challenges continued with the identified provider for youth residential services. BHRS pays single case agreements with The Camp in Santa Cruz County at a rate of

approximately $32,000 for a 30-day placement for one youth. Although The Camp is not Drug Medi-Cal certified, BHRS has been using The Camp for the past several youth placements as issues have arisen with other providers related to overall loss of funding from other counties and quality concerns.

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

RECOVERY SUPPORT SERVICES

The Voices of Recovery San Mateo County (VORSMC) is a welcoming place for individuals at all stages of recovery. Using a peer support model, the center offers free services and support from peers with lived experience. It helps individuals with substance use and/or mental health challenges acquire the tools and confidence needed to begin, maintain, and enhance their recovery. The center aims to reduce drug and alcohol relapse; build a strong and positive social network; increase self-awareness; promote accountability for substance use; reduce anxiety, stress, and depression; and foster a sense of hope and purpose.

Located in downtown Redwood City and conveniently close to public transportation, the center is open to all adults 18 years and older facing substance use and/or mental health challenges. The staff reaches out to individuals at any stage of recovery, including those who have not yet committed to their recovery, individuals early in recovery, those returning from residential treatment, sober living home residents, and individuals who have been in recovery for many years. The center serves underserved populations, including Latinx, Asian/Pacific Islanders, African Americans, low-income individuals, LGBTQIA+ community members, houseless individuals, the chronically unemployed, and justice-involved populations.

The VORSMC offers peer-based services in English and Spanish.

1. Evidence-based WRAP workshops
2. Peer mentoring and coaching
3. Skill development
4. Job readiness
5. Referrals and connection to resources including housing, education, job training, and outside behavioral health services as needed
6. Rewarding volunteer opportunities

PROGRAM IMPACT

VORSMC is strategically located to enhance access for underserved populations. Its central location near public transit removes transportation barriers, and all services are free, eliminating financial

VORSMC	FY 2023–24
Total clients served	115
Total cost per client	$2,150

constraints. The diverse staff reduce stigma and discrimination by sharing their own stories and experiences with substance use and mental health challenges, providing essential peer mentoring and coaching.

Following the recovery principle, the staff recognizes that everyone's path to recovery is unique and should be tailored to their specific needs and goals. They focus on empowering individuals to take control of their recovery process, make decisions, and set goals, always treating them with respect and promoting hope by sharing their journeys and experiences. These principles create a supportive environment for long-term recovery and help individuals lead fulfilling lives.

VORSMC also fosters partnerships and collaborations between health care providers and community organizations to create a network of support and referrals for services. They work to reduce disparities in access to care by providing WRAP training to health care providers, aiming to improve communication and trust between providers and the diverse backgrounds of the people they serve. VORSMC continuously educates the public about available health care resources through flyers and social media, encouraging individuals to seek care when needed. The staff also advocate for policies addressing social determinants of health such as housing, education, and transportation to help reduce disparities in San Mateo County, with the hope that these efforts will create a more equitable health care system.

SUCCESSES

VORSMC continues to provide intervention through various means. Since the COVID-19 pandemic, it offers hybrid groups with virtual support and peer mentoring. The crisis led to an increase in peers relapsing without adequate help. In response, the program facilitates entry into detox and residential treatment centers. This support has helped peers reconnect with the recovery community and access needed resources. While gradually returning to in-person support, VORSMC maintains virtual options. The following real stories illustrate the impact of VORSMC' support.

Client Success Story #1: In J.N.'s words, "Voices of Recovery play a crucial role in my sobriety and wellness by providing a platform for shared experiences and mutual support. Hearing stories from others who have faced similar struggles reminds me that I am not alone in my journey. These personal accounts often include practical advice, emotional insights, and coping strategies that have proven effective for others. This shared wisdom not only reinforces my commitment to sobriety but also equips me with new tools and perspectives to handle challenges. Furthermore, the sense of community fostered through Voices of Recovery instills a sense of belonging and accountability, which is vital for maintaining long-term sobriety. Additionally, being active in Voices of Recovery allows me to reflect on my progress and contribute to the recovery of others. By sharing my story, I can offer hope and encouragement to those who are at different stages of their sobriety journey. This act of giving back reinforces my commitment to staying sober, as it reminds me of how far I have come and the importance of continuing on this path. The process of articulating my experiences also helps me process my emotions and recognize my growth providing therapeutic outlet. In this way, Voices of Recovery not only supports my sobriety but also empowers me to be an active positive force within the recovery community."

Client Success Story #2: In H.N.'s words, "I have been addicted to drugs since the age of 14. I had found my way into a dark hole very fast and still around the age where I was trying to figure out exactly who I was. Developing my teens already with chaos at home, I was depressed and doing anything to get far away from the troubles related to my parents' divorce. I found running to drugs was my escape from reality. Reality became distorted. I started to lose all touch with normal, after many years of extended using starting with one drug and exceeding to many different varieties to change the way I felt. In and out of the justice system there had been many times where I found myself trapped and alone. Slowly over time, I started to lose the relationships with family and any friends I had ever made. My words and "sorrys" only lasted so long. Everyone that I cared about didn't want to hear the excuses without action anymore. So, I had started to allow myself to believe that if they are going to give up on me, then why should I try to rebuild anything better again? I had lost many years due to the justice system—years that cannot be replaced—but along the way, I started to understand that the choices I had been making were only going to repeat themselves unless I was willing to make the initial change to actually start my life. After losing everyone, I thought the only way I could become a better person was if I had someone who loved and cared for me. So, I looked for love in all the wrong places. I hit bottom many times, only to pick myself back up and get a little far and then lose it all again—having better started to become uncomfortable. How can normal be uncomfortable? There were many times I wanted to see normal again but it was so far from my understanding that giving up and living the lifestyle of the streets had become much more familiar. Going without, having to strive for shelter and food—that was normal. It took over 22 years for me to really want change for myself and my life. My exact moment for change was the day I had found myself in custody facing my second Romero hearing for burglary and theft charges. Stealing had become a quick way I found myself able to pay for my habit. I had become completely tired, tired of having nothing to be proud of and nothing to call my own. An adult in my later years, I had established nothing even remotely successful for myself and no experience that could help me professionally. I had an extensive criminal record. Starting over was going to be really hard—finding a profession where someone was willing to actually allow me to start an opportunity to grow, and that's where I found gratitude started to develop when I found Voices of Recovery. It was there that I started to not only love myself but find meaning in my life and find exactly what I wanted to accomplish. I finally had the willingness and desire to put in the effort for a better future not only for my personal life but for my career goals. It has taken time to really focus on what it is I wanted to accomplish with it being short-term or long-term goals. Goals were never something I had ever thought I would start to implement into my life. I no longer need to worry about problems in my life that are unmanageable, only by the simple fact that I didn't want to handle them most of the time in the past, but to meet these situations head on and solve my own problems willingly, learning from them and to growing from them. My life no longer has to be that of sadness and loss, and it is about hope and acceptance and a desire to want to change for myself. I am finally accomplishing more today than I have ever imagined possible. It was for the belief and opportunity I found at Voices of Recovery that allowed me to believe in myself, realize what it is I want to do with my life. I've come to realize the importance and value of my own life. I am worthy today and am grateful for what life has to offer, and what I can offer myself. It's a very empowering and enlightening feeling to know so much can start with the work you put into yourself. The sky's the limit!"

Quotes from WRAP groups:

- What was most helpful to you in today's group?

"Everyone getting along."

"Being able to honestly express myself with my peers and be heard and acknowledged."

"Support, connection, recovery!"

- Other comments:

"People are real."

"Keep coming back. It works!"

"Not long enough."

"Christian's story was really interesting."

CHALLENGES

Recovery Connection is experiencing operational challenges related to facility capacity because of significant growth in program participation. The rapid expansion has necessitated relocating support groups to upper level spaces and repurposing conference areas to accommodate increased attendance. To ensure accessibility compliance and maintain inclusive services, VORSMC installed an Americans with Disabilities Act (ADA)-compliant lift to facilitate access for participants with mobility requirements.

Although VORSMC has successfully attracted an expanding volunteer base, current staffing limitations and office workspace constraints have resulted in underutilization of volunteer resources. To address these operational inefficiencies and support continued growth, VORSMC has identified the need for additional funding to create two key positions: a program manager and a training coordinator. These roles would enhance organizational capacity by providing comprehensive support for staff operations and community engagement. The training coordinator would specifically focus on developing and implementing volunteer workforce development programs, ensuring that volunteers acquire valuable skills while contributing meaningfully to the organization's mission.

DEMOGRAPHICS

VORSMC Program Client Demographics (N=157)

	Number of clients	Percentage of total
Age		
0–15 years	0	0.0
16–25 years	6	4.0
26–59 years	97	62.0
60–73 years	22	14.0
74 years and older	0	0.0
Prefer not to answer/unknown	3	20.0

	Number of clients	Percentage of total
Primary language		
English	63	40.0
Spanish	24	15.0
Another language	7	5.0
Prefer not to answer/unknown	63	40.0
Race/ethnicity		
Asian or Asian American	0	0.0
Black or African American	16	10.0
Native Hawaiian or Pacific Islander	8	5.0
White or Caucasian	35	22.0
Latino/a/x or Hispanic	55	35.0
Multiple races/ethnicities	0	0.0
Another race, ethnicity, or tribe	24	15.0
Prefer not to answer/unknown	20	13.0
Sexual orientation		
Gay, lesbian, or homosexual	6	4.0
Straight or heterosexual	85	54.0
Bisexual	0	0.0
Queer	0	0.0
Another sexual orientation	2	1.0
Prefer not to answer/unknown	64	41.0
Gender identity		
Female/woman/cisgender woman	71	45.0
Male/man/cisgender man	75	48.0
Transgender woman/trans woman/trans-feminine/woman	0	0.0
Transgender man/trans man/trans-masculine/man	0	0.0
Non-binary/gender non-conforming	5	3.0
Prefer not to answer/unknown	6	4.0

OLDER ADULT SYSTEM OF CARE

OLDER ADULT SYSTEM OF INTEGRATED SERVICES

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

60 years and older who are living with SMI and are homebound because of mobility issues and functional limitations.

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

PROGRAM IMPACT

Older Adult System of Integrated Services	FY 2023–24
Total clients served	146
Total cost per client	$5,326

Improves timely access and linkages for underserved populations: The program continued to improve timely access to care for prospective clients by following established procedures. These procedures ensured that program staff conducted an initial assessment of the referral and connected individuals who met minimum eligibility requirements with case management services within 3 days. From there, if a client needed to meet with a psychiatrist, they were generally assigned one within a week of their case manager placement, with a first visit occurring 4–-6 days later.[10]

Compared with the prior fiscal year, the program became more efficient at linking clients with screening and treatment services. Previously, initial physicians' assessments were conducted by attending physicians, whose part-time schedules and demanding caseloads caused scheduling delays. To mitigate these delays, resident physicians—whose schedules are much more flexible—absorbed the responsibility of conducting initial physicians' assessments for most clients, aside from those considered complex cases or for whom providers had safety concerns. This process change has also benefited residents, enabling them to meet or surpass their graduate education quotas for conducting in-home visits and in-home assessments. In addition, the program complied with CalAIM requirements by implementing a "no wrong door" policy for referrals. Because of this policy, OASIS relaxed their eligibility restrictions, particularly the housing and mobility requirements.[11]

For cases that still did not meet their relaxed criteria, the OASIS program coordinated with staff from other San Mateo County programs, including AOT, Homeless Engagement Assessment and Linkage (HEAL), and Board and Cares (B&C). OASIS case managers worked with the partner programs to support the clients being referred to OASIS. OASIS staff attempted multiple times to contact a

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

[11] Previous OASIS policy stated that eligible clients must (a) have a stable housing situation and (b) be homebound within their residence because of physical limitations. In accordance with the new "no wrong door" policy, OASIS now accepts clients who may meet only one of the two criteria.

previously linked client who was recently experiencing homelessness, and the program directly transferred the client to the AOT team to receive care.

Reduces stigma and discrimination: The program continued to reduce stigma and discrimination for clients by maintaining their partnership with Project Sentinel. This organization provides housing advocacy, legal aid and consultation, and related solutions to clients who are pushed out of their housing because of discrimination over their age, cognitive decline, or an SMI diagnosis. The OASIS program's collaboration with Project Sentinel staff resulted in the restoration of several clients' prior housing arrangements. OASIS staff also continued their involvement with county health and equity initiatives that support seniors' well-being.

During this past fiscal year, the program also focused on enhancing social connectivity to reduce the stigma and discrimination affecting many clients who experienced isolation during the COVID-19 pandemic. To mitigate the negative effects that stigma can have on clients' mental health and social connectedness, the OASIS program arranged for a part-time behavioral health paraprofessional and onboarded multiple Vocational Rehabilitation Services trainees, who provide transportation assistance to OASIS clients. In addition, the program partnered with senior centers, such as the Coastside Adult Day Health Center, an organization that runs an adult day-care program. In addition to offering individualized health services such as nursing, medication monitoring, and occupational and speech therapy, senior centers provide clients with opportunities to connect with other community members through activities such as physical therapy, games, lunches, and other social events.

Increases the number of individuals receiving public health services: During the past year, the number of individuals receiving public health services through the OASIS program decreased from about 200–140 clients. Program staff attributed this decrease to challenges that are discussed in Section 5 of this report.

Reduces disparities in access to care: Most clients served by this program are from underserved communities and would not have access to necessary physical and mental health care because of financial limitations.[12] The OASIS team continued to provide case management, therapy, psychiatry, medical care, transportation services, and referrals to food assistance programs or other community-based services to help clients achieve a healthier life. The program continued their partnership with the Ron Robinson Senior Care Center and Upward Health to ensure that clients' medical needs were met. Because OASIS clients are often medically frail, the program used existing partnerships with primary care providers in the community to promote access to medical care. The program continued to collaborate with Puente Clinic, a coastal CBO serving clients who live alone and farther away from inland services. In addition, the OASIS team continued to connect clients with the Coastside Adult Day Health Center, an organization that runs an adult day-care program. The program also partners with IHSS providers, who aid disabled seniors in the safety and comfort of their homes. When clients are

[12] Underserved populations lacking access to adequate health care may include older adults, racial or ethnic minority groups, individuals with advanced behavioral health needs, or individuals experiencing homelessness. See https://toolkit.ncats.nih.gov/glossary/underserved-group/#:~:text=The%20U.S.%20Health%20Services%20Administration,or%20a%20high%20elderly%20population.

unable to live independently at home, staff also continued to connect them to B&C facilities, which are senior living facilities that care for residents who need assistance but do not require ongoing, skilled nursing care. To further reduce disparities in access to care, the program has been exploring new ways to partner with regional care clinics to coordinate case management responsibilities and provide clients with the best possible support.

During the past year, the OASIS program continued to reduce disparities in access to care by contributing to a cross-departmental effort to promote equitable access to COVID-19 vaccines, which was especially beneficial given seniors' increased vulnerability to the virus. The program followed a protocol for new clients to document their COVID-19 vaccination history and assess their interest in receiving informational updates in the future. When clients were unable to recall their vaccination history, OASIS staff worked with primary care physicians (PCPs) and nurse practitioners (NPs) to access these data. The OASIS team also transported and/or escorted clients to and from their vaccination appointments and tracked vaccine administration. Although the San Mateo County Board of Supervisors voted to end the county's state of emergency for the COVID-19 pandemic prior to the start of FY 2023–24,13 OASIS's documentation and assistance with vaccination access proved useful in mitigating the scale of recent outbreaks in B&C facilities. With declining client interest in vaccination support, the program is currently unsure if they will maintain the current scale of their COVID-19 operations in future years, although staff will continue offering the same services.

Implements recovery principles: The OASIS program fulfills MHSA objectives through its commitment to implementing recovery principles, described as follows:

- **Providing trauma-informed care:** To assist clients with hoarding tendencies, OASIS staff used the NMT framework.[14] Assessments generated through this trauma-informed approach help guide treatment plan modifications, including assigning in-field providers to help clients declutter and make their home environment safer. In addition, program staff often referred clients with AOD use disorders to an AOD counselor with the ARM team. The counselor worked with clients on trauma-informed harm reduction, motivational interviewing, and education about treatment options.
- **Promoting care coordination:** OASIS staff connected clients with Upward Health, an organization that consults with clients to address their concerns about housing or health issues and assesses whether a client needs additional IHSS. OASIS staff also continued to work with the HPSM to increase the level of support provided by IHSS caregivers, either by obtaining more hours with an IHSS caregiver or advocating for a different level of care for the client. Staff continued to minimize older adult client confusion by tracking and reducing the number of different providers and organizations that conduct home visits with clients. The OASIS team maintained their strong working relationships with BHRS-contracted providers to manage the care provided to clients within Residential Care

[13] See https://www.smcgov.org/ceo/news/board-supervisors-ends-covid-19-state-emergency.
[14] The stages of NMT include assessing developmental history, building a brain metric to describe level of brain functioning, and developing a detailed treatment plan. For more information on the NMT approach, see https://sussexpsychology.co.uk/neurosequential-model-therapeutics/.

Facilities for the Elderly and B&C facilities. They continued to consult and inform other teams of the OASIS program's services and even supported staff from other programs by checking to see whether their clients were eligible for Upward Health or IHSS services.

- Delivering culturally sensitive care: The OASIS program's case management team is composed of staff with diverse backgrounds who have strong connections with the communities they serve, including the African American community and communities that speak Spanish. The team successfully recruited two case managers who speak Mandarin and Cantonese to help provide care to the high proportion of individuals living in northern parts of the county who identify as Asian or Pacific Islander. Their translation assistance during psychiatrist visits with clients was very helpful. In addition, all staff are allies of the LGBTQ+ community.
- **Building social networks:** OASIS staff collaborated with families to build a strong support network for each client and facilitated community members' involvement in clients' recovery. For example, the program has a part-time behavioral health paraprofessional who helped advocate for clients. The program also gained additional Vocational Rehabilitation Services drivers, who are trained to build strong interpersonal connections with clients and provide transportation services.
- **Maintaining housing placements:** The team is well versed in consultations with family members and children, often advising family caregivers on how to advocate for better outcomes between clients and housing authorities. In the past fiscal year, the program handled multiple challenging cases of clients being evicted from their placements. In one case, program staff accompanied a client to the hospital, advocated for them to receive neuropsychological testing, and connected them to resources at the Institute on Aging within just a couple of months.[15] It could take years for an individual experiencing neurocognitive decline to receive neuropsychological testing and secure adequate housing without the staff's help.

The following table summarizes the health care use information for the 146 clients who were admitted to the OASIS program during the FY 2023–24. Among the OASIS clients, during the 3 months before program admission, there were 10 PES episodes and no inpatient/residential episodes. During the 3 months following their admission, none of the OASIS clients had a record of using the same health care services.

OASIS Clients' Health Care Use (FY 2023–24)

	3 months before OASIS admission	3 months after OASIS admission
Number of PES episodes	10 [a]	0
Number of inpatient/residential episodes	0	0
Total inpatient residential stays (in days)	0	0

Note. OASIS = Older Adult System of Integrated Services; FY = fiscal year; PES = psychiatric emergency services.

[15] For more information on the nonprofit organization Institute on Aging, see https://www.ioaging.org/.

[a] 10 episodes among 10 clients, or one episode per client.

SUCCESSES

The OASIS team celebrated substantial improvements in communication and care coordination this past year, which had been reported as challenges during the previous FY 2022–23. The team achieved these improvements through the implementation of process changes and strengthening their relationships with partner organizations. To improve communication, they started regularly inviting representatives from different organizations to staff meetings. For example, recent staffing changes within the Lanterman-Petris-Short conservatorship office had created communication barriers for OASIS staff attempting to coordinate with conservators for consent forms or recertifications. Inviting Lanterman-Petris-Short staff to OASIS meetings helped to improve coordination between the teams. OASIS staff also strengthened their partnership with the Coastside Adult Day Health Center to improve care coordination for existing clients and boost new referrals. Clients benefited from increased socialization at the day program, whose group activities align with recent San Mateo County initiatives focused on preventing older adults from experiencing isolation and improving mental well-being.

In addition to the team's newfound success with communication and care coordination, they continued to excel in building therapeutic alliances with clients through increased face-to-face interaction and connections to in-person services such as the California Clubhouse.[16] This social and vocational rehabilitation program provided emotional and psychological stimulation to county residents living with SMI.

Last, OASIS staff are proud of their increased language capacity for serving clients who speak Mandarin and Cantonese. With the addition of a new multilingual case manager, they were able to engage with these clients and support the psychiatrist in delivering culturally appropriate care. This achievement is especially exciting considering that clients who speak Mandarin and Cantonese are traditionally resistant to seeking treatment for mental health.[17]

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

Client Success Story #1: A 77-year-old OASIS client living with posttraumatic stress disorder, major depressive disorder, and attention deficit disorder had become increasingly dependent on their IHSS caregiver because of experiencing recurring delusions, incontinence, and overall neurocognitive decline. Staff became concerned that the client would be evicted from their current residence because of multiple arguments with neighbors and episodes of sundowning—a combination of symptoms that people living with dementia often experience in the evening, including confusion,

[16] See https://californiaclubhouse.org/ for more information.
[17] See https://www.uclahealth.org/news/article/confronting-mental-health-barriers-asian-american-and-2#:~:text=Overall%2C%20Asian%20Americans%20are%2050,Ito.

anxiety, wandering, hallucinations, and difficulty sleeping.[18] The client's current IHSS caregiver was struggling to meet their care demands and had upcoming extended medical leave, prompting additional concerns about the client's safety. Historically, the client had been resistant to relocating to a B&C facility or skilled nursing facility and had signed themself out of previous stays at these facilities on multiple occasions. OASIS staff explored the option of coordinating with Adult Protective Services; however, they learned that the client would not be eligible for Adult Protective Services while paired with a caregiver. Fortunately, a case manager who had recently joined the OASIS team had strong, positive working relationships with care facilities in the area from their previous role as a social worker. This new staff member leveraged their connections and built a therapeutic alliance with the client to successfully coordinate a 6-week respite care stay at a skilled nursing facility for the client during the caregiver's leave. The case manager was instrumental in providing emotional and physical support to the client during and after their housing transition, meeting frequently with the client during their stay at the skilled nursing facility. The OASIS team is hopeful that the client's positive experience during this skilled nursing facility stay will encourage them to reconsider relocating permanently to a B&C facility, thereby ensuring they have access to a more appropriate level of care in the future.

Client Success Story #2: A 75-year-old OASIS client living with complex medical needs and who speaks Spanish had been living with their partner of many years, whom they relied on for personal care and companionship. This client was isolated in their apartment, which is located on the second floor in a building with no elevator, because of mobility limitations that prevent them from using the stairs. OASIS staff frequently conducted home visits to support the client in managing their symptoms of depression and anxiety. Recently, the client's partner had to travel out of the country, causing the client to experience symptoms of severe anxiety and distress. The client described feeling as if they were dying during this time of separation. In response, the OASIS team provided the client with additional psychiatric care and therapy at home, and an OASIS case manager coached them on use of breathing and grounding techniques that have subsequently led to the client reporting improvements in anxiety levels. This mental health support prevented the client from needing emergency room visits and decreased the frequency of calls to their OASIS case manager. Because of the limited mobility that the client is experiencing, they would not have had access to these services without the help of the OASIS program.

Client Success Story #3: An 88-year-old OASIS client with a history of experiencing symptoms of schizophrenia, psychosis, and anxiety had been living with and caring for their disabled adult son in their family home for several decades. In recent months, worsening of the client's medical concerns and deterioration of overall health and cognitive skills had prevented them from being able to adequately care for themself or their son. However, the client refused to leave their family home for relocation to a B&C facility because they did not want to be separated from their son. The OASIS team worked closely with the client and their primary care team to ensure that they received adequate in-home medical and psychiatric care. However, the client's native language was not English, and this language barrier created challenges for their health care providers. OASIS staff

[18] See https://www.webmd.com/alzheimers/manage-sundowning.

connected the client to language-based services to help the client communicate with their care teams and social worker. They also coordinated with other community agencies to provide the client with additional care and support, including IHSS, daily food delivery, and peer socialization activities. Without the assistance of the OASIS team, the client likely would have been relocated from their family home to a B&C facility and separated from their son.

CHALLENGES

OASIS staff encountered challenges related to staffing, low numbers of enrolled clients, and coordinating respite support for unique cases in FY 2023–24. During the past year, the number of individuals receiving care through the program decreased from about 200 to 120 clients. The program's capacity to serve clients decreased because of the recent retirement of three long-tenured case managers, who were responsible for managing and administering long-acting injectable medications to clients in the field. The exit of these three staff members prompted the reevaluation and subsequent transfer of many former clients to higher levels of care in skilled nursing facilities. Additional reasons for the decrease in clients include fewer referrals and the deaths of some clients.

After the departure of the program's nurse in FY 2022–23, the program has not been able to hire for this position. The lack of an in-house nurse to provide medical expertise has created barriers to medical case management[19] and delivery of long-acting injectables. As a temporary solution while seeking a permanent hire, staff have outsourced these responsibilities to nurses from other clinics. However, this outsourcing, in combination with staff turnover within OASIS and in other partnership organizations, has created process delays in the short term. Finally, staff have expressed difficulties related to coordinating respite care for certain clients who do not meet program age requirements or who do not require the higher levels of care offered at a skilled nursing facility.

To address staffing challenges, the program recruited a new psychiatric social worker who was onboarded in September. They are still looking to hire a psychiatric nurse and more case managers. The program is hopeful that these additional staff will regrow the program's client capacity in the next fiscal year. In an effort to comply with CalAIM, and in anticipation of greater staff capacity to handle increased caseloads, OASIS relaxed their program eligibility rules to accept non-homebound or unhoused clients on a case-by-case basis. In the near future, the program hopes to fully eliminate these requirements. The program is also hoping to receive more referrals from partner organizations such as the Coastside Adult Day Health Center. OASIS staff are collaborating with the program's deputy director and medical director to create additional solutions that mitigate these challenges.

Client Challenge Story: An individual younger than 60 years living with a traumatic brain injury did not meet the OASIS program's age eligibility criteria. Because of challenges with recurrent substance use and difficulty following community rules, this individual was unable to maintain their housing placements at B&C facilities. They also experienced challenges with low executive functioning, had partial paralysis, and were confined to a wheelchair because of their traumatic brain injury, which made them ineligible for many of the nearby housing facilities. Although the individual was too young

[19] The nursing position is responsible for managing a full caseload of 25 to 30 clients.

to receive services from the OASIS program, OASIS staff accompanied the individual to the hospital, advocated on their behalf in conversations with multiple levels of hospital staff, and successfully appealed for them to be granted a long-term hospital stay. In addition, OASIS staff collaborated with the Institute of Aging to secure a permanent residence for the individual following their hospital stay. After 2 months of complex case conferences that required input from multiple OASIS case managers, the OASIS program achieved a B&C placement for the individual at the A&J Assisted Living Facility in Colma, California.

DEMOGRAPHICS

The following table summarizes the demographic information of the 146 clients who were admitted and actively a part of the OASIS program during FY 2023–24. All but two clients were 60 years or older. Most clients identified as White or Caucasian (37.9%), with other (18.5%) and Asian (12.3%) being the next most commonly identified races. Whereas most clients spoke English as their primary language (69.6%), 14.3% reported Spanish and 7.5% reported Mandarin as their primary language. Most identified as not being Hispanic or Latino (52.7%). It is important to note, however, that 93.2% of respondents did not report information on their sexual orientation, 24.7% of respondents did not report information on their ethnicity, and 22.6% of respondents did not report information on their race.

BHRS OASIS Program Client Demographics (N = 146)

	Number of clients	Percentage of total
Age		
0–15 years	0	0
16–25 years	0	0
26–59 years	2	1.4
60 years and older	144	98.6
Primary language		
English	112	69.6
Spanish	23	14.3
Mandarin	12	7.5
Cantonese	6	3.7
Russian	2	1.2
Tagalog	1	0.6
Other Chinese language	1	0.6
Unknown/not reported	4	2.5
Race		
White or Caucasian	54	37.0
Other	27	18.5
Asian	18	12.3
Black or African American	9	6.2
Multiple	4	2.7

	Number of clients	Percentage of total
Native American	1	0.7
Unknown/not reported	33	22.6
Ethnicity		
Not Hispanic or Latino	77	52.7
Hispanic or Latino	33	22.6
Unknown/not reported	36	24.7
Gender assigned at birth		
Female	108	74.0
Male	38	26.0
Sexual orientation		
Straight or heterosexual	7	4.8
Declined to state	3	2.1
Unknown/not reported	136	93.2

Note. BHRS = Behavioral Health and Recovery Services; FY = fiscal year; OASIS = Older Adult System of Integrated Services.

PEER COUNSELING PROGRAM

The Peer Counseling Program (formerly, Senior Peer Counseling Program) from the Peninsula Family Service (50% CSS, 50% PEI) comprises 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, including those who identify as LGBTQ+, with support offered in languages such as English, Mandarin, Cantonese, Spanish, and Tagalog. The Peer Counseling Program provides peer support by trained and supervised older adult volunteers. The program serves older adults, 55 years and older, who reside in San Mateo County and are isolated, depressed, and anxious. The program targets the underserved older adult population who may be monolingual in Spanish, Mandarin, Cantonese, or Tagalog or who identify as LGBTQ+.

In FY 2023–24, the Peer Counseling Program served 603 unduplicated individuals in San Mateo County through their one-on-one peer counseling and group sessions. Program outcomes, successes, and challenges are included in the PEI section of this MHSA Annual Update document.

CRIMINAL JUSTICE INTEGRATION

PATHWAYS COURT MENTAL HEALTH PROGRAM AND HOUSING

Pathways—a partnership among the San Mateo County Superior Court, probation department, district attorney, Private Defender Program, sheriff's office, Correctional Health Services, NAMI, and BHRS—is an alternative to incarceration for eligible adult residents of San Mateo County. The Pathways program serves individuals (clients) living with a functionally impairing SMI who have been

arrested for a crime, are statutorily eligible for probation, and agree to undergo Pathways-supported treatment and community rehabilitation in lieu of incarceration.

Since Pathways began in 2006, 177 participants have been served by the program and 10 graduated from the program in the last fiscal year (FY 2023–24). During the reporting period for FY 2023–24, Pathways employed four case managers, two full-time clinicians, and one mental health program specialist who collectively served 47 clients. The Pathways judge presents all program graduates with signed certificates and waives court costs in recognition of the clients' hard work. In addition, some graduates' legal charges are expunged.

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

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

In addition to providing ICM services, Pathways staff lead rehabilitation skills groups and organize community-building activities. Pathways's lead clinician and a PSW co-facilitate a weekly socialization and skills group at the Pathways Clubhouse, a nonprofit organization that seeks to foster an inclusive, supportive community for clients with mental illness. The objectives of this weekly group are to improve clients' communication skills and alleviate their SMI and SUD symptoms. Pathways also offers process-oriented groups—one for men and another for women—that meet weekly to reinforce existing support systems and promote healthy coping skills. Last, Pathways runs two cognitive behavioral therapy (CBT) groups. The two clinicians and two case managers who facilitate these groups apply evidence-based CBT practices from the Thinking for a Change model, which teaches cognitive strategies that can disrupt and replace negative thought processes.

As in prior years, Pathways hosted multiple in-person or virtual social events in FY 2023–24 that enabled clients to build and maintain relationships with other program participants, staff, program graduates from prior years, and community members. Pathways graduates from past years often attend the annual picnic, among other events, and serve as role models for current Pathways participants.

PROGRAM IMPACT

Increasing public health services utilization through engagement with community partners: In FY 2023–24, Pathways program staff continued to educate

Pathways	FY 2023–24
Total clients served	47
Total cost per client	$2,159

other county programs (e.g., the county's Private Defender Program[20]) and clinics about their referral process through refresher presentations. Heightened awareness of the Pathways program and its mission tends to drive increases in referrals, which can ultimately lead to more widespread utilization of public health services among eligible residents living with SMI.

Improving timely access for recently incarcerated clients through ICM: Under California's timely access mandate, the HPSM is required to provide mental health services within 2 weeks of the initial request. The Pathways program's ICM team helps the HPSM fulfill this mandate by working expeditiously to place newly referred Medi-Cal clients with an outpatient mental health provider following their release from jail. The timeliness of this referral process is also important because client adherence to a psychiatric medication treatment regimen is often a precondition for acceptance into the program.

Reducing stigma and discrimination by educating clients and engaging with community partners: In FY 2023–24, Pathways staff continued to take proactive, concrete steps to combat stigma and discrimination related to clients' mental health and SUD diagnoses after they were referred to the program. The following are some examples of continued efforts:

- Providing a safe space for clients to speak openly about their struggles with mental illness and addiction during group-based skills sessions.
- Collaborating with local NAMI and other community-based partners to organize and promote various educational activities, including the annual NAMI awareness walk, Mental Health Month speaking engagements, and suicide prevention initiatives.
- Encouraging clients to enroll in the OCFA's Lived Experiences Academy, an 8-week training program whose leaders encourage participants to share details of their experiences related to mental health and/or substance use challenges. This program continues to help clients empower themselves, further the healing process, fight stigma, and educate others about behavioral health conditions.

In the past year, Pathways clients have participated in several events designed to foster an inclusive community and reduce the stigma of mental illness or other aspects of clients' identities. For example, clients attended events related to health equity, LGBTQ+ pride, and spirituality. Pathways staff also organized initiatives for clients from Pacific Islander and Latino communities.

In addition, program staff have participated in training sessions to ensure that they continue to provide culturally competent services for Pathways clients. For example, staff attended SOGI training sessions in the past year.

Addressing disparities in access to care: In FY 2023–24, Pathways staff routinely helped clients from traditionally underserved populations overcome barriers to using public health services. Many newly referred clients appear to have difficulty independently navigating their health care options. The

[20] See https://www.smcgov.org/private-defender-program.

Pathways team continues to support clients by guiding them through all the steps required to obtain appropriate services in a timely manner. When the stigma associated with certain offenses proves problematic, it may be harder for these clients to access care, but Pathways staff continue to advocate for clients' rights to receive care.

Implementing recovery principles: In FY 2023–24, Pathways staff continued to demonstrate their commitment to using several recovery principles, described as follows:

- Promoting care integration: Staff schedule recurring case conferences with the care team for clients who have enrolled in a residential or outpatient SUD treatment program. This coordination is critical to ensuring the timely development of either (a) a transitional care plan or (b) documentation that the court must review before issuing a mandate for continued treatment in a residential facility. Case conferences also keep program staff apprised of Pathways clients' relapses, which often require treatment plan modifications. For example, staff often provide struggling clients with more ICM services to minimize the risk that clients fail to attend subsequent appointments with clinicians and/or probation officers.
- Facilitating the involvement of community members: Staff connect clients living with SMI and and/or SUD with Voices of Recovery San Mateo County, a nonprofit organization that fosters peer-led opportunities for "education, wellness, advocacy, and support for those seeking long-term recovery from alcohol and other drugs."[21]
- Delivering trauma-informed care: Pathways employs staff with specialized training in recovery counseling who organize recovery events tailored to the needs of current clients and program graduates.

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

The following table summarizes the health care use information for the 33 clients who were admitted and actively a part of the Pathways program during FY 2023–24. During the 3 months before program admission, there were 12 psychiatric emergency services (PES) episodes and no inpatient/residential episodes or days of stay among Pathways clients. During the 3 months following their admission, none of the Pathways clients had a record of using these health care services. Please note that these results are as of early October 2024 and may not reflect all health care utilization during the 3 months after admission for those clients admitted late in the fiscal year.

Number of unduplicated clients served: 33 active participants

Total number of clients: 33 active participants

[21] See https://www.vorsmc.org/.

Pathways Clients' Health Care Use (FY 2023–24)

	3 months before admission	3 months after admission
Number of psychiatric emergency services episodes	12[a]	0
Number of inpatient/residential stays (in days)	0	0
Total inpatient residential stays (in days)	0	0

[a] 12 episodes among 12 clients, or one per client.

The following table displays Pathways clients' probation violations before and after they were admitted to the program. Among the 33 clients with probation violation data who were admitted and actively a part of the Pathways program during FY 2023–24, three (9.1%) had a probation violation before they were admitted to the program, and nine (27.3%) had a probation violation after they were admitted to the program.

Pathways Clients' Probation Violations (FY 2023–24)

	Before admission	After admission
Number of clients with probation violation	3	9
Percentage of clients with probation violation	9.1	27.3

The following table displays the number and the percentage of Pathways clients who were taken into custody before and after they were admitted to the program. Among the 33 clients with custody data who were admitted and actively a part of the Pathways program during FY 2023–24, 31 (93.9%) were taken into custody before they were admitted to the program, and only seven (21.2%) were taken into custody after they were admitted to the program.

Pathways Clients Taken into Custody (FY 2023–24)

	Before admission	After admission
Number of clients taken into custody	31	7
Percentage of clients taken into custody	93.9	21.2

The following table summarizes the housing information for clients with housing data who were admitted and actively a part of the Pathways program during FY 2023–24. More than half (51.5%) reported living in a home or an apartment, five reported living in an unlisted environment (15.2%), four reported living in a residential setting (12.1%), and four reported living in a sober living environment (12.1%).

Pathways Clients' Housing Status (FY 2023–24)

Housing	Number of clients	Percentage of clients
Home/apartment	17	51.5
Other	5	15.2
Residential	4	12.1
Sober living environment	4	12.1
Incarcerated	3	9.1
Unhoused	0	0.0
Total	**33**	**100.0**

The following table summarizes the employment information for clients with employment data who were admitted and actively a part of the Pathways program during FY 2023–24. Among these clients, 33.3% reported being employed, 33.3% reported being unemployed, and 33.3% reported unlisted employment, such as Social Security Disability Insurance, as seen in the Other category in the following table.

Pathways Clients' Employment Status (FY 2023–24)

Employment	Number of clients	Percentage of clients
Employed	11	33.3
Not employed	11	33.3
Other	11	33.3
Total	**33**	**100.0**

SUCCESSES

Program leadership emphasized that Pathways's weekly socialization and skills-building groups continued to be successful in FY 2023–24. The men's, women's, and CBT skills groups, which are held once a week, continue to help clients learn about and practice healthy coping skills in their daily lives. Pathways staff noted that, over time, the close rapport and trust that develops between group participants gives clients a sense of safety, agency, and confidence. In addition, positive peer support within the socialization groups has been prominent in the past year.

In FY 2023–24, staff referred more clients to the county's Vocational Rehabilitation Services than in FY 2022–23. Vocational Rehabilitation Services helps individuals living with SMI and other disabilities build their occupational skillsets and seek employment. Pathways staff also began referring clients to another county-based resource, Service Connect, which provides employment services for former inmates.

Client Success Story: A client was initially hesitant to join the Pathways program, and his probation officer had concerns about his behavior. However, as the client continued to engage in Pathways activities, he built trust with program staff and his probation officer. He soon became an active member in group sessions and had a positive influence on his peers and Pathways staff members.

After graduating from the program, this client enrolled in a peer support specialist (PSS) program and volunteered for several programs and groups. For example, he helped set up a spiritual event for the Interfaith National Day of Prayer. He also volunteered with the AACI for Juneteenth celebration events and graduated from the OCFA's LEA. During the past FY, this client has organized more than 10 peer-led activities.

CHALLENGES

Managing initial residential treatment placements for clients continued to be challenging in FY 2023–24. Several sober living environments have closed in the past few years, and these closures impact clients residing in the living environments and present challenges for maintaining sobriety. In addition, there are few housing options for clients after they finish the program, which may also put them at a higher risk of recidivism and relapse.

Program staff have also observed challenges with client safety in sober living environments and similar residential living spaces. For example, some clients have expressed concerns about their roommates, explaining that they do not always feel safe participating in virtual group sessions from their home during the week. Pathways staff are addressing these concerns by finding different, safer placements for affected clients.

The program also continued to face challenges with limited resources and funds. Limitations to the use of funds made it difficult to support clients in securing stable, long-term housing and continued to be the greatest unmet need for the program this past year. The program has received funding through Core Service Agencies[22] in the past year, which has helped staff advocate for unhoused clients and link them to housing resources. In the future, it would be beneficial for the Pathways program and its leadership team to support the identification of specific residential placements for the clients they serve and set up contracts to allocate money to those placements, as they currently do not have contracts in place with residential facilities.

Client Challenge Story: Pathways staff connected one client with the county's Vocational Rehabilitation Services, which the client has found very beneficial. However, they learned that they were not eligible to apply for Supplemental Security Income benefits. Unfortunately, the process of applying for benefits such as Supplemental Security Income can take a long time. While clients wait to hear back about their status, Pathways is permitted to cover their rent, but these arrangements cannot be sustained indefinitely because of program budget constraints. For this reason, some residential centers will not accept Pathways clients, who are required to show proof of sufficient funds or income streams to pay several months of rent. Fortunately, this particular client has since received a housing voucher. However, they are currently struggling to find an apartment that will accept them because of their history of involvement with the criminal justice system.

[22] See https://www.smcgov.org/hsa/core-service-agencies-emergency-safety-net-assistance

DEMOGRAPHICS

The following table summarizes the demographic information of the 33 clients who were admitted and actively a part of the Pathways program during FY 2023–24. Most clients were between the ages of 26 and 59 years (84.8%) and spoke English as their primary language (87.9%). Eleven clients (33.3%) identified a race not listed, and four clients identified as multiple races (12.1%), White/Caucasian (12.1%), or Black or African American (12.1%). Most clients identified as Hispanic or Latino (48.5%). More than half of clients (63.6%) identified as straight or heterosexual, but it is important to note that 27.3% did not report their sexual orientation.

Pathways Program Client Demographics (N = 33)

	Number of clients	Percentage of total
Age		
0–15 years	0	0.0
16–25 years	2	6.1
26–59 years	28	84.8
60 years and older	3	9.1
Primary language		
English	29	87.9
Spanish	4	12.1
Race		
Other	11	33.3
Multiple	4	12.1
White or Caucasian	4	12.1
Black or African American	4	12.1
Filipino	3	9.1
Unknown/not reported	7	21.2
Ethnicity		
Hispanic or Latino	16	48.5
Not Hispanic or Latino	12	36.4
Unknown/not reported	5	15.2
Gender assigned at birth		
Male	19	57.6
Female	15	42.4
Sexual orientation		
Straight or heterosexual	21	63.6
Gay, lesbian, or homosexual	2	6.1
Declined to state	1	3.0
Unknown/not reported	9	27.3

PATHWAYS HOUSING SERVICES

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

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

OTHER SYSTEM DEVELOPMENT

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

PRENATAL TO THREE PROGRAM

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

- The Prenatal to Three initiative coordinates mental health treatment and psychoeducation for pregnant women, postpartum women up to 1 year after childbirth, and children through age 5 years who choose to receive program services after being referred by San Mateo County Health, Family Health Services, pediatricians, obstetrician-gynecologists, or staff from the BHRS ACCESS Call Center.
- The Partners for Safe and Healthy Children program manages mental health treatment and psychoeducation for families with children through age 5 years who have an open Child and Family Services (CFS) case.
- The Prenatal to Three Teen Parent program serves pregnant teenagers, teenage mothers up to 1 year after childbirth, and children through age 5 years with teenage mothers.
- Prenatal to Three initiative activities include conducting initial mental health assessments to inform the creation of treatment plans; providing psychotherapy and psychoeducation to clients; and offering case management services, including referrals to psychiatrists, Alcohol and other Drugs (AOD) treatment providers, and community-based organizations (CBOs). Staff clinicians rely on assessment tools to screen for mental illness in adults and identify developmental areas for children who may have been affected by trauma. Although therapeutic interventions vary depending on the results of the assessment, staff clinicians commonly provide some form of child-parent psychotherapy, play-based

therapy for children through age 5 years, individual therapy for adults, dyadic therapy for caregivers, and specialized care for prenatal and postpartum clients. In addition, several staff use the NMT approach, trauma-informed CBT, eye movement desensitization and reprocessing (EMDR) psychotherapy, dialectical behavior therapy, motivational interviewing, occupational therapy, and infant massage. Initiative staff also address unmet social needs by distributing free household items, such as diapers, or by connecting families with affordable housing or childcare support resources.

Staff in the Partners for Safe and Healthy Children program attend the CFS court case and coordinate referrals for any judge-mandated activities, which often include family therapy, parenting classes, or anger management sessions. Finally, case managers for the Partners for Safe and Healthy Children program conduct regular home visits and attend Child and Family Team events.[23]

PROGRAM IMPACT

Child welfare partners	FY 2023–24
Total clients served	695
Total cost per client	$536

Improving timely access for underserved populations: Under California's timely access mandate, the HPSM is required to provide mental health services within 2 weeks of the initial request.[24] The Prenatal to Three initiative improves timely access and linkages for underserved populations by following procedures designed to connect Medi-Cal clients to appropriate mental health services within the required time frame.[25] Protocols for individuals referred by a county provider or ACCESS Call Center[26] staff differ from the protocols for individuals referred by CFS staff. These protocols, which differ on the basis of urgency of the referral, are described in greater detail as follows:

- **Nonurgent referrals:** Prenatal to Three and Prenatal to Three Teen Parent program staff make at least three phone-based contact attempts within 10 business days of receiving nonurgent referrals. Details are captured in a Client Services Information assessment record. If staff are unable to reach the referred individual, they send them a letter explaining how they can begin receiving program services and listing other county-based resources.

[23] Child and Family Team events are recurring meetings attended by clients and members of their support network, including local school, probation, BHRS, and CFS staff as well as other health care providers. Child and Family Team is a collaborative, strengths-based approach to supporting families involved with the court system, and it prioritizes consideration of clients' stated needs and preferences.

[24] For more information, see https://www.vchealthcareplan.org/providers/docs/CATimelyAccessLegislationAndRequirements.pdf.

[25] Underserved populations lacking access to adequate health care may include older adults, racial or ethnic minority groups, individuals with advanced behavioral health needs, or individuals experiencing homelessness. See https://toolkit.ncats.nih.gov/glossary/underserved-group/#:~:text=The%20U.S.%20Health%20Services%20Administration,or%20a%20high%20elderly%20population.

[26] The ACCESS Call Center provides information, assessment, and referral to mental health and/or SUD treatment in SMC. For more information on the ACCESS Call Center, see https://www.smchealth.org/contact-info-pod/access-call-center.

- **Crisis and urgent CFS referrals:** For CFS referrals categorized as an emergency, Partners for Safe and Healthy Children staff are expected to contact the referred individual within 24 hours. Noncrisis referrals from CFS are to be addressed within 48 hours.

In FY 2023–24, Prenatal to Three staff also continued to implement standardized screening and care transition tools, which all counties were required to adopt under the CalAIM initiative. The screening tools help providers to assess referrals and quickly determine whether the symptoms of mental illness are mild-to-moderate or moderate-to-severe, which has streamlined workflows and reduced wait times for newly referred clients.

Reducing stigma and discrimination: As in prior years, Prenatal to Three staff helped reduce the prevalence and severity of stigma by providing clients with psychoeducation about the SMI they are experiencing during routine therapy sessions and special group sessions. In FY 2023–24, Prenatal to Three leadership continued to receive monthly updates on available BHRS trainings and encouraged staff, external providers, and representatives from other CBOs to enroll in these trainings. Staff continued to attend county-run cultural humility training sessions. In part, these trainings help staff to expand their capability to serve clients who have experienced discrimination-related stress that can exacerbate mental health issues.

Increasing the number of individuals receiving public health services: Prenatal to Three staff immediately start assisting new clients rather than placing them on a waitlist, so the number of individuals receiving public health services through the initiative or its referrals is steadily increasing. Initiative staff leverage an intensive case management (ICM) approach to meet this increasing demand for linkages to appropriate mental health services. In FY 2022–23, staff vacancies made it more difficult to process high volumes of referrals. However, in FY 2023–24, the initiative was successful at hiring new staff to fill these vacancies, enabling it to increase the number of clients served. Because staff retention continues to be an issue, initiative leadership will continue their hiring efforts.

During the past year, Family Health Services has been providing less support to the Prenatal to Three initiative with ICM. To fill this gap in services and secure support and resources for their clients, staff have collaborated with external partners who share similar client populations, including providers, obstetricians, pediatricians, and other local CBOs. These efforts include holding meet and greets, updating their website, and creating informational flyers. Staff will continue to explore additional ways to more efficiently and effectively communicate with county providers.

Reducing disparities in access to care: The Prenatal to Three initiative reduces disparities in access to care by tailoring service delivery methods to meet the needs of each client. Many Medi-Cal clients lack access to reliable transportation, making it much more difficult for them to travel to clinicians' offices for mental health care. As in past years, initiative staff overcame these obstacles by offering to conduct therapy, psychiatric care, and ICM services through in-person home visits. However, with homelessness a growing issue in San Mateo County, many of the shelters and other places of residence typically offered to clients have become overcrowded, making it difficult or impossible for staff to conduct in-home visits with clients in a safe, confidential space. To counter this issue and facilitate more in-person visits, the initiative issued vouchers covering the costs of taxi rides to and

from the office. As a result, the program saw an increase in client utilization of in-person appointments at the clinic compared with previous years. Although telehealth visits are still available, clients continued to prefer in-person care over virtual appointments with staff.[27]

Implementing recovery principles: Finally, Prenatal to Three staff demonstrate their commitment to using several recovery principles, described as follows:

- **Delivering culturally sensitive care:** Supervisors continued to prioritize the hiring of bilingual staff, including up to six interns on an annual basis, to better serve the large number of clients who are monolingual Spanish speaking.[28] In the past year, the initiative also recorded an increase in referrals for Portuguese-speaking clients. The initiative plans to hire Portuguese-speaking staff to assist during therapy visits with these individuals.
- **Facilitating the involvement of community members:** Initiative staff continued to hold informal support group activities called Café con Padres (Coffee with Parents). Clients are paired with other parents trained as family partners—behavioral health paraprofessionals[29] with relevant lived experience—to discuss their recent life challenges and come up with strategies for parenting effectively while simultaneously managing SMI and/or SUD symptoms. The initiative is also working to expand the group support services offered to clients. In FY 2023–24, a speaker presented training tips and other ideas for group occupational therapy sessions.
- **Promoting care integration across providers:** Staff regularly pursue opportunities to collaborate with BHRS staff from other divisions. For example, many Prenatal to Three therapists attend clients' appointments with a psychiatrist to provide emotional support.
- **Providing trauma-informed care:** In FY 2023–24, leadership continued efforts to recruit an AOD specialist to expand the initiative's capacity for SUD treatment referrals and care coordination.

This section provides a comparison of health care use data from periods that extend to 3 months before and after the clients were admitted to the Prenatal to Three initiative. The following table summarizes the health care use information for the clients who were admitted and actively part of the Prenatal to Three initiative during FY 2023–24. During the 3 months before program admission,

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

[28] Culturally sensitive care is a health care delivery approach that involves tailoring services to the unique cultural background of each client. Examples of culturally sensitive care include providing information in a client's native language, using traditional remedies in combination with evidence-based treatments, and offering food choices that respect special dietary restrictions in hospitals or other residential care settings. For more information, see https://uprisehealth.com/resources/what-is-culturally-sensitive-care/.

[29] A behavioral health paraprofessional is an individual who supports mental health disorder recovery but does not have a professional background in mental health. They may serve in roles including PSS/PSW, community health worker, and behavioral health technician/aid. For more information, see https://www.nga.org/publications/the-emerging-field-of-behavioral-health-paraprofessionals/#:~:text=Behavioral%20Health%20Technicians/Aides.

there were 536 psychiatric emergency services (PES) episodes, one inpatient/residential episode, and four total days of inpatient residential stay among the Prenatal to Three clients. During the 3 months following clients' admission, none of the Prenatal to Three clients had a record of using the same emergency and crisis health care services. Please note that these results are as of early October 2024 and may not reflect all health care utilization during the 3 months after admission for those clients admitted late in the fiscal year.

Prenatal to Three Clients' Health Care Use (FY 2023–24)

	3 months before (including the day of) admission	3 months after admission
Number of psychiatric emergency services episodes	536[a]	0
Number of inpatient/residential episodes	1	0
Total inpatient/residential stay (in days)	4	0

[a] 536 episodes across 581 clients.

SUCCESSES

Prenatal to Three initiative providers were particularly successful in delivering trauma-informed care interventions in FY 2023–24. These interventions included NMT assessments, which allow providers to refer clients to creativity-enhancing services such as equine therapy, sensory interventions, and family recreation activities such as swimming and martial arts. Clinicians increasingly used EMDR therapy, which showed positive results for adult clients. They also received formal training on child-parent psychotherapy, which better equipped clinicians to assist families with recovery and healing after stressful or traumatic events.[30]

Staff reported that many clients were coping with grief over the past year, which the staff attributed to loss of family members and increased community violence in San Mateo County. Staff also mentioned experiencing secondary grief while supporting their clients through these difficult events. In response, the program provided formal training on Acceptance and Commitment Therapy,[31] which staff used to better support grieving clients. During Acceptance and Commitment Therapy training, staff were also encouraged to reflect on how Acceptance and Commitment Therapy principles can be applied to their own mental health to lessen the adverse impact of the client stories. Encouraging initiative staff to care for their own mental health in turn created better outcomes for their clients, the staff said. Staff were better equipped to maintain therapeutic alliances with their clients and create a safe space for clients to discuss sensitive topics. The client success story below highlights the benefits that one client received from a therapeutic alliance with Prenatal to Three initiative staff. In

[30] See https://childparentpsychotherapy.com/.

[31] Acceptance and Commitment Therapy is an action-oriented psychotherapy approach that aims to expand psychological flexibility through the following six core processes: acceptance, cognitive defusion, being present, self as context, values, and committed action. For more information, see https://www.psychologytoday.com/us/therapy-types/acceptance-and-commitment-therapy.

addition, the initiative achieved a full staff roster, which further improved staff well-being by allowing an appropriate distribution of caseloads.

Client Success Story: A 27-year-old client with a history of experiencing complex childhood trauma and more than 10 years of domestic violence had reported symptoms of depression and anxiety. Their husband was not a reliable source of support for the client or their four children under 10 years old. The client contacted the Prenatal to Three program because they were feeling hopeless and alone and said they wanted to become independent enough to leave their husband, support their family, and set a better example for their children. During the client's first visit to the program, their case manager provided them with resources, including the Community Overcoming Relationship Abuse (CORA) for domestic violence support and prevention services and First 5 San Mateo County for childcare support. The client immediately began using the resources and attending sessions with their Prenatal to Three provider. The program was flexible with scheduling sessions, allowing them to bring their young children to in-person sessions and using telehealth visits when necessary. The client stated that the sessions helped them to feel better and motivated to put in the work required to heal. Within 6 months in the program, the client left their husband, filed for divorce, moved into emergency housing with their children, and secured a job. This client reportedly leveraged the coping skills they developed during their sessions to manage mental health symptoms, stating that they were grateful for the support they received from the program.

CHALLENGES

Identifying Language Support for Non-English-Speaking Families

In FY 2023–24, staff noticed an influx of families that do not speak English emigrating from Brazil to San Mateo County. Portuguese is the main language spoken by these families. Although the program tried to use an interpreter during sessions with these families, some clinicians and families have indicated that the interpreter's Portuguese translations were not clear. This barrier has led many families to become disinterested in receiving services from the Prenatal to Three initiative. To date, the initiative has had difficulty identifying a bilingual therapist or individual who could serve as an interpreter for these families, but they plan to continue searching. As of this year, the initiative implemented a standard practice of translating documentation into clients' native language. This new hire would also help with maintaining this practice.

Navigating Surge in Intimate Partner Violence Cases

As in previous years, staff observed a continual increase in the overall prevalence and severity of intimate partner violence experienced by their clients. Staff regularly refer clients who experience intimate partner violence to the county's CORA, including crisis intervention, housing assistance, and legal services. However, clinicians have reported that clients are having difficulty getting assistance from this resource. In FY 2023–24, there were a few high-profile cases in which mothers had reached out to CORA for support with domestic violence they experienced in San Mateo County. When CORA failed to provide help to these individuals, it resulted in tragic deaths or severe injury. The initiative is looking for new ways to address the limited bandwidth of local crisis intervention and support services organizations to better assist victims of domestic violence.

Troubleshooting Paucity of Resources

As in FY 2022–23, Prenatal to Three staff have experienced difficulties connecting clients and their families to social services, specifically for affordable housing, homeless shelters, childcare, and necessities such as diapers. Often, there are lengthy waitlists for obtaining these resources, especially for free or partially subsidized housing. In addition, when case managers must focus their time and energy on providing these basic needs to clients, it leaves very little time for them to achieve mental health goals. Without sufficient childcare resources, client participation decreases, and it becomes more difficult for them to maintain their jobs. Some clients have even had to forgo job or training opportunities because of difficulties with securing childcare. Staff also noted experiencing marked difficulty in providing services to families dealing with SUD and addiction.

To overcome the systemic issues related to affordable housing, staff have been advocating for policy changes that would create better outcomes for clients. The current policy requires families, even those with young children, to first become unhoused and live on the street to be eligible to receive a hotel voucher. Program staff are collaborating with First 5 San Mateo County, an organization that provides funding and advocacy to achieve equity for underserved families with young children.[32] Their goals are to (a) secure additional funding from core agencies that serve families with children ages 0–5 years and (b) expedite the procurement of hotel vouchers for clients.

Last, clients would also benefit from additional support from family partners. The initiative recently requested funding for a full-time family partner to support the work of their existing part-time family partner. The ICM services provided by family partners and other Prenatal to Three initiative staff help prevent families from remaining in a state of crisis.

DEMOGRAPHICS

The following table summarizes the demographic information for the 695 clients who were admitted and actively a part of the Prenatal to Three initiative during FY 2023–24. Most clients were between the ages of 26 and 59 years (62.6%) or 16 and 25 years (23.6%). A majority of clients spoke Spanish as their primary language (60.0%), with English (34.5%) and Portuguese (2.7%) being the second and third most common languages, respectively. Most clients identified as a race not listed (72.4%) and identified as Hispanic or Latino (73.1%). It is important to note, however, that 17.6% of respondents did not report information on their race, 0.3% did not report information on their ethnicity, and 96.0% did not report information on their sexual orientation.

Prenatal to Three Program Client Demographics (N = 695)

	Number of clients	Percentage of total
Age		
0–15 years	96	13.8
16–25 years	164	23.6
26–59 years	435	62.6

[32] See https://first5sanmateo.org/.

	Number of clients	Percentage of total
Primary language		
Spanish	417	60.0
English	240	34.5
Portuguese	19	2.7
Russian	2	0.3
Tagalog	2	0.3
Farsi	2	0.3
Arabic	2	0.3
Other non-English	1	0.1
Turkish	1	0.1
Unknown/not reported	10	1.3
Race		
Other	503	72.4
Multiple	30	4.3
White or Caucasian	15	2.2
Black or African American	10	1.4
Filipino	7	1.0
Asian Indian	3	0.4
Tongan	2	0.3
Samoan	1	0.1
Hispanic or Latino	1	0.1
Cambodian	1	0.1
Unknown/not reported	123	17.6
Ethnicity		
Hispanic or Latino	508	73.1
Other	75	10.8
Not Hispanic or Latino	2	0.3
Gender assigned at birth		
Female	645	92.8
Male	50	7.2
Sexual orientation		
Straight or heterosexual	25	3.6
Declined to state	2	0.3
Bisexual	1	0.1
Unknown/not reported	668	96.0

PUENTE CLINIC

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

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

PROGRAM IMPACT

Puente Clinic—dual diagnosis	FY 2023–24
Total clients served*	271
Total cost per client	$2,264

Improves timely access and linkages for underserved populations: Puente Clinic and GGRC have jointly created a referral form (updated in spring 2023) to facilitate recording and transmitting of comprehensive referral information. This special arrangement allows dedicated attention to clients dually diagnosed with intellectual disability and mental illness, as this client population often gets ignored and underserved because of limited ability to self-advocate and self-refer. A GGRC social worker sends this referral form to the Puente Clinic's social worker to initiate a screening process to identify Medi-Cal clients who meet medical necessity criteria. When the Puente Clinic receives this form, the case is quickly reviewed for appropriate level of service and treatment provider. During COVID-19 pandemic restrictions, Puente transitioned from an in-office-

only program to its current hybrid model of offering telehealth, in-office, or in-home/field-based services. Clients and their caregivers determine which service method is best for their needs.

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

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

Reduces disparities in access to care: Puente Clinic clients come from diverse social backgrounds. Each provider has received multiple cultural humility trainings and applies the learning to clinical care and service coordination involving clients, families, caretakers, and parallel professionals. The Puente Clinic providers constantly help clients who cannot advocate for themselves to pursue ancillary services that cover needed social benefits. In clinical sessions, interpretation services are provided as needed through phone or in-person arrangement, which includes sign-language interpretation.

Implements recovery principles: The Puente Clinic providers infuse hopefulness in clients, families, and caretakers, to help each client to achieve the highest level of functioning one could get. The successful outpatient treatment model that Puente Clinic provides helps clients to live in the least restrictive setting in the community. Many clients of the clinic came out of an institution setting, such as a development center, where clients often experienced multiple types of traumas of a verbal and physical nature, but Puente Clinic helps these clients to process their trauma experience and to recover over time. When a client is cognitively capable, supportive psychotherapeutic treatment is always provided to enhance personal agency in achieving life goals. The clinic works closely with GGRC and the Department of Rehabilitation to find the best educational and vocational opportunities for clients and works with local community groups to promote social connection and increase educational resources for clients. Clients of the Puente Clinic also suffer from SUD; a case in 2024 highlighted the need for a Puente client to receive opioid replacement therapy.

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

Psychiatric Emergency Services Use

	FY 2019–20	FY 2020–21	FY 2021–22	FY 2022–23	FY 2023–24	Mean FY 2019–24
Unique client count	7	3	8	8	11	7.4
Episode count	24	14	21	11	16	17.2

In FY 2023–24, Puente clients had an increase in PES visits compared with FY 2022–23. The episode count of 16 is close to our 5-year mean of 17.2. One positive outcome related to PES visits is that one client who frequently used PES services reduced his number of PES visits from nine (FY 2021–22) to three (FY 2022–23) and, most recently, down to two (FY 2023–24).

Medication-related episodes: We have continued to track the number of billable medication-related episodes per year per client. This number reflects the level of medication-related psychiatric interventions needed for the year. Medication-related episodes included initial assessments, medication follow-up visits (in person, telehealth, or face to face), and phone calls with clients and/or their caregivers in which medications or side effects were discussed. For example, a stable client who is seen once every 3 months might have four medication support visits in the year; a client with active medication changes might require monthly visits and register 12 medication support episodes per year.

SUCCESSES

Client Success Story #1: A 32-year-old nonverbal male GGRC client with a history of bipolar disorder and severe intellectual disability lives with his parents and sister. He has been followed at Puente Clinic for medication management for insomnia and aggression. P.T.'s symptoms impaired his ability to participate in a day program. P.T.'s parents had difficulty navigating the health care system and did not fully understand P.T.'s diagnoses and need for ongoing medication treatment, leading to missed appointments and medication nonadherence. With close follow-ups with a new psychiatrist and psychoeducation with the family about P.T.'s diagnoses and medication, P.T.'s mood, sleep, and behavior significantly improved on a low-dose antipsychotic. He was able to start the day program full time. The psychiatrist anticipated that he may have reemergence of symptoms during the transition to the day program and was able to respond quickly and effectively when P.T. had

difficulties during the transition. He is now enjoying the day program, and the family is also very happy that he is doing well and spending time outside of the home.

Client Success Story #2: W.D. is a 70-year-old gentleman with diagnosis of intellectual disability, undifferentiated schizophrenia, and seizure disorder, who was seen initially by a Puente psychiatrist, having just been discharged from the hospital for pneumonia. During the hospitalization, one of his medications (valproic acid, prescribed for a seizure disorder but was mistaken as a psychiatric medication) had been stopped because of a side effect of low platelets. During the outpatient visit, the client experienced a grand mal seizure requiring emergency services response, and the Puente psychiatrist was able to assist the team in understanding the sequence of events. This episode instigated cooperation between the Puente doctor, primary doctor, neurology, and regional center, which led to the review of medications. The collaboration also identified a need to change the client's placement in a care home that could facilitate the client's changing needs on the basis of age and medical comorbidities. Since the transition to a more appropriate level of care, the client has been stabilized on seizure medication, his psychiatric medications have been reduced—previously, two antipsychotic medications had been streamlined to one at a lower dose—and his symptoms and level of interaction have much improved such that he is now able to tolerate and participate in exams—previously, he became agitated and resistive with providers. He has continued to be stable in his new living environment and is participating in day programming.

CHALLENGES

Client Challenge Story #1: H.W. is a 59-year-old man with diagnoses of schizophrenia (paranoid type), methamphetamine use disorder (severe), and intellectual disability (mild). He has chronically missed his appointments with all health care providers, which had been offered both in person and as telepsychiatry to attempt to accommodate his missed appointments. He has continued to use methamphetamine periodically, thought to be obtained with income from his disability checks. He lives with his elderly mother, who is now showing signs of dementia. During a hospitalization in late 2024, a urine sample he provided tested positive for methamphetamine as well as fentanyl, a potent opioid. Upon further questioning, he admitted that he has started to use opioids as well as methamphetamine and is only sporadically taking his prescribed antipsychotic medication. The Puente team called a case conference with his GGRC case management team to discuss options. The team called Adult Protective Services, who opened a case on the basis of the elderly mother and her potential inability to care for herself. The Puente team also notified the Integrated Medication Assisted Treatment (IMAT) team, a group of substance use professionals within our system who specialize in getting people into rehabilitation and/or buprenorphine treatment for opioid and other SUDs. The client was prescribed the opioid-reversing medication naloxone and trained in its use. The client himself has continued to miss appointments, sporadically takes his antipsychotic medication, and continues to use substances. We are attempting more outreach.

Client Challenge Story #2: W.R. is a 68-year-old woman with diagnoses of anxiety disorder, unspecified and intellectual disability, moderate. The client was temporarily placed in a skilled nursing facility in early 2024 because of an orthopedic injury complicated by cellulitis and other complications. After getting discharged in spring 2024, she was noted to be agitated and irritable. Psychiatric medications have been given that would traditionally have helped with this agitation, and

they have largely been ineffective. Upon further examination, the treating psychiatrist noted a waxing/waning pattern associated with delirium, a medical condition that is not effectively treated with psychiatric medications. The primary care doctor arranged a medical work-up, which showed no obvious source of delirium. She has been hospitalized medically several times in the past few months. During one hospitalization, she was found to have a urinary tract infection. The other hospital visits have not found a cause of delirium. She continues to have outbursts in the home, and the source of her agitation remains unknown. The treating psychiatrist is working with the primary care doctor on continuing to find a source of the problem.

DEMOGRAPHICS

Puente Clinic Program Client Demographics (N=272)

	Number of clients	Percentage of total
Age		
0–15 years	0	0
16–29 years	36	13
30–59 years	155	57
60 years and older	81	30
Race		
Another race	53	19.5
Unknown/not reported	26	9.5
White or Caucasian	126	46
Multiple	6	2
Black or African American	32	12
Filipino	14	5
Asian Indian	2	0.6
Hispanic or Latino	2	0.6
Other Asian	9	3
Chinese	20	7
Pacific Islander	1	0.3
Ethnicity		
Hispanic or Latino	43	16
Unknown/not reported	24	9
Not Hispanic or Latino	205	75
Sex assigned at birth		
Female	111	41

	Number of clients	Percentage of total
Male	161	59
Unknown/not reported	0	0

TRAUMA-INFORMED INTERVENTIONS

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

- General adult clients (ages 26 years and older)
- TAY clients (ages 16–25 years)
- Criminal justice-involved clients reentering the community following incarceration

Training and certification in NMT: Twice annually, the NMT program offers a 9-week, 18-hour class on the Six Core Strengths,[33] a framework devised by neuroscientist Bruce Perry to explain how trauma disrupts children's development. The Six Core Strengths training is a prerequisite for a 10-month course (Phase I training) that teaches county clinicians how to conduct NMT assessments for adults and guides them through the process of obtaining their certification.[34] NMT-certified providers rely on assessments of clients' functional capacities in four domains—sensory integration, self-regulation, relational, and cognitive—to inform the selection of individualized therapeutic interventions for the three populations mentioned above.

Eleven county clinicians who work with adult clients currently hold an NMT certification. In FY 2023–24, the NMT program specialist led a Phase I NMT-certification training course and offered a technical assistance program to support existing licensed NMT practitioners. The Phase II training program to become mentors consisted of five drop-in sessions, during which certified clinicians could draw on the support of the NMT manager while completing an assessment for one of their clients.[35]

NMT-trained clinicians perform two primary activities: (a) conducting initial and follow-up NMT assessments and (b) creating and refining customized treatment recommendations. As part of the

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

[34] Certification requires a total investment of about 120 training and study hours. Instruction consists of didactics, prerecorded case presentations, one-on-one mentoring on how to use the tool, discussion of required readings, case reviews (including treatment planning), a day-long video training, and a live assessment. For more information on NMT certification requirements, please see https://www.neurosequential.com/nmt.

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

initial assessment, clinicians document observations of a client's current presentation[36] and collect information on their relational history, noting any evidence of past difficulty building or maintaining healthy relationships. Entering these data into the NMT portal generates a metric known as a brain map that shows the client's functioning compared with that of a healthy adult of the same age. Clinicians review the brain map to identify relative strengths and vulnerabilities across the four functional domains.

Based on this analysis, clinicians recommend specific therapeutic interventions that promote the development of functional capacities within the domain(s) in which the client showed the largest potential for improvement. Program staff commonly refer clients to one or more MHSA-funded contracted service providers that offer guided therapeutic activities, including trauma-informed yoga, equine therapy, swimming, martial arts, art, music, intensive speech therapy, and EMDR psychotherapy. In addition, the NMT program provides flex funding to cover the cost of gym memberships and finances clients' self-care tools, including weighted blankets, sound machines, and gliding chairs. Clients' use of these therapeutic services and self-care tools complements traditional mental health care services, such as talk-based therapy and psychiatric medications. The program reassesses clients at least yearly to analyze changes in their functioning and modify their treatment plan as appropriate.

PROGRAM IMPACT

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

Trauma-informed interventions (neurosequential model of therapeutics)	FY 2023–24
Total clients served	48
Total cost per client	$8,080

- **Delivering trauma-informed care:** NMT-trained clinicians match interventions with the client's developmental readiness and strive to foster an environment that feels safe to the client. In FY 2023–24, the NMT program continued to conduct its Six Core Strengths training course for county clinicians, including the recently added Trauma 101 section. The individual who teaches the self-regulation component of the Trauma 101 section is an SUD expert from the AOD unit of BHRS. Their professional training and experiences enable them to effectively deliver information about SUD within the context of trauma, helping participants understand how early adversity and trauma may be connected to SUD later in life. Understanding this connection better equips clinicians to treat both trauma and SUD. In addition, an increasing number of clinicians are obtaining training in EMDR, a tool that is used effectively within the framework of NMT to further build clients' capacity to process

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

traumatic memories.[37] The NMT program director plans to continue encouraging clinicians to receive EMDR training in future years.

- **Promoting care integration:** NMT-trained clinicians also connect with other providers to develop individualized care plans, minimizing the distress that clients commonly experience in other health care settings and maximizing their capacity for recovery. For example, clinicians sometimes present a client's sensory profile data in meetings with residential treatment providers to explain why the client may be misbehaving in this setting and to recommend accommodations that the client may need to function optimally.

Reducing discrimination by educating providers and public assistance program staff: The NMT model promotes greater compassion for neurodiversity by helping clinicians better understand past experiences that have caused the client to try to meet their needs in maladaptive ways. Clinicians also use NMT findings to advocate for their clients with judges, probation officers, and other staff involved in Child Protective Services cases as well as residential treatment facility staff and employees of other CBOs. In FY 2023–24, the NMT program started to participate in discussions about client placement and share information with residential care teams, including program directors and case managers.

In addition, the NMT program helps to reduce the shame that clients feel when working through mental health challenges. Staff help clients understand their behaviors as survival instincts developed from their traumatic past, rather than faults in their personality. For example, some clients may think they are innately "bad" people because of past relationship challenges or difficulties curbing substance use. Learning about the adaptive nature of their behaviors helps to reduce their shame and enables them to work toward changing behaviors that no longer serve them well.

Reducing disparities in access to care: The NMT program reduces disparities in access to high-quality, trauma-informed care by empowering county clinicians to connect clients with low income with supplemental therapeutic and enrichment services and resources that they could not otherwise afford, including equine therapy and intensive speech services.[38] Clients report experiencing joy and reward from exposure to these services, which they say enhance their ability to reach their mental health goals. In FY 2023–24, the NMT program increased their collaboration with CBOs to meet the higher demand from referrals. For example, they were able to increase referrals for equine therapy by partnering with a ranch that recently became a Medi-Cal-approved provider. After overcoming some difficulties related to transportation, the NMT program now arranges for clients ages 20 years and older to visit the ranch every Friday.

[37] See https://my.clevelandclinic.org/health/treatments/22641-emdr-therapy.

[38] Because clients referred to the NMT program are already receiving mental health services through a county clinic or contracted service provider, such as Caminar or the Edgewood Center for Children and Families, the NMT program does not directly address the timeliness of or disparities in access to initial mental health services.

Another organization that the NMT program has continued to partner with is the Riekes Center in Menlo Park. This state-of-the-art, community-oriented exercise facility offers exercise programs, music classes, theater classes, nature awareness activities, archery, and adaptive sports for people living with disabilities. The center assists individuals with goal setting and mentorship and is experienced working with at-risk populations through their veterans' support programs. As of FY 2023–24, both adult and youth NMT clients are able to use this resource. The NMT program carefully vets all providers with which they are considering establishing new service contracts to ensure that they are welcoming and inclusive environments for clients from diverse backgrounds.

In addition to providing therapeutic programs and activities, the NMT program also provides enrichment supplies to support clients' well-being on an as-needed basis. For example, staff purchased a sound machine, eye mask, and essential oils diffuser to assist one client with relaxing and sleeping at night because they suffered from sleep disturbances caused by past sexual abuse trauma that they had experienced at night. Items may also be tailored to an individual's hobbies or interests, such as art supplies. These items allow clients to activate neural reward pathways through engagement in enriching hobbies rather than harmful behaviors such as substance use.

Increasing the number of individuals receiving public health services: The NMT program specialist routinely coaches clinicians on ways they can conduct NMT assessments more efficiently. Over time, this technical assistance has enabled trained providers to treat a greater number of clients with developmentally appropriate mental health services that would otherwise be inaccessible. This expanded capacity has been especially helpful during FY 2023–24 because of the increased referral rate from BHRS organizations including Caminar, Telecare, and Cordilleras, obviating the need to implement a waitlist for NMT services. The program manager continues to further expand the capacity of the program by regularly conducting training for new clinicians, the most recent round of which started in August.

Because only 12 trainees can be accepted into each 10-month NMT training course, the program manager strategically admits trainees to maximize the benefit derived from the program's training capacity. For instance, one of the new trainees is an individual from a CBO who has previously assisted with multiple NMT referrals and has worked closely with the program manager for 2 years. Because there is usually a high rate of turnover for CBO staff, the NMT program specialist reasoned that it would be beneficial to invest resources in developing and strengthening rapport with an individual who has proven to be a rare stable contact from an important CBO partner. The support of this NMT-trained CBO staff member will increase the efficiency of conducting assessments for referrals from the CBO. The program specialist has also used additional connections across BHRS organizations to help identify more clinicians who are good candidates for NMT Phase I training. These connections include a growing number of psychiatric residents who are interested in receiving training and obtaining NMT-financed enrichment items for their treatment rooms, such as gliding chairs, sand trays, weighted lap pads and blankets, sound machines, and fidget toys. The training is mutually beneficial for the program and residents because it allows residents to further their clinical educations while expanding the network of trained providers available to support the NMT program's increasingly large caseload.

This section provides a comparison of health care use data from periods that extend to 3 months before and after the clients were admitted to the NMT program. It also presents a breakdown of NMT clients by report status and changes in score with follow-up reports as well as a comparison between the client score and the typical associated-age score.

The following table summarizes the health care use information for the 48 clients who were admitted and actively a part of the NMT program during FY 2023–24. During the 3 months before program admission, the NMT clients collectively had three PES episodes and no inpatient/residential episodes or days of stay. During the 3 months following their admission to the program, none of the NMT clients had a record of emergency or crisis services. Please note that these results are as of early October 2024 and may not reflect all health care utilization during the 3 months after admission for those clients admitted late in the FY.

Number of unduplicated clients served: 48 active participants

Total number of clients: 48 active participants

Neurosequential Model of Therapeutics Clients' Health Care Use (FY 2023–24)

	3 months before admission	3 months after admission
Number of psychiatric emergency services episodes	3 [a]	0
Number of inpatient/residential stays (in days)	0	0
Total inpatient residential stays (in days)	0	0

[a] Three episodes across three clients, or one per client.

The following table displays the number of clients who had only one NMT Metrics Report and the number of clients who had a follow-up report status during FY 2023–24. Of the 48 clients referred, 50.0% (*n* = 24) had one report, 50.0% (*n* = 24) had a follow-up report, and 0.0% (*n* = 0) had no reports.

Neurosequential Model of Therapeutics Clients' Report Status (FY 2023–24)

	Number of clients	Percentage of clients
Has follow-up report	24	50.0
Has only one report	24	50.0
Total	**48**	**100.0**

The following table summarizes the change in scores for clients with a follow-up report provided by the NMT program by score type during FY 2023–24. Among the 24 clients with a follow-up report, 75.0% (18) improved their sensory integration and self-regulation scores, and 66.7% (16) improved their relational and cognitive scores. Of these same 24 clients, 29.2% (7) showed no change in their cognitive score and 20.8% (5) showed no change in their relational score. Finally, 20.8% of clients (5) with a follow-up report exhibited decreases in their self-regulation scores, and 12.5% of clients (3)

with a follow-up report exhibited decreases in their sensory integration and relational scores, respectively.

Change in Scores for Neurosequential Model of Therapeutics Clients With a Follow-Up Report (*N* = 24; FY 2023–24)

	Increase in score		No change in score		Decrease in score	
	Number of clients	Percentage of clients	Number of clients	Percentage of clients	Number of clients	Percentage of clients
Sensory integration score	18	75.0	3	12.5	3	12.5
Self-regulation score	18	75.0	1	4.2	5	20.8
Relational score	16	66.7	5	20.8	3	12.5
Cognitive score	16	66.7	7	29.2	1	4.2

The following table summarizes the change in percentage points between baseline and follow-up report scores relative to the typical associated-age score by score type during FY 2023–24. On average, there was a 3.6% increase between baseline and follow-up for the relational score, a 2.9% increase for the self-regulation score, and a 2.3% increase for the cognitive score. On average, there was a 0.69% decrease between baseline and follow-up for the sensory integration score.

Change in Neurosequential Model of Therapeutics Clients' Scores Relative to the Age Typical Score (*N* = 48; FY 2023–24)

	Baseline report average client score/age typical score (%; *N* = 48)	Follow-up report average client score/age typical score (%; *N* = 24)	Change in percentage points
Sensory integration score	81.6	80.9	–0.69
Self-regulation score	72.6	75.5	2.9
Relational score	75.0	78.6	3.6
Cognitive score	83.6	85.9	2.3

SUCCESSES

Engaging With Clients Through Guided Therapeutic Activities

During FY 2023–24, NMT clients continued to benefit from their participation in activities such as yoga classes, equine therapy, and classes held at the Riekes Center. Clients, especially those in the pain clinic, reported benefiting from their participation in group-based or private yoga classes. After relying primarily on medication for pain, some clients from the pain clinic reported improvements since trying yoga. The yoga instructor's understanding of addiction and mobility issues reportedly helped NMT clients feel safe when practicing yoga. Clients said that these therapeutic activities have improved their quality of life by reducing SMI symptoms. For example, clients have reported the ability to reestablish a sense of control over their lives and avoid feelings of isolation by connecting with other people from the community. Other clients have attributed their regained sense of trust

and improved relational abilities to their participation in yoga, equine therapy, or activities at the Riekes Center. To support continued client engagement with these activities and program retention, the program also prioritized teaching clinicians how to maintain therapeutic alliances with their clients.

Clients also showed progress on goals after participation in EMDR sessions, as highlighted in the example below.

Client Success Story: In FY 2023–24, a client in their 60s who lives in a residential care facility expressed an interest in becoming more involved in their NMT assessment process. The client appeared very receptive to learning more about the effects of trauma they had experienced, agreeing to try out some interventions—such as EMDR and art therapy—that their NMT clinician recommended after reviewing the client's assessment results. NMT staff obtained approval from the client's treatment team to administer EMDR, although the treatment team had reservations about whether the client would consistently engage in the therapy. To prepare the client for the processing phase of EMDR therapy, the NMT clinician met with the client weekly at their residential facility to practice several soothing and regulating techniques. To date, the client has worked on processing and integrating childhood memories through EMDR therapy. The client has stated that they feel more stable and grounded because of these sessions. They also report less frequent flooding of negative memories. The client shared that sessions with their NMT clinician enabled them to self-regulate difficult feelings and stop themself from relapsing into substance use. The client has also continued to create art using materials provided through the NMT program. The curators of a local exhibition recently chose to display some of the client's artwork.

CHALLENGES

Meeting Caseload Demand From Increasing Referrals

Staffing shortages have made it difficult for the NMT program to meet the rapidly increasing client referral rate and caseload demand in FY 2023–24. The NMT manager mentioned that the program will need implementation support to maintain service levels in FY 2024–25. An ideal long-term solution to these capacity constraints would include additional funding for new mental health positions. Earlier this year, the NMT program manager developed a job description for new clinical positions and presented it to their supervisor. As an alternative to hiring for a new clinical position, the program manager also proposed the idea of onboarding an intern.[39] However, there is concern that an intern would not be experienced enough to work with clients living with SMI, trauma, and SUD and coordinate with multiple treatment teams.

In addition, the program continues to receive referrals for adult and youth NMT assessments from teams that do not possess an NMT-trained staff member. To mitigate this issue, the NMT program

[39] This intern would likely support both NMT and Prenatal to Three programs because of the NMT program manager's involvement in the Prenatal to Three initiative.

continues to train additional staff and expand the network of clinicians who are able to conduct NMT assessments and provide recommendations based on the results.

Continuously Supporting NMT-Trained Clinicians to Maintain Their Licenses

In FY 2023–24, the NMT program manager continued to lead a technical assistance program geared specifically toward supporting already certified clinicians in staying up to date on assessments and certification maintenance requirements. This program involves meeting with the trained clinicians five times per year. Despite the success of this training program, the NMT program manager feels that they could better support these trained clinicians. For example, they are interested in reimplementing a retired process called consultation groups to keep trained clinicians informed on current NMT practices and resources.

Managing High Volumes of Administrative Tasks

As in prior years, NMT program staff continued to struggle with managing the high volume of administrative tasks, including managing and renegotiating contracts with external service providers, tracking flex funds, and processing adjunct services referrals. These tasks reduce the time that the NMT program manager has available to spend on client services, such as completing brain maps or expanding provider capacity through training and coordinating visits with various county teams.

The program also lacks tracking tools for managing follow-up assessments, limiting the program's ability to collect and track data on client progress. Ideally, clinicians should create a new map every 6 months to 1 year to assess changes in each client's functioning, which would then inform decisions to continue or modify specific therapeutic interventions. Unfortunately, some clients were not remapped as frequently this year. During FY 2023–24, NMT program staff planned to enlist the support of another clinician who offered to create a spreadsheet template for tracking NMT program referrals and follow-ups. Although implementation of these plans has been delayed, the NMT program manager intends to complete onboarding of this clinician soon, which should increase the program's capacity to handle administrative demands. After a tracking process is in place, the program will deliver reminder emails to clinicians to ensure that follow-up assessments are conducted in a timely manner.

DEMOGRAPHICS

The following table summarizes the demographic information for the 48 clients who were admitted and actively a part of the NMT program during FY 2023–24. More than half of the clients were between the ages of 16 and 25 years (56.3%). Most clients spoke English (45.8%), with Spanish being the next most common language (6.3%). Most clients racially identified as being Hispanic or Latino (41.7%) or White/Caucasian (33.3%). A majority were female (56.3%), and 27.1% of clients reported being straight or heterosexual. It is important to note, however, that 54.2% of clients did not report their ethnicity when asked, and 60.4% did not report their sexual orientation.

Neurosequential Model of Therapeutics Program Clients Demographics (N = 48)

	Number of clients	Percentage of total
Age		
0–15 years	0	0.0
16–25 years	27	56.3
26–59 years	15	31.3
60 years and older	6	12.5
Primary language		
English	22	45.8
Spanish	3	6.3
Mandarin	1	2.1
Cantonese	1	2.1
Unknown/not reported	21	43.8
Race		
Hispanic or Latino	20	41.7
White or Caucasian	16	33.3
Other	8	16.7
Asian American	3	6.3
Black, Afro-Caribbean, or African American	1	2.1
Ethnicity		
Not Hispanic or Latino	12	20.8
Hispanic or Latino	10	25.0
Unknown/not reported	26	54.2
Gender assigned at birth		
Female	27	56.3
Male	21	43.8
Sexual orientation		
Straight or heterosexual	13	27.1
Lesbian or gay	3	6.3
Bisexual	2	4.2
Asexual	1	2.1
Unknown/not reported	29	60.4

EVIDENCE-BASED PRACTICE CLINICIANS

Evidence-based practice clinicians	FY 2023–24
Total clients served	739
Total cost per client	$1,186

System transformation is supported through an ongoing series of WET trainings to increase the utilization of evidence-based treatment practices across the BHRS system of care and better engage consumers and family members as partners in treatment and contribute to improved consumer quality of life. MHSA funding supports clinical staffing including marriage and family therapists, psychiatric social workers, and mental health counselors specialized in providing services for youth and adult clients and expanding the delivery of evidence-based practices. These positions are placed throughout BHRS regional clinics and programs.

SCHOOL-BASED MENTAL HEALTH

The SBMH program identifies students living with SMI and connects them with appropriate behavioral health services that support students to continue receiving classroom instruction. In FY 2023–24, SBMH staff provided clinical assessment; talk, art, and play therapy; and case management services to 327 students across 23 school districts. Roughly 80% of participating students are eligible for Medi-Cal. Staff serve the following groups:

- Newly referred students expected to meet medical necessity criteria for an IEP on the basis of SMI screening results.
- Current special education students living with SMI, identified in a prior school year.

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

A manager and four supervisors oversee SBMH program operations. They assign one of 22 San Mateo County mental health clinicians to newly enrolled students and serve as liaisons between each school district's staff and BHRS-affiliated service providers. Before a student begins receiving school-based behavioral health supports, a SBMH supervisor reviews the SMI screening form submitted by school staff. For referrals deemed appropriate, an SBMH clinician then conducts an assessment with the student to determine whether they meet the diagnostic criteria for SMI. Clinicians identify behavioral health services, on the basis of the assessment, to support optimal functioning in school. Finally, the

SBMH clinician presents a subset of the assessment results at an IEP meeting. If the IEP team agrees with the clinician's recommendation for behavioral health services, the clinician will work with the student's support network to finalize the treatment plan.

In addition to the services covered by a student's IEP, SBMH clinicians can provide individual and group therapy during school hours as well as family counseling outside of school. Medi-Cal students can also meet with county psychiatrists for prescription mental health medication management. SBMH clinicians may also recommend that school staff refer students with maladaptive behaviors that fall beneath the severity threshold required of an IEP to either Fred Finch Youth & Family Services or Edgewood Center for Wraparound services. The Wraparound model is designed to prevent higher level placements, such as residential placement, incarceration, or hospitalization, by helping students develop self-calming skills and embrace other strategies for curbing inappropriate behaviors.[40] SBMH clinicians and educators present to the Identification, Placement, and Review Committee to request approval for the referral.[41]

In addition to delivering services required under the terms of each IEP, SBMH clinicians facilitate student referrals to off-site providers of behavioral health services. Many students are encouraged to participate in movement-based therapeutic activities, such as yoga and equine therapy sessions led by community-based partners from the NMT program. Furthermore, SBMH clinicians refer students who could benefit from and meet eligibility criteria for therapeutic behavioral services to Fred Finch Youth & Family Services.

PROGRAM IMPACT

School-based mental health	FY 2023–24
Total clients served	327
Total cost per client	$989

Reduces disparities in access to care: In FY 2023–24, the SBMH program continued to reduce disparities in access to care by increasing the total number of students living with SMI who were receiving public health services. For example, program staff offered to deliver behavioral health service visits in school for students living with SMI. This particularly helped reduce disparities in care for students whose parents worked multiple jobs or relied solely on public transportation. In addition, in the past year, SBMH staff helped to resolve inequities for struggling families. For example, an unhoused family began living in a temporary living space outside of their school district,

[40] Wraparound models emphasize the importance of care coordination across a student's support network, which may include their family, friends, teachers, mental health professionals, and other community members. The models also encourage each student, their caregivers, and mental health professionals to collaborate on the development of a treatment plan and to identify strengths that can be leveraged to support behavioral change. For more information, see https://www.smchealth.org/sites/main/files/file-attachments/full_service_partnership_evaluation_report_full_july_2014_f_1.pdf.

[41] As described at https://www.smchealth.org/article/mhsa-dollars-help-create-support-systems-around-clients, "The Interagency Placement Review Committee evaluates youth referrals in collaboration with BHRS managers, Children and Family Services, and Juvenile Probation. They look for characteristics, like risk of entering or transitioning out of a residential program, and whether a child is living with a family who is willing to participate in and support their treatment."

and the district said that the students should switch to a different district that is closer to the temporary residence, rather than providing transportation services to their current school. SBMH staff advocated for providing transportation services to and from the students' current school.

Improves timely access and reduces stigma and discrimination: The rapid development of IEP packages by individual school staff continued to be a driver of timely access to care. In FY 2023–24, SBMH provided some in-school behavioral health services, or linkages to external behavioral health services, to students with Medi-Cal coverage while staff worked on their initial assessments. Doing this in tandem ensured that recently referred students could quickly access the support they required to function well at school. In the initial meeting with the family of a client approved for an IEP, program staff informed the client and their family of all the services and resources they can offer and provided them with informational packets for future reference.

In FY 2023–24, the SBMH program continued to reduce the prevalence and severity of stigma by doing the following:

- Providing students with the support they need to remain in their current classrooms; this support promoted feelings of inclusion that would not have been possible if behavioral disruptions persisted and required a transfer to a more secluded environment.
- Training staff on how to use coping and psychoeducation strategies in the classroom.
- Providing parents with psychoeducation to help them understand and navigate the special education and mental health systems without feeling stigmatized by caring for youth with "special needs."

In addition, county clinicians strived to mitigate discriminatory attitudes toward students living with SMI by arranging to speak with special education instructors. They continued to collect and share background information on individual students and their families, including key challenges and limitations. They then used this information to suggest ways that school staff might work more effectively with those students, instead of simply identifying this behavior as "acting out."

Implements recovery principles: In FY 2023–24, program staff continued to demonstrate a commitment to implementing recovery principles. SBMH program clinicians promoted a high degree of student and family involvement in the development of treatment plan goals to make the process collaborative, empowering students to take an active role in their own care. Patient self-activation was also accomplished through referrals to clinicians from therapeutic behavioral services, who helped students learn to verbalize their needs and advocate for themselves. Moreover, staff provided culturally sensitive care by matching families to culturally and linguistically appropriate services. In FY 2023–24, the program onboarded bilingual and trilingual clinicians who can provide services in multiple languages to meet the needs of a greater number of clients whose preferred language is not English. These clinicians have shown that they are willing to travel to different places in the county to provide linguistically appropriate services for clients who speak Portuguese or Spanish, for example. Having bilingual clinicians enables clients to speak with their care team in their chosen language, rather than using interpreter services to communicate with them.

This section provides a comparison of health care use data from periods that extended to 3 months before and after the clients were admitted to the SBMH program. It also displays details on SBMH clients' status of IEP and non-IEP goals.

The following table summarizes the health care use information of the 327 clients who were admitted and actively a part of the SBMH program during FY 2023–24. During the 3 months before program admission, these clients had 117 PES episodes and one inpatient/residential episode lasting 15 days. During the 3 months following their admission, none of the SBMH clients had a record of using these crisis services. Please note that these results are as of early October 2024 and may not reflect all health care utilization for those clients admitted late in the FY.

SBMH Clients' Health Care Use (FY 2023–24)

Health care utilization metric	3 months before admission	3 months after admission
Number of PES episodes	117	0
Number of inpatient/residential stays (in days)	1	0
Total inpatient residential stays (in days)	15	0

Note. SBMH = school-based mental health program; FY = fiscal year; PES = psychiatric emergency services.

Status of SBMH Clients' IEP Goals (FY 2023–24)

IEP goal completion status	Number of clients	Percentage of clients
Not completed	91	27.8
Completed	91	35.8
Partially completed	117	27.8
Not completed	91	27.8
Unknown	28	8.6
Total	**327**	**100.0**

Note. SBMH = school-based mental health program; IEP = individualized education plan; FY = fiscal year.

The following table summarizes the status of non-IEP goals for the 327 clients who were admitted and actively a part of the SBMH program during FY 2023–24. Almost two thirds of clients completed or partially completed their non-IEP goals, and close to one third of clients did not.

Status of SBMH Clients' Non-IEP Goals (FY 2023–24)

Non-IEP goal completion status	Number of clients	Percentage of clients
Not completed	90	29.1
Partially completed	110	33.6
Completed	95	27.5
Unknown	32	9.8

Total	**327**	**100.0**

Note. SBMH = school-based mental health program; IEP = individualized education plan; FY = fiscal year.

SUCCESSES

In FY 2023–24, the SBMH program provided support services to clients who were transitioning out of the program and graduating from high school. The program helped clients look for and apply for jobs and took them to look at colleges they were interested in attending.

Program staff attributed observed improvements in clients' mental well-being and socialization to the program's therapy services, which they highlighted as a particularly successful intervention in FY 2023–24. Therapists' flexibility and availability to meet the clients in their home or at school and incorporate parental support and involvement were important to clients' progress. The following detailed client stories highlight two clients' personal growth as a result of the program's therapy services.

Client Success Story #1: A client, K, began the Baden Therapeutic Day School program right after eighth grade. It was a challenging time to start, as he joined at the height of the COVID-19 pandemic, when SBMH was providing schooling and mental health services virtually. K had a history of trauma and several hospitalizations for suicidality. When the program returned to providing in-person services after one academic school year of doing distance learning and telehealth, he was shy and guarded, often wearing a hoodie to obscure his head and avoid unwanted attention. Staff noted that he kept to himself and didn't talk much to other students or teachers. Moreover, the client did not say much in therapy and did not believe that therapy sessions would be beneficial. He often made digs at this therapist and was hesitant to open up to them. However, he enjoyed walking and taking walks around the community with his therapist. His therapist said that the walks helped him open up, allowing him to fully engage in the sessions. Over time, K became equally engaged with the other aspects of the program. He became more comfortable with self-expression and demonstrated his funny and sociable side, ultimately becoming a role model and leader in the program. During his last year of school, he developed an interest in cooking. He and a SBMH staff member made several dishes together that he shared with his peers. He was also able to attend a culinary program at the mainstream high school. The client graduated last May and is now enrolled in a culinary arts program at a community college, where he is doing very well.

Client Success Story #2: One SBMH therapist worked with a client who had a poor school attendance record, often missing weeks of class at a time. To address the client's absenteeism, the therapist started conducting home visits and escorting the client on community outings, which they later replaced with short trips to school. Accompanying the client on school visits helped him adjust to the new environment that he encountered upon his transition to high school. As a result of the regular, weekly meetings with his therapist and compliance with prescription medication, this client has experienced improvements in his mental health and attendance record in a relatively short amount of time. For example, the client's anxiety has decreased, and he has started socializing more with friends. In the past year, he missed only 3 or 4 days of school. Because of the tremendous progress

that the client has made thus far, his clinician recommended decreasing the frequency of his SBMH support services.

CHALLENGES

The SBMH program faced staffing shortages during FY 2023–24. In the past year, some school district staff asked SBMH staff to become more involved in their schools and in new programs for students living with SMI. Unfortunately, the SBMH program did not have enough staff members to provide these additional services. In addition, the program leadership experienced difficulty advocating for hiring the three new clinicians. To help existing clinicians manage caseloads and continue to provide high-quality services for clients, leadership enforces a limit on the number of cases that each clinician can take on at any given time. Although demand for program services has continued to increase, staff learned recently that there is no room in the budget for the SBMH program to hire additional staff in the near future.

In the past year, SBMH continued to experience challenges providing services over the summer to students whose schools did not offer an extended school year program. Program staff continued to advocate for services being offered throughout the summer.

DEMOGRAPHICS

The following table summarizes the demographic information of the 327 clients who were admitted and actively a part of the SBMH program during FY 2023–24. Most clients were younger than 15 years (54.4%), and the rest were between the ages of 16 and 25 years (45.6%). A majority spoke English as their primary language (63.9%). Most identified with an unlisted race (45.3%), as White/Caucasian (20.2%), or as multiple races (11.3%); 56.3% identified as Hispanic or Latino; 66.1% identified as male; and 95.1% of clients had unknown or unreported sexual orientation data.

School-Based Mental Health Program Client Demographics (N = 327)

	Number of clients	Percentage of total
Age		
0–15 years	178	54.4
16–25 years	149	45.6
Primary language		
English	209	63.9
Spanish	98	30.0
Other	3	0.9
Tagalog	2	0.6
Korean	1	0.3
Arabic	1	0.3
Thai	1	0.3
Unknown/not reported	12	3.7

	Number of clients	Percentage of total
Race		
Other	148	45.3
White or Caucasian	66	20.2
Multiple	37	11.3
Asian	19	5.8
Black or African American	8	2.4
Hispanic or Latino	1	0.3
Tongan	1	0.3
Native American	1	0.3
Unknown/not reported	46	14.1
Ethnicity		
Hispanic or Latino	184	56.3
Not Hispanic or Latino	109	33.3
Unknown/not reported	34	10.4
Gender assigned at birth		
Male	216	66.1
Female	111	33.9
Sexual orientation		
Straight or heterosexual	10	3.1
Declined to state	3	0.9
Lesbian, gay, or homosexual	1	0.3
Bisexual	1	0.3
Other	1	0.3
Unknown/not reported	311	95.1

CRISIS MANAGEMENT

The BHRS clinical services manager oversees all crisis services in San Mateo County, supporting the oversight and operations of the BHRS Psychiatric Emergency Response Team and various contracted crisis services. This includes developing contracts and monitoring the smooth implementation and operation of these contracted services. In addition, the manager oversees the operations of the county crisis response team that responds to large-scale community crises and mutual aid requests from neighboring counties for community disasters. Furthermore, the manager provides trainings and presentations on the county crisis continuum of care to system partners including schools, the County Office of Education, law enforcement, emergency medical services, and community stakeholder groups.

The crisis response team is composed of trained “volunteer” clinicians from across BHRS who are skilled in psychological first aid and short-term crisis response. They provide crisis management to victims and survivors soon after large-scale community crises, such as mass shootings, plane crashes,

winter storms, and community tragedies. In FY 2023–24, the crisis response team responded to support multiple tragic events in various San Mateo County school districts, ranging from extensive sexual assaults of students by their teacher to youth suicide and other accidental tragedies.

In addition, the crisis services manager has worked on planning, designing, and implementing a 24/7 non-armed mental health mobile crisis response service in the county, as mandated by the California Department of Health Care Services (DHCS) to implement the Medi-Cal Mobile Crisis Response Implementation Benefits for their Medi-Cal beneficiaries. For the first time in the county's history, there will be a countywide mobile crisis response team to address behavioral health crises. This team, consisting of a licensed mental health clinician and a peer support specialist (PSS), will be available to "anyone, anywhere, anytime" who needs the service. The mobile crisis response team started with a soft launch for the afternoon shift in May and was operational 24/7 on August 31, 2024.

Finally, the crisis services manager has been collaborating with various stakeholders, including but not limited to The Center on Homelessness, Human Services Agency, San Mateo Health, Correctional Health Services, San Mateo Medical Center LEAP Institute, and BHRS executive members. The focus is on redesigning and strengthening the partnership and coordination with other Homeless Outreach Teams (HOTs) in the county to increase capacity, efficiency, timely coordination, and communication in supporting unhoused individuals countywide.

PROGRAM IMPACT

The crisis services vision in San Mateo County aims to enhance rapid response to behavioral health crises for all youth and adults, regardless of insurance status, while ensuring high-quality care and comprehensive follow-up. The crisis manager is committed to delivering crisis services promptly, respectfully, and with cultural sensitivity, always maintaining a person-centered approach. The goal is to establish a coordinated network of behavioral health crisis programs, ensuring seamless access and consistent standards of care across all services.

SUCCESSES

Successes in this FY 2023–24 were tied largely to (a) planning and preparing for the contracting, interfacing with a wide spectrum of highly invested stakeholder groups, interfacing with DHCS and multiple system partners including law enforcement and emergency medical services, and launching the implementation of a countywide 24/7 mobile crisis response service, the first of its kind in our county; (b) supporting and responding to large-scale community crises with our BHRS crisis response team and responding to and providing immediate, short-term emotional support to the victims and survivors of disasters, community crises, and tragic events; and (c) proactively working with systems' partners and community stakeholders in addressing the increasing homelessness crisis in our county.

CHALLENGES

With the increasing needs and expansion of crisis-related services, as well as the growing complexities of addressing unhoused populations, compounded by new initiatives related to crisis work and unhoused populations, the workload has intensified. Currently, one full-time equivalent crisis services manager oversees all of these responsibilities. As the scope of work continues to

expand, the program may benefit from ongoing evaluation of staffing needs to ensure continued effective service delivery.

PEER AND FAMILY PARTNER SUPPORTS

PEER SUPPORT WORKERS AND FAMILY PARTNERS

San Mateo County BHRS remains committed to supporting peer support specialists (PSSs), peer support workers PSWs (PSWs), and family partners, who are integral to both the youth and adult systems. These dedicated individuals, many from historically underserved communities, provide crucial direct services to BHRS clients. Their unique form of support stems from two sources: their lived experience with recovery—either personal or as family members of those affected by behavioral health challenges—and their deep understanding of the cultural and social conditions that their clients face. This shared background enables them to connect with clients in a more authentic and meaningful way, fostering trust, reducing traditional power dynamics, and promoting mutual respect.

Peer supports: There are 13 PSS/PSW positions in the BHRS adult system funded by MHSA. They are embedded throughout the system in a variety of teams: OASIS, Pathways, and the five BHRS regional clinics. In addition, a previously part-time PSW position has been transitioned to full time to meet growing service needs. This commitment highlights the ongoing value that BHRS places on peer-driven support, particularly the ability of peers to understand and relate to the lived experiences of clients from underserved communities, as a core component of its behavioral health services.

- One on the TAY program (full-time position)
- One on the OASIS team (part-time position)
- One on the Crisis and Outreach team (full-time position)
- One on the Coastside Mental Health team (full-time position)
- Two on the South County Mental Health team (full-time positions)
- One on the East Palo Alto Mental Health team (full-time position)
- One on the Central County Mental Health team (full-time position)
- Two on the North County Mental Health team (full-time positions)
- One on the Community Assistance, Recovery, and Empowerment Court team (full-time position)
- Two on the Service Connect team (full-time positions)

This program provides peer-based support services to individuals in behavioral health recovery through PSSs and PSWs within the San Mateo County BHRS Adult System. These peer supporters bring valuable lived experience to their roles and operate across various service areas including OASIS, Pathways, and regional clinics. Following CalMHSA Medi-Cal Peer Support Certification

standards, the program aims to bridge the gap between clinical services and lived experience through five key activities: direct peer support, recovery navigation and advocacy, collaborative goal setting, system integration and team collaboration, and reducing stigma and power imbalances.

The program delivers these activities through one-on-one and group support sessions in which peer workers share their recovery experiences and help clients navigate the behavioral health system. Through direct peer support, they provide emotional support and practical advice. Recovery navigation involves helping clients access resources and advocating for their needs. Collaborative goal setting focuses on developing coping strategies and building self-confidence. System integration ensures that peer support aligns with other medical interventions through multidisciplinary collaboration. Finally, by working with clients on equal footing, the program helps reduce stigma and power imbalances typically found in clinical settings while ensuring comprehensive, person-centered care for individuals at various stages of recovery.

Family supports: Family PSSs (FPSSs) represent diverse cultural and linguistic experiences, including being bicultural and bilingual in English, Spanish, and Tongan. They provide individual support to caregivers of youth and young adults, sharing their lived experiences with the families they serve. Currently, only one FPSS provides support to adult clients and their family members through the Pathways program. Some case management is included in their family support services. They also offer group support to parents and caregivers to connect with others caring for youth with behavioral health needs, encourage self-care, share community resources, and provide guidance in navigating the youth Systems of Care.

San Mateo County BHRS currently employs nine FPSSs and one family partner, all with lived experience supporting family members with behavioral or mental health challenges. They are distributed as follows:

- One FPSS on the Adult Pathways Mental Health Court team (full-time position)
- One FPSS on the SBMH team serving youth families (full-time position)
- One FPSS on the Youth Services Center Team (Juvenile Justice System; full-time position)
- One family partner in the Pre-3 Program serving pregnant women, adults, and parents of children ages 0–5 years (part-time position)
- Five FPSSs embedded within the Regional Youth Clinics (full-time positions)
- One vacant family partner position in the TAY program (full-time extra help position)

Family partners represent diverse cultural and linguistic experiences, including being bicultural and bilingual in English, Spanish, and Tongan. BHRS family partners/FPSSs can be referred to provide support for families that are not receiving services on the teams that they are embedded on. Cultural and linguistic matches are key factors in making these assignments.

Family partners/FPSSs provide individual support to parents of youth and young adults, sharing their lived experiences with the families they serve. Some case management is part of their support of

families. They also provide group support to parents/caregivers by providing educational activities concerning children and their mental health.

Family partners/FPSSs also bring their lived experience to the broader community by participating in the following community groups, committees, and initiatives: Latino Collaborative (LC), Pacific Islander Initiative (PII), North County Outreach Collaborative (NCOC), Immigrant Forum, Pride Initiative (PI), Long-Term Shelter Stayers Multi-Disciplinary Team to share resources and strategize on ways to support individuals in shelters to access stable housing, Bay Area Regional Pacific Islander Taskforce, and BHC Youth Committee Meeting.

PROGRAM IMPACT

In FY 2023–24, the following trainings were offered to the peers:

Peer and family partners	FY 2023–24
Total clients served by family partner/family peer support specialist	323
Total clients served by family partner/family peer support specialist	147
Total clients served	470
Total cost per client	$4,608

- Workplace Violence Prevention Plan training
- Cultural Humility 101
- Avatar NX training
- Information technology security awareness training
- Annual BHRS-compliance training
- CalAIM trainings
- Becoming Visible—Using Cultural Humility in Asking Sexual Orientation Gender Identity (SOGI) Questions
- Prevention and management of assaultive behaviors
- Boundaries and confidentiality for peers
- Group facilitation for peers
- Recovery planning for peers
- Law and ethics for peers
- Documentation training
- Digital Literacy Train the Trainer series, including smart phone tech, protecting safety and privacy, and combating phishing and scamming
- Naloxone-Narcan training
- Peer Support 101
- 8-hour retreat including yoga and arts and crafts for stress management
- Fraud, Waste, and Abuse Training for BHRS

- Virtual critical incident training for BHRS
- Virtual confidentiality training for BHRS

In FY 2023–24, FPSSs strengthened access to mental health services and resources for underserved communities through enhanced outreach and engagement. Through their participation in committees and expanded community networks, FPSSs identified new resources and partnerships, leading to increased behavioral health service utilization. Through HEIs, FPSSs deepened their understanding of community needs.

FPSS/family partner committee participation:

- Immigrant Forum (10 monthly meetings)
- PII Committee (nine monthly meetings)
- LC (six monthly meetings)
- California Systems of Care Bay Area Regional (six bi-monthly meetings with behavioral health directors and family partners/FPSSs)
- BHC Youth Committee (two monthly meetings)
- East Bay Housing (three meetings)
- Long-Term Shelter (six weekly meetings)
- Coastside Collaborative (four monthly meetings)
- Mental Health Awareness Month events

PROGRAM NARRATIVE:

Enhanced access and linkages for underserved populations: The BHRS PSSs and PSWs play a vital role in improving access to care by serving as bridges between underserved populations and the behavioral health system. Their lived experience, combined with their diverse backgrounds, allows them to build trust with clients who might otherwise be hesitant to engage with traditional mental health services. Many of the peers come from the same historically underserved communities as the clients they serve, giving them personal knowledge of the cultural, social, and economic challenges these populations face.

By offering peer-driven, culturally responsive support, they help clients navigate complex systems, connect them to essential resources, and facilitate access to behavioral health services, such as psychiatric care and counseling, as well as to services addressing concurrent recovery needs, including housing, benefits, community engagement, and substance use treatment. The peers are embedded in key teams across San Mateo County, including OASIS, Pathways, and regional clinics, ensuring that they are accessible to diverse and underserved populations.

Implementing recovery principles: Peer support is deeply rooted in the principles of recovery, which emphasize hope, empowerment, and client-driven care. PSSs and PSWs model recovery by sharing their own journeys and encouraging clients to take active roles in their own treatment plans. The

diverse backgrounds of the peers enrich this process, as they can relate to the cultural and community-specific recovery challenges faced by clients. They work collaboratively with clients to set recovery-oriented goals, promote self-efficacy, and provide ongoing emotional and practical support.

By integrating peer workers into the care team, the program ensures that recovery principles are woven into every aspect of service delivery, creating an environment in which clients feel empowered, valued, and capable of achieving long-term wellness. The reduced power differential between peer workers and clients aligns with a core recovery principle of mutual respect and shared decision making, fostering an inclusive, client-centered approach to recovery.

Stigma and discrimination reduction: The peers play a significant role in reducing stigma and discrimination by normalizing the experience of mental health challenges and recovery; educating clients, their families, and the communities about the facts of behavioral health; and serving as role models, demonstrating that recovery is possible. Peers share their personal stories of recovery, demonstrating that individuals can lead fulfilling lives despite having behavioral health challenges. This representation is especially powerful coming from a diverse group of peers who reflect the cultural and ethnic backgrounds of the communities they serve, further breaking down stigma in historically marginalized populations.

By fostering open, empathetic conversations, peer workers help clients feel less isolated and more accepted, creating a more supportive and inclusive environment. This peer-led approach challenges societal misconceptions about mental illness and SUDs, within both the client population and the broader community.

Increased utilization of public health services: The program increases the number of individuals receiving public health services by actively engaging those who might be reluctant or unaware of available resources. PSSs/PSWs, all of whom have firsthand experience of the barriers that underserved communities face in accessing care, use outreach and direct client interactions to encourage people to seek help earlier and more consistently. They guide clients through the process of accessing services, offering support, advocacy, and reassurance, which reduces barriers to entry.

By leveraging their shared cultural and life experiences, peers build comfort and trust in the system, encouraging more individuals, including those who may have previously avoided or discontinued care, to use public health services. Peers also help increase the number of clients as existing clients heal and encourage others in their families and communities who may need services to engage with BHRS.

Reducing disparities in access to care: Peer workers are uniquely positioned to address disparities in access to care, particularly for populations that are marginalized, such as individuals from low-income backgrounds, racial and ethnic underserved communities, and older adults. Because BHRS PSSs/PSWs themselves come from historically underserved communities, they offer culturally informed support and serve as strong advocates for equitable access to services. Their understanding of the challenges that these populations face allows them to provide tailored assistance and advocacy.

By being embedded in teams that specifically serve vulnerable populations (such as OASIS for older adults and Pathways for those involved in the justice system), BHRS ensures that these individuals have someone who understands their unique challenges and can advocate for timely, appropriate care. Peers also help clients overcome socioeconomic and systemic barriers that often prevent them from accessing services, further reducing disparities in care.

SUCCESSES

PSS/PSW

Increased respect and recognition for peers: Peers report a noticeable shift in the respect they receive from their teams since becoming Medi-Cal certified. They feel more confident engaging with colleagues as equals and using their lived experiences as behavioral health service consumers to inform and contribute to the team's work. This change reflects a broader cultural shift within the clinic, fostering inclusivity and collaboration.

Enhanced supervision and professional support: The quality of supervision for peers has significantly improved, with supervisors demonstrating greater respect and understanding of the unique needs of peer roles. Peers are now supported and encouraged to pursue continuing education opportunities, with dedicated time allocated for professional development.

Empowerment to advocate for change: Peers feel more comfortable addressing issues and advocating for necessary changes within the system. For example, peers encountered a troublesome situation in the community and engaged a psychiatrist to write to the health department director, leading to the creation of a new system policy on drug testing. This accomplishment highlights the growing trust and influence of peers in shaping policies.

Peers as role models for clients: Peers have observed a positive shift in how clients view them, recognizing peers as qualified professionals who have lived experience similar to theirs. Clients now speak more respectfully about peers and feel inspired by seeing individuals with similar experiences succeed in their roles within the county. This dynamic provides hope, reduces stigma, and demonstrates the potential for recovery, even as peers retain elements of their cultural identity from before entering treatment while modeling that recovery is possible.

Peers' role in transforming clinics: Peers have contributed to transforming the clinic environment. By supporting clients to comply with treatment plans, medication regimens, program rules, group agreements, and other requirements, peers have helped clients feel empowered to express their needs and understand their rights. Peers have helped foster greater trust between clients and all program staff. This transformation has strengthened the sense of mutual respect and collaboration across the programs.

Family Partner/FPSS

Medi-Cal PSS certification: During this FY, two family partners obtained their Medi-Cal PSS certification, and seven already-certified FPSSs completed the Parent, Caregiver, and Family Member Peer Specialization Training approved by CalMHSA.

Clients and Families' Successes

- **Family transitioning from shelter to permanent housing initial situation:** Family had been living in a shelter for more than 12 months. Support provided: FPSS connected caregiver to mental health services. Outcome: Family transitioned to permanent housing, showing progress in both mental health and housing stability.
- **Family reengaged with mental health and benefits initial situation:** Family struggled with youth's medication adherence and benefit management. Support provided: FPSS guided benefits recertification and treatment engagement. Outcome: Family stabilized access to essential services, with both caregiver and youth managing their health needs.
- **Parental support and engagement in advocacy initial situation:** Father lacked hope and tools to support his child. Support provided: FPSS offered psychoeducation and Parent Café connection. Outcome: Father engaged successfully, built community with other parents, and became empowered to advocate.
- **Reenrollment in medical insurance initial situation:** Caregiver was disengaged from treatment team and insurance process. Support provided: FPSS connected parent with medical specialist. Outcome: Client's medical insurance was successfully reestablished.
- **Building trust and parenting skills initial situation:** Parent struggled with communication and expressing love. Support provided: FPSS shared lived experience and culturally informed parenting skills. Outcome: Parent developed effective parenting skills and better met children's emotional needs.
- **Support through Individual Education Plan (IEP) initial situation:** Caregiver needed help navigating IEP process. Support provided: FPSS guided IEP evaluation and qualification. Outcome: Client enrolled in STARS therapeutic day school program.
- **Housing support and childcare application initial situation:** Mother needed help with housing and childcare applications. Support provided: FPSS assisted with organizing applications and 4Cs childcare services. Outcome: Mother gained housing search clarity and secured childcare for youngest daughters.
- **Caregivers' understanding and confidence in youth's diagnosis initial situation:** Grandparents were concerned about youth's diagnosis and behaviors. Support provided: FPSS provided ongoing education about diagnosis and management. Outcome: Caregivers developed better understanding, empathy, and confidence.
- **Client progress in case management and recovery initial situation:** Client struggled with mental health challenges and service disconnection. Support provided: FPSS delivered weekly case management and recovery support. Outcome: Client graduated from Pathways, secured employment, and established stable living environment.

Message from clinician to Yolanda Ramirez on June 26, 2024: "I just spoke to a client's mom via interpreter. She shared that Sonia (FPSS) is a huge help and support to her and she is very grateful."

Quotation from Mariana G., caregiver, Half Moon Bay: “My family partner has been a great support for me and my family. I have three children receiving mental health services, and my family partner is always open to listening to my concerns. She also helps me connect with the school staff and obtain resources to maintain housing for my family. I am very grateful for Sonia’s support and her responsiveness to my calls.”

CHALLENGES

PSS/PSW

- **Standardization of peer work across teams:** There remains significant variation in how PSWs and PSSs are used across programs. Whereas some teams fully embrace their role and integrate their work in alignment with Medi-Cal standards, others, including some supervisors, have been slower to adopt these practices. Engaging and training certain unit supervisors have proven challenging, as they are often overwhelmed with managing large teams and handling numerous responsibilities.
- **Challenges of peer support in a rural community:** A PSS in a small rural area faces several unique challenges. First, client participation in group sessions is low because of concerns about privacy in the small, close-knit community where gossip is prevalent. Second, the area lacks wellness and entertainment options, requiring clients to travel far for these activities. Finally, limited public transportation and narrow, one-lane roads make it difficult for clients to reach destinations, further complicating access to services and resources.
- **Rebuilding client engagement after pandemic:** A PSS at South County Clinic has struggled to reestablish group activities, with clients showing less connection and engagement following the COVID-19 pandemic. Many clients have become detached from the clinic, and the peer faces limitations in resources—financial, activities, and time—which make it difficult to provide adequate support and foster engagement.
- **Housing-related challenges for clients in recovery:** A PSS faces significant challenges related to clients’ living situations. Many clients, particularly those recently released from long-term incarceration, reside in shelters or sober living environments, which can create stressors and triggers in their recovery process. These environments often are not ideal for their transition back into the community. Although affordable housing remains a major issue and persistent challenge, the peer reminds clients that shelters and sober living environments are temporary stepping stones toward more stable housing.
- **Expanding peer involvement at community events:** The system needs to support peers in being more active within the community by hosting resource tables at fairs, resource events, and other gatherings to increase outreach and engagement.
- **Educating leadership on the value of peer support:** Higher levels of the health department and county government still need to be better educated about the work of PSWs and PSSs. Peers who attended Board of Supervisors meetings observed that the supervisors need to be better informed and reminded of the critical importance of peer support work.

Family Partner/FPSS

- Families face challenges accessing out-of-county services, such as transportation after hospital discharge. In addition, youth alcohol and drug services remain limited.
- Many families are not ready to engage with family partners. More training is needed to improve family dynamics and strengthen communication between families and providers.
- Housing remains a significant issue, with clients being denied housing despite following proper procedures. A potential solution is creating workshops to teach families how to navigate the housing system and advocate for themselves.
- Some caregivers, particularly monolingual Spanish speakers, face literacy challenges that require more assistance in navigating community resources. Caregivers are encouraged to register for literacy classes, with a focus on empowering them to become more independent.
- There is a language barrier for Farsi-speaking clients, with forms often unavailable in a timely manner. Solutions include advocating for more immediate access to translation services.
- Caregivers continue to face difficulties in motivating youth to attend school, complete chores, and attend their clinical appointments.
- Initially, participation in a weekly women's group was low, but after a structured approach was implemented that focuses on stabilization, trust building, and accountability, group dynamics have improved significantly, leading to better engagement.

DEMOGRAPHICS

Family Support Worker Program Client Demographics (N=147)

	Number of clients	Total number of clients	Percentage of total
Age			
0–15 years	93	147	64
16–25 years	37	147	25
26–59 years	15	147	10
60 years and older	0	147	0
Unknown/not reported	2	147	1
Primary language			
English	40	147	26
Spanish	102	147	70
Tongan	1	147	1
Farsi	1	147	1
Another	0	147	0
Unknown/not reported	3	147	2

	Number of clients	Total number of clients	Percentage of total
Ethnicity			
Hispanic or Latino	105	147	71
Pacific Islander	2	147	1
Native American, Alaska Native, or Indigenous	2	147	1
Black or African American	12	147	8
Asian	5	147	3
Arab or Middle Eastern	1	147	1
Caucasian	16	147	11
Filipino	1	147	1
Unknown/not reported	3	147	2
Sex assigned at birth			
Male	69	147	47
Female	78	147	53
Unknown/not reported	0	80	0

THE BARBARA A. MOUTON MULTICULTURAL WELLNESS CENTER

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

The Mouton Center:

- *Reduces stigma and discrimination:* Through MHFA, culturally responsive peer support groups, WRAP groups, and so on, stigma and discrimination are addressed with participants by facilitating discussions about mental health. Understanding results in empathy and authentic concern for those suffering with a mental illness and empowers them to speak up on behalf of others.
- *Increases number of individuals receiving public health services:* The Mouton Center staff facilitate connections between people who may need mental health and/or substance use services or other professional services to relevant programming and/or treatment by conducting the following:

Performing initial screening and engaging potential clients.

Providing brief interventions to motivate more extensive assessment and intervention.

Referring members who may need behavioral health services to appropriate agencies in the behavioral health system of care for assessment and follow-up treatment as needed.

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

PROGRAM IMPACT

For FY 2023–24, The Mouton Center reported 37 outreach events, all of which were individual events. There were 37 total attendees across all individual events. All individual outreach events lasted 55 minutes.

The Mouton Center	FY 2023–24
Total clients served	37
Total cost per client	$4,957

- Outreach events:

Events most frequently took place in unspecified locations (78.4%; *n* = 29).

The 37 events resulted in 30 mental health referrals and no substance use treatment referrals.

- Outreach event attendees:

Most attendees were female (54.1%; *n* = 20); 43% were male (45.9%; *n* = 17).

All attendees identified as heterosexual (97.3%; *n* = 36), except one who identified as queer (0.3%).

Attendees were older adults (60 years and older; 56.8%; *n* = 21) or adults (26–59 years; 43.2%; *n* = 16).

The top three racial/ethnic categories of attendees were White/Caucasian (40.5%; *n* = 15), Tongan (16.2%; *n* = 6), or Asian (16.2%; *n* = 6).

SUCCESSES

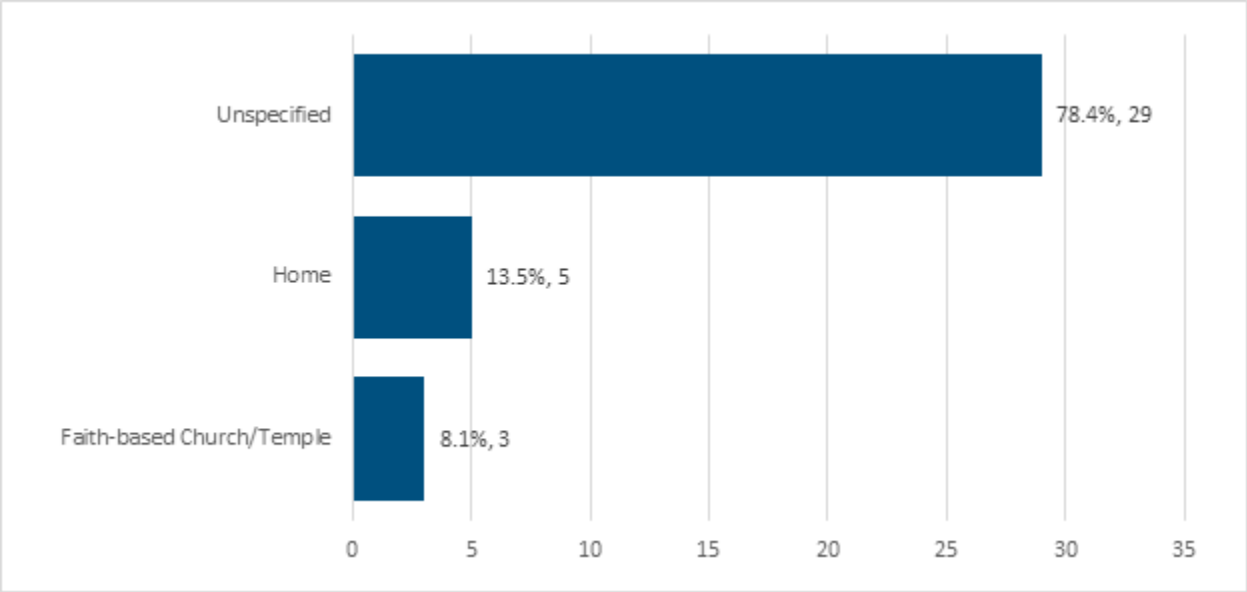
Since the COVID-19 pandemic, The Mouton Center gradually opened its programming hours and activities to the community during this FY. A great success is the launching of Wellness Wednesdays for the community in May 2023. Wellness Wednesdays are sessions that are open to the community to come and focus on their wellness while enjoying a healing activity. Topics and activities have included painting, candle making, journaling, and sharing one's narrative. One of The Mouton Center's clients, Timoteo, reported at one of the sessions that he was so excited to get to come back to the wellness center because he always feels welcomed and relaxed when he attends, so he was grateful to be able to participate in the sessions. Another mother noted that she has a son with special needs; she attends the evening painting sessions as a self-care activity for herself so she can, in turn, take care of her son's needs. There are many other stories of community members who have been attending these sessions who have all agreed that wellness offerings are a great way to care for oneself in order to then care for their families and community at large.

CHALLENGES

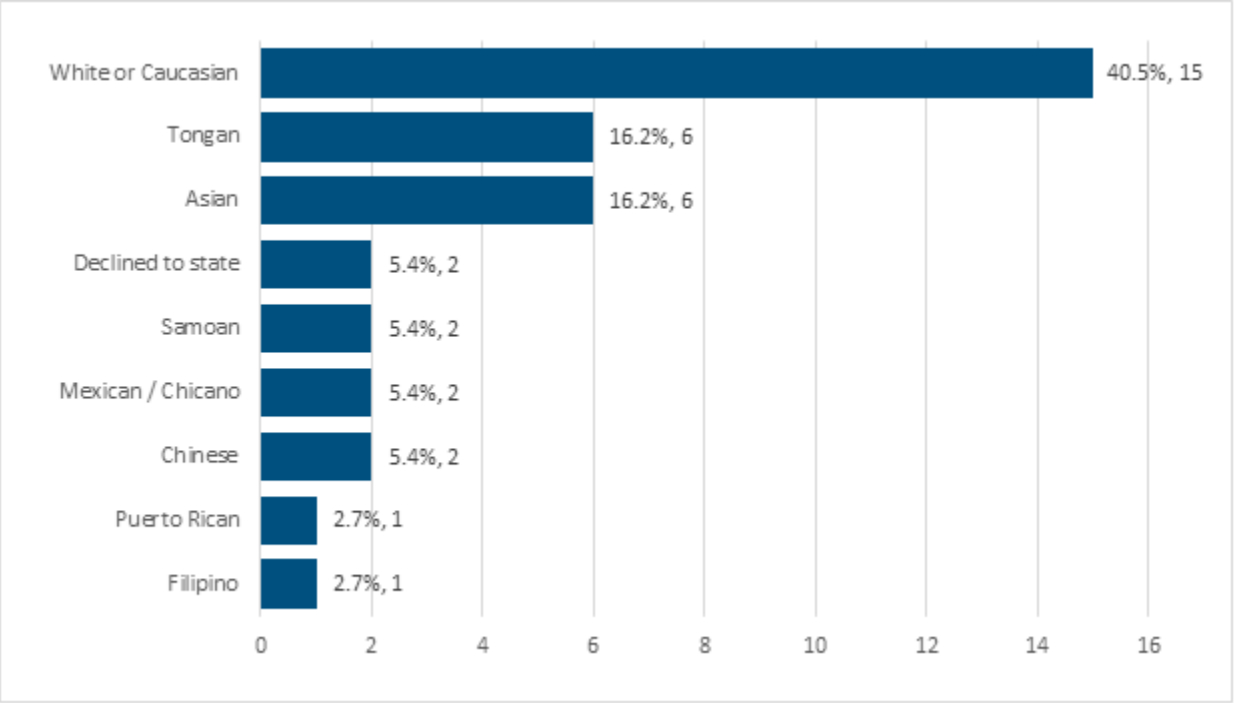
The Mouton Center, like so many other organizations, has been challenged by staff shortages. It's been a great challenge to hire staff since the COVID-19 pandemic. Some staff who have been hired have come for a short period but have had to leave for various reasons. The organization continues to pivot to meet the challenge and hold job fairs and open houses to attract interest and new members.

DEMOGRAPHICS

Counts of The Mouton Center Outreach Events

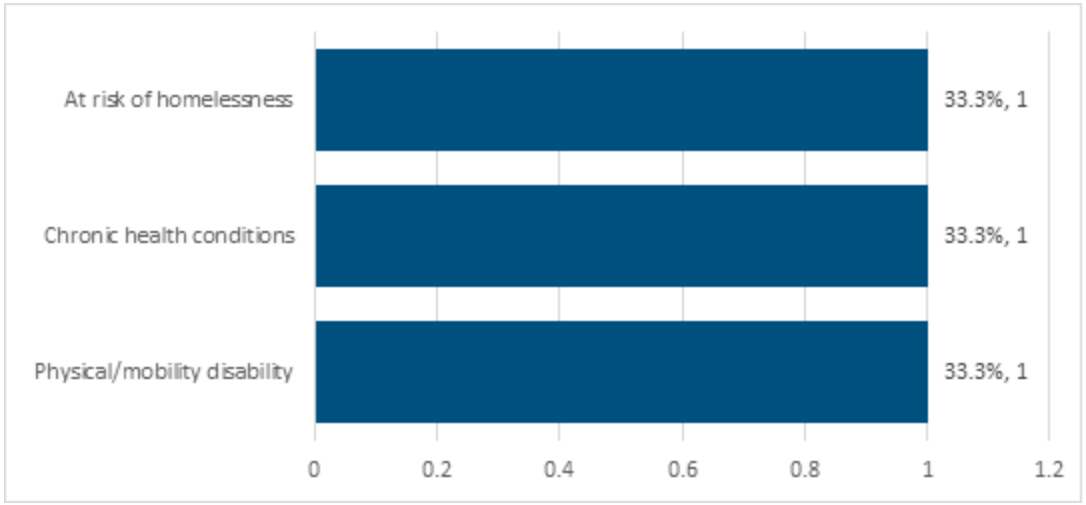


Counts and Percentages of Racial/Ethnic Categories: The Mouton Center Attendees



In FY 2023–24, The Mouton Center attendees at outreach events reported being in special population groups. Of the people who reported being part of a special population, one reported being at risk of homelessness (33.3%), one had chronic health conditions (33.3%), and one had a physical/mobility disability (33.3%).

Special Populations Served: The Mouton Center Attendees at Outreach Events, FY 2023–24



Note. Attendees could select more than one special population; therefore, the percentages may add up to more than 100%.

CALIFORNIA CLUBHOUSE

California Clubhouse's mission is to give individuals whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. The Clubhouse provides social and rehabilitative services to adults 18 years and older living with SMI.

Program components include the following:

1. **Work Ordered Day:** The Work Ordered Day runs from 8:30 a.m. to 5:00 p.m., 52 weeks per year. Members and staff work side by side as colleagues, performing the work of the Clubhouse. All operations are open to members and staff to ensure equity of access and engagement. Instead of traditional talk therapy, members and staff share responsibility for running every aspect of the Clubhouse. Activities include administration, research, hospitality, enrollment and orientation, outreach, hiring and training, public relations, and advocacy. Each day begins with a morning meeting, where members contribute agenda items and sign up for duties. Following this, business and hospitality units meet to set goals, create plans, and identify collaboration partners.
2. **Employment services:** The Clubhouse supports members in returning to work through transitional employment and career development programs. Transitional employment offers structured, supported experiences in local businesses, whereas the career development program provides employment readiness skills and job search assistance.
3. **Education services:** Support for members looking to resume their education.
4. **Wellness program:** Promoting both mental and physical health.
5. **Social activities:** Building meaningful connections through various events and outings.
6. **Young adult program:** Creating supportive paths for young adults newly diagnosed with mental illness.

California Clubhouse is part of Clubhouse International, a worldwide organization united by adherence to international standards. These standards, reviewed biennially, guide Clubhouse values and provide a bill of rights for members and a code of ethics for staff, board, and volunteers.

California Clubhouse in San Carlos is an evidence-based therapeutic community empowering people with mental illness to thrive through access to employment, socialization, education, skill development, and improved wellness opportunities. As the only accredited Clubhouse in the Bay Area Peninsula, California Clubhouse serves the entire population of San Mateo County, collaborating with San Mateo County Medical Center, Stanford University, local shelters, and criminal justice programs. California Clubhouse has 400 members (160 active yearly) and serves 70 individuals monthly, providing more than 1,800 hours of engagement (30 hours per person). By offering a stigma-free environment, California Clubhouse provides a vital sense of belonging for individuals living with mental illnesses who often face marginalization.

Target Population

Anyone with a mental health diagnosis can become a member. California Clubhouse programs serve adults (age 18 years and older) with psychiatric disabilities, many of whom suffer from profound loneliness and disconnection from community. Fifty-five percent of members are racial minorities, with 11% Hispanic, 10% Black/African American, 10% Asian, 3% Native Hawaiian/Pacific Islander, 1% American Indian, and 20% multiple races; 80% are unemployed or underemployed; and 58% have not completed high school or college. Most members report low or very low income due to systemic barriers.

PROGRAM IMPACT

California Clubhouse	FY 2023–24
Total clients served	125
Total cost per client*	$3,166

Improves timely access and linkages for underserved populations: The membership procedure aims to quickly process new applications with a turnaround time of less than a week. The process includes a tour, membership application, eligibility verification, and orientation, ensuring that those seeking resources can become members quickly.

Reduces stigma and discrimination: California Clubhouse offers a refreshing change of perspective; members are welcome because of their diagnosis. With 55% of members being Black, Indigenous, or People of Color, all experiencing mental health struggles, the Clubhouse promotes a culture of equity, empathy, and belonging. To increase accessibility, the Clubhouse has translated marketing materials into various languages and is expanding its health fair presentations to reach underrepresented communities.

Increases number of individuals receiving public health services: The Clubhouse maintains close relationships with county services and uses experienced members and staff to assist in accessing services. Members interested in public health services are provided information and help in accessing them, including services such as CalFresh, Vocational Resource Services, and Housing.

Reduces disparities in access to care: California Clubhouse addresses this through several approaches. It creates a welcoming space that encourages social connection, reducing isolation and loneliness. The Clubhouse takes a holistic approach, addressing social determinants of mental health including economic stability, education, built environment, and food security. Peer support plays a crucial role in destigmatizing mental health through shared experiences. Accessibility is ensured by making membership free, voluntary, and for a lifetime. The Clubhouse empowers members through a nonhierarchical consensus-based approach, offering many ways for members to engage, refine skills, and practice agency.

Implements recovery principles: The Clubhouse model is based on 37 thoughtfully written principles called “standards.” The overall theme is based on the value of staying engaged in meaningful work as a powerful strategy to maximize well-being. California Clubhouse involves members in operational decisions, including staff hiring and program planning. It conducts surveys to gather member

preferences for changes and improvements, ensuring that the community's needs are met effectively.

SUCCESSES

Success Story #1: Amy—member since 2018
California Clubhouse's transitional employment program had great success this past year. The member who was placed hadn't worked since 2007 because of her mental health condition. After joining California Clubhouse and building her skills and confidence, she was placed last November in our transitional employment worksite. She excelled and ended up getting her own affordable income studio apartment and an emotional support dog and became her own payee. In addition, she was offered permanent employment! She is thriving.

Success Story #2: Albert—member since 2024
"The California Clubhouse has been great for me! It has provided structure to my days and allowed me to keep my work skills sharp while allowing me to engage and interact with others in a supportive and low stress but productive work environment." Albert recently went back to work and is loving his new job! He shared his job search journey with the members of the business unit at California Clubhouse. Recently, he was hired as the director of information technology at Mission Valley Regional Occupational Program.

CHALLENGES

The biggest challenge that California Clubhouse faced this past year was the transition of the founding executive director and the search for a new executive director. This was quite a lot of transition for the Clubhouse community. The board of directors was intimately involved, and some of it was just the nature of the growth necessary with change. For the future, California Clubhouse is documenting more processes so that vital information is not lost.

DEMOGRAPHICS

California Clubhouse Program Client Demographics (N=125)

	Number of clients	Total number of clients	Percentage of total
Age			
0–15 years	0	125	0
16–25 years	6	125	5
26–59 years	93	125	74
60 years and older	25	125	20
Unknown/not reported	1	125	1
Primary language			
English	94	125	75
Spanish	2	125	2

	Number of clients	Total number of clients	Percentage of total
Tongan	0	125	0
Farsi	0	125	0
Another	2	147	2
Unknown/not reported	27	125	21
Ethnicity			
Hispanic or Latino	2	125	2
Native Hawaiian or Pacific Islander	5	125	4
Native American, Alaska Native, or Indigenous	1	125	1
Black or African American	8	125	6
Asian	6	125	5
Arab or Middle Eastern	2	125	2
Caucasian	54	125	43
Filipino	3	125	2
Another	33	125	26
Unknown/not reported	11	125	9
Sex assigned at birth			
Male	58	125	46
Female	42	125	34
Unknown/not reported	25	125	20
Intersex	Number of clients	Total number of clients	Percentage of total
Yes	1	125	1
No	94	125	75
Unknown/not reported	30	125	24
Gender identity			
Male/man/cisgender	56	125	44
Female/woman/cisgender woman	38	125	30
Transgender male	1	125	1
Transgender female	0	125	0
Questioning/unsure	1	125	1
Genderqueer/non-conforming	2	125	2
Unknown/not reported	27	125	22
Sexual orientation			
Gay, lesbian, or homosexual	1	125	1
Straight or heterosexual	72	125	58
Bisexual	6	125	5
Questioning/unsure	2	125	1

	Number of clients	Total number of clients	Percentage of total
Another sexual orientation	6	125	5
Unknown/not reported	38	125	30
Veteran			
Yes	6	125	4
No	108	125	87
Unknown/not reported	11	125	9
Disability/learning difficulty			
Difficulty seeing	4	125	3
Difficulty hearing or having speech understood	2	125	2
Dementia	0	125	0
Developmental disability	2	125	2
Physical/mobility disability	3	125	2
Chronic health condition	4	125	3
Learning disability	10	125	8
No disability	29	125	23
More than one disability	16	125	13
Unknown/not reported	45	125	36

PRIMARY CARE INTEGRATION

Primary care integration strategies identify persons in need of behavioral health services in the primary care setting, connecting people to needed services. Strategies include systemwide co-location of BHRS practitioners in primary care environments to facilitate referrals, perform assessments, and refer to appropriate behavioral health services.

PRIMARY CARE INTERFACE

The Primary Care Interface (PCI) program is funded 20% CSS and 80% PEI. PCI integrates mental health services within primary care. The program started in 1995 and partners with San Mateo County primary care clinics to provide easier access to mental health services at one clinic, and it is now embedded in five different primary care clinics throughout the county. Since its inception, the program staff grew from one therapist and nurse to a multidisciplinary team with more than 23 staff who are marriage and family therapists, licensed clinical social workers, and case managers.

In FY 2023–24, the PCI program served 685 unduplicated individuals in San Mateo County. Clients are mostly referred out, on the basis of their needs, into psychiatry, therapy, case management, or all three in some cases. The PCI program also provides direct substance use counseling. Program outcomes are included in the PEI section of this MHSA Annual Update document.

INFRASTRUCTURE STRATEGIES

Infrastructure strategies fund BHRS administration, information technology, support staff, evaluation consultants, and the Contractors' Association.

CONTRACTORS' ASSOCIATION

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

- Improve capacity to provide integrated models for addressing trauma and co-occurring mental health and substance use disorders
- Improve its capacity to incorporate evidence-based practices into day-to-day resources
- Improve its cultural competency
- Improve its capabilities to collaborate, partner, and share resources and information with other association members

Caminar acts as the fiscal agent, oversight, and accountability to this program. See Appendix 5 for the data on each funding recipient and what needs were met.

OUTREACH AND ENGAGEMENT

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

FAMILY ASSERTIVE SUPPORT TEAM

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

Examples of FAST activities and interventions include crisis intervention; facilitating 5150; collaborating with law enforcement in service of clients and family; forensic mental health linkage; diagnosis; psychiatric and medication consult; motivational interviewing; destigmatizing mental health; obtaining benefits such as disability, housing, financial, legal, food, and clothes; connecting to behavioral health and AOD services; primary care; peer support; shelter; social rehabilitation; and permanent housing. FAST uses collaboration and warm handoffs to facilitate best outcomes.

FAST comprises a licensed mental health clinician, psychiatrist for consultation, and two paraprofessionals. FAST works mostly in dyads with mental health consumers and their families. One person is assigned to the family (family partner) and the other assigned to the consumer (peer provider). These units provide assessment, intervention, goal establishment, and plan implementation. FAST has interpreter services in Spanish, Mandarin, and Tagalog.

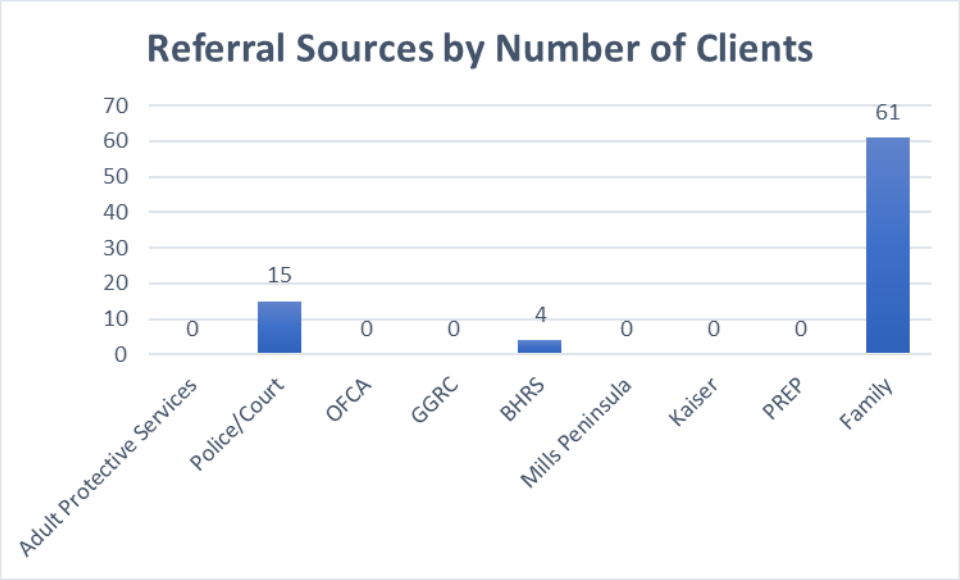
PROGRAM IMPACT

Pre-Crisis (Family Assertive Support Team)	FY 2023–24
Total clients served	80
Total cost per client	$4,717

FAST collects the following data: age, gender, diagnosis, Level of Care Utilization System (LOCUS) score, county region, ethnicity, referral source, type of contact, referral outcome, prior connection to mental health services, and pre- and posthospitalization/jail contact. There were 80 clients served by FAST in FY 2022–23, and 100% received a diagnosis. Of these, there were zero homicides and zero suicides. The rate of hospitalization and incarceration was higher before contact with FAST and reduced after contact with FAST. Of the 80 clients, 69 of them had zero contact or current connection with outpatient mental health services prior to FAST contact. The remaining 11 had some history of mental health services ranging from months/years/decades prior to contact with FAST but had dropped out of treatment; 47 were successfully connected with outpatient mental health services. The majority of those not connected were connected to some level of social services, benefits, housing, medical services, and so on.

The collected Level of Care Utilization System scores indicate that the majority of clients were experiencing SMI symptoms with significant disability and were in need of intensive behavioral health treatment and adjunct services after FAST. The ethnicity of clients served closely reflected the demographic distribution of San Mateo County residents. The negative outcomes and concomitant suffering for individuals and families alike were diminished from contact and services with FAST.

Referral Sources by Number of Clients



SUCCESSES

Client Success Story: "Stella"

Stella, a 68-year-old Mexican American female, moved from Nebraska to California and into her brother's house with his family. Her living situation in Nebraska had become precarious and her mental health had deteriorated. Her brother invited her to live with him until she could find housing and psychiatric help and get stabilized.

After she became a resident of San Mateo County, she was referred to FAST by her family, as they had successfully received help from FAST for their adult son in years past. Stella was open and amenable to help with obtaining medical insurance benefits and finding a psychiatrist for treatment and medication. Stella had a rare mental health condition, dissociative identity disorder, and specifically requested a specialist in her condition.

The FAST team assisted her in obtaining benefits, researching and locating a nationally renowned psychiatrist with a focus in treating dissociative identity disorder, and getting her into treatment. Stella is currently doing much better and is now stable with family relations strengthened, housing situation secured, and proper psychiatric treatment in place.

CHALLENGES

One significant challenge in the work of FAST is the symptom of anosognosia—"the inability or refusal to recognize a defect or disorder that is clinically evident." Whereas FAST regularly encounters this challenge in its work and has developed strategies to address it, an even more critical impediment to successful outcomes is the premature discharge of clients from inpatient hospitalization (5150) while they are still seriously impaired.

Of particular concern is when these discharges occur without a coherent and comprehensive discharge plan. This practice not only compromises client safety but also undermines the potential for successful community reintegration. Such premature discharges can place vulnerable clients at risk, as they may still be experiencing acute symptoms and lack adequate support systems or follow-up care.

Comprehensive policies and protocols are urgently needed to ensure appropriate lengths of stay, thorough discharge planning, and coordinated follow-up care for all clients.

DEMOGRAPHICS

FAST Program Client Demographics (N=80)

	Number of clients	Total number of clients	Percentage of total
Age			
0–15 years	0	80	0
18–45 years	53	80	66
46 years and older	27	80	34
Region			

	Number of clients	Total number of clients	Percentage of total
Central	28	80	35
South	14	80	18
Coastside	5	80	6
Northeast	20	80	25
North	8	80	10
East Palo Alto	5	80	6
Ethnicity			
Hispanic or Latino	34	80	42
Pacific Islander	1	80	1
Native American	0	80	0
African American	0	80	0
Asian	10	80	13
Arab or Middle Eastern	4	80	5
Caucasian	26	80	33
Filipino	5	80	6
Unknown/not reported	0	80	0
Sex assigned at birth			
Male	29	80	36
Female	51	80	64
Unknown/not reported	0	80	0

THE CARIÑO PROJECT

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

In FY 2023–24, the Cariño Project served 572 unduplicated clients in San Mateo County through their clinical component (therapy and case management), and 2,028 individuals (duplicated) were also engaged through various services including groups, training, arts activities, and other supports.

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

ADULT RESOURCE MANAGEMENT

The ARM program provides trauma-informed and culturally responsive mental health support to adults living with SMI and/or SUD who are unhoused or at risk of becoming unhoused.[42] The program provides early identification, engagement, and case management services to eligible adults.

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

- ICM/outreach and support: All four MHCs are assigned to this subunit. Referrals focus on clients who are being discharged from psychiatric hospitals and Mental Health Rehabilitation Centers and are in temporary need of ICM support until other community resources, such as an FSP or a BHRS regional clinic case manager, can take over. The ARM team also receives referrals from BHRS regional clinics that need field support for clients who are at high risk for rehospitalization.
- Navigation Center and Safe Harbor liaison: Two of the four MHCs are assigned to either the Navigation Center or the Safe Harbor Shelter. If no other outpatient team is physically present at the shelter, the MHCs provide intensive field case management. Otherwise, MHCs function as the liaison between the shelter and other county mental health programs, coordinating with FSP staff or a regional clinic's embedded FSP counselor.
- PES/AOD coordination: Two of the four MHCs work with clients in need of detox and AOD treatment follow-up and linkage. They receive their referrals directly from community members or San Mateo Medical Center PES staff during the morning briefing meetings.
- Transportation coordination: All MHC and PES staff operate a patient transportation shuttle on a rotating schedule. They provide transport for clients living with SMI to medical, behavioral health, and court appointments in the community in addition to transporting clients to and from facilities located in other counties.

[42] At risk of becoming homeless criteria and definition can be found at https://files.hudexchange.info/resources/documents/AtRiskofHomelessnessDefinition_Criteria.pdf.

PROGRAM IMPACT

Adult Resource Management	FY 2023–24
Total clients served	59
Total cost per client	$38,830

Improves timely access and linkages for underserved populations: During FY 2023–24, the ARM program has continued to review referrals within 1 day and connect each client to program services within 3 days of receiving the referral. Staff also continued to give presentations to educate employees of other programs about ARM services. In addition, the program has continued to review their outreach and intervention strategies during staff meetings and one-on-one meetings with clients. The program hosted a half-day training on strategic planning, which involved identifying areas of focus for improving program services and expanding staff use of harm reduction strategies in interactions with clients.

Reduces stigma and discrimination: The ARM program reduces discrimination faced by clients. For example, the program employs a mental health counselor who works with clients to address discrimination against clients living with SMI. The counselor helps secure and maintain safe housing for clients living with SMI. If needed, they also help them obtain legal support and complete housing applications. During the past year, ARM staff continued to attend at least one cultural humility training run by the county, and the ARM supervisor continued to incorporate cultural humility and trauma-informed frameworks during both one-on-one and staffwide meetings. In addition, ARM staff still use a recently updated referral form that is more inclusive and reflective of a broader range of gender identities and pronoun preferences.

Increases the number of individuals receiving public health services: Although behavioral health treatment referrals for individuals at the county's Navigation Center[3] and Safe Harbor[4] are reviewed by a different team, ARM staff are present and provide clients at these shelters with various types of support, such as linking them to other welfare-enhancing services. For example, the ARM team continues to connect clients to different public health and human services programs and resources, including CalFresh, Supplemental Security Income program benefits, housing assistance and support programs, primary health programs, and other general assistance. In addition, ARM staff refer some clients to Vocational Rehabilitation Services, which helps county residents living with disabilities, including SMI, develop occupational skillsets and gain employment.

Reduces disparities in access to care: The ARM team continued to work with the OCFA in FY 2023–24 to obtain cell phones for clients so they can access services, keep appointments, and stay connected with providers. To mitigate the harm experienced by clients who are precontemplative about treatment for their SUD, the ARM team carries Narcan and fentanyl testing strips. Approximately 50% of ARM staff are bilingual or bicultural, so they are able to provide services in multiple languages for clients who are monolingual.

Implements recovery principles: The ARM team integrates recovery principles into the services that ARM staff provide in the community:

- During FY 2023–24, the program discussed how to better serve populations impacted by fentanyl and methamphetamine use. In service of this goal, staff leverage harm reduction

approaches and motivational interviewing frameworks to engage clients in various stages of recovery, including those who are still precontemplative about treatment.

- In FY 2022–23, the ARM team worked with the Palm Avenue Detox center to support linking clients in need of SUD detox services. However, the center was recently closed. To work around this closure in FY 2023–24, the team's SUD counselor connected clients to other external resources, such as peer-run mental health services organizations in San Mateo County, including California Clubhouse[5] and Heart and Soul,[6] which provide long-term support services to individuals experiencing mental health challenges.

This section provides a comparison of health care use data from periods that extended to 3 months before and after the clients were admitted to the ARM program. It also displays a breakdown of the ARM services by subunit and further details within each subunit.

The following table summarizes the health care use information of the 59 clients who were admitted and actively part of the ARM program during FY 2023–24. Among these clients, during the 3 months before program admission, there were 20 PES episodes, 20 inpatient/residential episodes, and 413 total days of inpatient residential stay. During the 3 months following admission, no ARM clients had a PES episode, inpatient/residential episodes, or residential stays.

ARM Clients' Health Care Use (FY 2023–24)

	3 months before ARM admission	3 months after ARM admission
Number of PES episodes	20 [a]	0
Number of inpatient/residential episodes	20	0
Total inpatient/residential stay (in days)	413	0

Note. ARM = Adult Resource Management program; FY = fiscal year; PES = psychiatric emergency services.
[a] 20 episodes among 34 clients.

The following table summarizes the services provided by the ARM program by subunit tasks during FY 2023–24. As noted in Section 2 (Program Description), MHCs within the ARM team are assigned one or more specific subunit tasks, and clients may be enrolled in more than one subunit task. The total number of clients (*N* = 87) by subunit task therefore exceeds the total number of clients served by the ARM program in general (*N* = 59), as some received both ICM and shelter services. During FY 2023–24, 66.7% (*N* = 58) received ICM/outreach and support services; 24.1% (*n* = 21) used Maple Street Shelter, Safe Harbor Shelter, and Navigation Center of San Mateo County, and 9.2% (*n* = 8) received transportation coordination services.

Services by Subunit (FY 2023–24)

Subunit	Number of clients	Percentage of clients
Intensive case management/outreach and support	58	66.7
Maple Street Shelter, Safe Harbor, and Navigation Center Shelter liaison	21	24.1
Transportation coordination	8	9.2

Total	**87**	**100.0**

Note. FY = fiscal year.

The following table displays the breakdown of clients served by the mental health shelters subunit. Of the 21 clients served through this subunit, most attended Safe Harbor Shelter (47.6%) or Navigation Center Shelter (47.6%) during FY 2023–24.

Mental Health Shelters (FY 2023–24)

Mental health shelter	Number of clients	Percentage of clients
Safe Harbor Shelter	10	47.6
Navigation Center Shelter	10	47.6
Maple Street Shelter	1	4.8
Total	**21**	**100.0**

Note. FY = fiscal year.

The following table summarizes the transportation destinations for the eight clients who used the transportation coordination services provided by the ARM program once each during FY 2023–24; 62.5% of transports were with dental appointment in San Mateo, and 12.5% of the transports were for each of the remaining destinations (Care Plus Board and Care, South San Francisco, San Mateo Medical Center, and Stanford Wound Clinic, Redwood City).

Transportation Coordination Services (FY 2023–24)

Transportation destination	Number of transports	Percentage of transports
Dental appointment in San Mateo	5	62.5
Care Plus board and care, South San Francisco	1	12.5
San Mateo Medical Center	1	12.5
Stanford Wound Clinic, Redwood City	1	12.5
Total	**8**	**100.0**

Note. FY = fiscal year.

The following table summarizes the status of ICM clients for the ARM program during FY 2023–24. Of the 58 clients served through this subunit, most completed their goals (39.7%) or were an active client (24.1%).

Intensive Case Management: Client Status (FY 2023–24)

Status of intensive case management clients	Number of clients	Percentage of clients
Completed goals	23	39.7
Active	14	24.1
Did not engage	11	19.0

Was not admitted to program/admitted to other program	9	15.5
Died	1	1.7

SUCCESSES

During FY 2023–24, the ARM program's use of motivational interviewing frameworks and harm reduction approaches continued to be successful interventions. These services were particularly successful for clients who were unhoused, had a significant history of trauma, or had co-occurring mental health and substance use disorder.

The following stories highlight clients' personal growth and successes after enrolling in the ARM program.

Client Success Story #1: A 54-year-old male client diagnosed with schizoaffective disorder and amphetamine use disorder was referred to ICM services after receiving an eviction notice from a supportive housing service. This client had poor psychiatric medication compliance, and during periods in which he was not taking medications prescribed to treat his mental health conditions or had consumed other substances not prescribed by his care team, his behavior was often erratic. He would become verbally aggressive toward his neighbors, screaming offensive comments and threats, which eventually prompted one neighbor to file a restraining order. After reviewing the referral details, an ARM case manager worked diligently to build a trusting relationship with this client and his mother, providing legal resources, psychoeducation, and linkages to substance use treatment providers, among other services. With support from this case manager, the client worked with his treatment team to try out a medication adjustment that led to an amelioration of his symptoms. Because of demonstrated behavioral improvements, the client's eviction notice was rescinded, and he has now remained abstinent from methamphetamine use for several months. At the encouragement of his case manager, the client has recently participated in the California Clubhouse. He enjoys assisting others when he is there and would also like to pursue higher education in the future, as he has a passion for art and is engaging in artistic hobbies.

Client Success Story #2: The ARM team received an ICM services referral for a female client with three young children. Although this client had a history of severe trauma—including emotional, physical, and sexual abuse experienced as early as 10 years old—she had not previously received support for her condition, which clinicians diagnosed as symptoms of posttraumatic stress disorder. After engaging with the ARM program, the client received emotional support and counseling, assistance with applying for financial aid and food support benefits, and transportation support for travel to and from her primary care provider and behavioral health appointments. With support provided by her ARM case manager, the client has since secured financial and food benefits through a Human Services Agency. Furthermore, when the client and her children were on the verge of homelessness, her case manager helped her seek hoteling support through a Human Services Agency emergency shelter program. The ARM case manager also helped this client connect with her local CORE Services Agency and complete a Coordinated Entry System assessment for admittance into the San Mateo County family shelter system waitlist.

CHALLENGES

Intermittent staff vacancies continued to present challenges in FY 2023–24. Two mental health counselors took a leave of absence, which meant that two other mental health counselors had to cover their caseloads for several months. At times, these counselors felt burned out by the volume of their responsibilities, and the administrative burden of their increased caseloads occasionally impacted the number of clients they had time to see during the work week. However, the program is now fully staffed.

In addition, there was a relatively low number of PES referrals to the program in FY 2023–24 relative to prior years. In an effort to boost referrals, staff are continuing to give presentations to other programs to increase awareness of ARM services.

DEMOGRAPHICS

The following table summarizes the demographic information for the 59 clients who were admitted and actively a part of the ARM program during FY 2023–24. Most clients (66.1%) were between the ages of 26 and 59 years, and 33.9% were 60 years or older. A majority were female (52.5%). Whereas most spoke English as their primary language (93.2%), 5.1% reported Spanish and 1.7% reported Uzbek as their primary languages. Most clients identified as White or Caucasian (39.0%), with Black or African American (15.3%), other (13.7%), and multiple races (13.7%) being the next most commonly identified races. For those who reported an ethnicity, most identified as Hispanic or Latino (18.6%) or African American (6.8%). Most clients reported being straight or heterosexual (28.8%). It is important to note, however, that 66.1% did not report information on their sexual orientation, 61.0% did not report information on ethnicity, and 10.2% did not report information on their race (FY 2023–24).

Adult Resource Management Program Client Demographics (N = 59)

	Number of clients	Percentage of total
Age		
0–15 years	0	0.0
16–25 years	0	0.0
26–59 years	39	66.1
60 years and older	20	33.9
Primary language		
English	55	93.2
Spanish	3	5.1
Uzbek	1	1.7
Race		
White or Caucasian	23	39.0

	Number of clients	Percentage of total
Black or African American	9	15.3
Other	8	13.6
Multiple	8	13.6
Asian	6	6.8
Pacific Islander	4	1.7
Unknown/not reported	1	10.2
Ethnicity		
Hispanic or Latino	11	18.6
African American	4	6.8
Chinese	2	3.4
Multiple	2	1.7
Vietnamese	1	1.7
Native American	1	1.7
Uzbek	1	1.7
Tongan	1	1.7
Unknown/not reported	36	61.0
Gender assigned at birth		
Female	31	52.5
Male	28	47.5
Sexual orientation		
Straight or heterosexual	17	28.8
Lesbian or gay	2	3.4
Bisexual	1	1.7
Unknown/not reported	39	66.1

Note. ARM = Adult Resource Management program; FY = fiscal year.

HOUSING LOCATOR, OUTREACH, AND MAINTENANCE

The Housing Locator, Outreach, and Maintenance program will provide housing locator services provided by mental health counselors and peer navigators; the development and maintenance of a new BHRS Housing website with real-time housing availability information; linkages to BHRS case managers; and landlord engagement including community mental health awareness. Outreach and field-based services will be provided to support ongoing and long-term housing retention, including a team of occupational therapists and peer counselors with co-occurring mental health and substance use capacity to support independent living skills development.

This program was anticipated to launch this FY 2022–23. However, implementation was delayed because of the administrative Request for Proposal processes that BHRS had to prioritize for various programs and is currently on hold pending analysis of impacts to MHSA funding from Proposition 1, BHSA.

HEAL PROGRAM HOMELESS OUTREACH

The purpose of the HEAL program is to provide field-based behavioral and mental health services to unhoused clients who are not yet receptive to entering a mental health clinic. The target population of the HEAL program is individuals living with mental illness who are unhoused or living in encampments on the street. The program provides outreach, engagement, assessment, short-term therapeutic intervention, and linkage to longer term treatment for clients with mental health challenges and SUD. The HEAL program supports clients experiencing a broad spectrum of mental health challenges, including those with mild to moderate conditions and those living with SMI. Program clinicians also make seamless referrals to the HEAL psychiatrist, who provides medication evaluation and field-based medical support services to clients who may benefit from psychotropic medications.[43] HEAL clinicians also offer therapy groups and workshops for clients at various shelters.[44]

The program team currently consists of the program manager and four clinicians. Each clinician supports clients within a specific region of San Mateo County. Although the program is not directly involved in making shelter or housing placements, HEAL clinicians closely collaborate with existing regional Homeless Outreach Teams (HOTs) that provide outreach and case management services with the goal of linking individuals to safer shelter and housing options.

HEAL staff regularly coordinate with partner organizations to improve program and client outcomes. In addition to HOTs, these partners include the Center on Homelessness, Human Services Agency, Health Care for the Homeless, and street medicine teams.[45]

PROGRAM IMPACT

Homeless Engagement Assessment and Linkage	FY 2023–24
Total clients served	108
Total cost per client	$775

Improves timely access and linkages for underserved populations: The program ensures timely access and linkage to care by following established procedures. These procedures ensure that program staff contact individuals within 2 business days of the referral to schedule an initial appointment. The HEAL team is currently the only BHRS program that exclusively accepts referrals for individuals who are unsheltered or unhoused. Referrals are usually submitted by other organizations that support unhoused populations in San Mateo County. Individuals experiencing homelessness often self-refer after encountering HEAL clinicians in the field

[43] Psychotropic medications affect behavior, mood, thoughts, or perception. For more information, see https://www.healthline.com/health/what-is-a-psychotropic-drug.
[44] See https://www.smchealth.org/sites/main/files/file-attachments/hchfh_funded_program_description_handout_final_for_website.pdf?1695765290.
[45] Funded through the Public Health Sector of San Mateo Medical Center, street medicine teams mostly provide mobile outreach and primary care services to individuals experiencing homelessness. However, they also have an on-staff psychiatric NP to deliver psychiatric care. The HEAL team relies on the street medicine team to administer long-acting injectable medications to clients; presently, there are no HEAL staff members who can administer medications in the field.

and learning about the program's services. Although the ACCESS Call Center also accepts self-referrals, this avenue is less commonly used because unhoused individuals are unlikely to have access to a phone.[46]

Reduces stigma and discrimination: The HEAL program's target population is at increased risk of stigma and discrimination. In addition to being unsheltered and experiencing inequity due to social determinants of health, they also have complex behavioral and mental health needs that require a careful, nuanced approach to treatment of SMI and SUD. Individuals in this population are likely to have a long history of trauma, which is exacerbated by their lack of safe and stable housing. The program reduces stigma and discrimination for this population by engaging clients and bridging their access to county-run and external treatment services and resources.

To enhance the program's ability to fulfill this MHSA objective, program staff at all levels consistently work to expand their connections to services for unhoused individuals and agencies in the county. The program manager networks with leadership from these external organizations, whereas HEAL clinicians regularly connect with their service providers. In addition, the HEAL program manager has co-delivered presentations with Center on Homelessness staff, Human Services Agency staff, and representatives from other service partner organizations in meetings with various city managers throughout the county. These presentations have helped to further reduce stigma and discrimination against individuals who are unhoused or unsheltered.

Increases the number of individuals receiving public health services: Since the program was established in August 2022, staff have been unrelenting in their efforts to rapidly expand the program's capacity. For example, since the previous FY, they have prioritized continuous recruitment efforts to fill several new positions. In FY 2023–24, the program successfully onboarded two new full-time HEAL clinicians. With the addition of these new staff members, the program has been able to accept more referrals and ultimately support a greater number of individuals in different regions of San Mateo County. The program plans to continue their efforts to hire three additional full-time clinicians in the next FY.

To increase the number of referrals received, the HEAL team has strengthened its partnership with HOTs. The HOTs locate individuals who are unsheltered and unhoused in San Mateo County and refer any with symptoms of mental health or behavioral health challenges to the HEAL team.

In addition, the HEAL program's continuous efforts to network with officials from city governments and other services agencies across the county further enhance the program's ability to reach potential job applicants, promote HEAL services, and secure additional resources for clients.

Reduces disparities in access to care: Individuals who are unsheltered or unhoused face disproportionately greater barriers to accessing health care services. The program directly addresses disparities in access to care by conducting outreach to their target population and engaging clients in services. Addressing clients' mental and behavioral health challenges enhances the HOTs' abilities to

[46] See https://www.smchealth.org/general-information/behavioral-health-services-resources.

successfully obtain and maintain safer housing placements for these individuals. In addition, one of the recently onboarded HEAL clinicians is conversant in Spanish, which has increased the program's linguistic capacity. As a result, the program has been able to support referrals for Spanish-speaking unhoused individuals. Last, the HEAL program managers' networking with city managers has helped to reduce disparities in access to care by increasing awareness of the services that are available to unhoused individuals with complex behavioral health needs.

Implements recovery principles: The HEAL program fulfills MHSA objectives through its commitment to implementing recovery principles, described below:

- **Providing trauma-informed care:** Program staff are aware that many of the clients who enter the program have a long history of trauma and have been experiencing substance use issues for an extended period of time. Clinicians' holistic care approach helps clients address SUD in combination with other mental and behavioral health needs, gradually enabling them to achieve stability. Clinicians determine the frequency of client meetings on the basis of the specific needs, readiness, and care plan goals of each client to gradually reduce substance use. The program considers a client to have achieved stability when their mental health and SUD are sufficiently managed, allowing the client to meet basic daily needs such as food, water, shelter, clothing, and rest.
- **Empowering individuals to define their path to recovery:** At times, clients are resistant to placement in a shelter because of symptoms of paranoia or previously negative experiences in shelters. HEAL clinicians are understanding of clients' hesitations and will continue providing field-based services in the street or in encampments until clients are ready to be connected with more stable housing solutions.
- **Securing housing placements:** Although the HEAL program is not directly involved in placing individuals in housing, clinicians often connect clients to a vocational specialist. This staff member provides vocational training, assistance with housing applications, and administrative and emotional support during clients' interviews with housing facilities. HEAL staff also assist clients in obtaining shelter by facilitating the coordinated entry process to the homeless crisis response system.[47]
- **Promoting care coordination:** The HEAL program closely collaborates with partner organizations, such as the street medicine team, HOTs, and Health Care for the Homeless to deliver care to clients. HEAL coordinates with the street medicine teams to provide mobile outreach and primary care services. HEAL clinicians also connect clients to the HEAL psychiatrist for psychiatric medication support services whenever needed. During FY 2023–24, HEAL clinicians developed stronger connections with HOT staff to coordinate warm handoffs of clients between the two programs.

[47] For more information, see https://www.smcgov.org/ceo/homeless-crisis-response-system-overview.

This section provides a comparison of health care use data from periods that extend to 3 months before and after the clients were admitted to the HEAL program. It also presents a breakdown of HEAL clients by engagement and treatment.

The following table summarizes the health care use information for the 108 clients who were admitted and actively a part of the HEAL program during FY 2023–24. During the 3 months before program admission, among HEAL clients, there were 74 PES episodes and one inpatient/residential episode with 2 days of stay. During the 3 months following program admission, none of the HEAL clients had a record of using these health care services.

Number of unduplicated clients served: 108

Total number of clients: 108

Homeless Engagement Assessment and Linkage Clients' Health Care Use (FY 2023–24)

	3 months before admission	3 months after admission
Number of psychiatric emergency services episodes	74	0
Number of inpatient/residential episodes	1	0
Total inpatient residential stays (in days)	2	0

The following table summarizes the engagement of HEAL clients during FY 2023–24. Note that for clients with more than 60 days of engagement, program staff will engage clients in a treatment plan. Of the 108 clients, the average number of days enrolled was 168. Of the 108 clients, 63.9% (*n* = 69) were engaged for more than 60 days; of these, 98.6% had a treatment plan.

Homeless Engagement Assessment and Linkage Clients' Engagement and Treatment Plan (FY 2023–24)

	Total
Average days of engagement [a]	168
Number of clients engaged more than 60 days [a]	69
Percentage of clients engaged more than 60 days	63.9
Number of clients engaged more than 60 days with treatment plan	68
Percentage of clients with treatment plan if engaged for more than 60 days	98.6

[a] Days of engagement were calculated by subtracting discharge date from admission date.

SUCCESSES

FY 2023–24 marked the HEAL program's second year of operation, throughout which they celebrated substantial growth. Efforts to enhance the program's capacity are evident from the expansion of the clinician team, community outreach to generate referrals to the program, and strengthened relationships with partner organizations. The HEAL program excelled at care coordination to create better outcomes for clients, as evident from the team's increased collaboration with HOT case managers. The warm handoff that occurs between HOT and HEAL staff enhances client engagement and receptivity to the holistic mental, psychosocial, and substance use clinical services that HEAL

provides, and many clients have expressed their appreciation to program staff. The program's nonjudgmental, community-based approach to care has helped clients build trust in services offered to them, which in turn enhances their ability to secure stable housing through the HOTs. HOT staff have also generated a greater number of referrals for prospective clients to the HEAL program.

In addition, the program has successfully communicated with city officials and other agencies to understand their concerns about the region's unhoused population. With this increased communication, HEAL has increased the program's visibility, which will hopefully continue to generate additional resources for the program in the future. These successes align the program with the CEO's vision of achieving Functional Zero[48] for the unhoused population, thereby providing interim or permanent housing to every person who is unsheltered and unhoused in San Mateo County.[49]

The following client success story highlights the benefits derived from the HEAL program's enhanced relationships with partner organizations.

Client Success Story: One client was experiencing symptoms of schizophrenia including psychosis, paranoia, and auditory hallucinations that created barriers for maintaining placement in a homeless shelter. They had been dismissed from multiple shelters because of behavioral challenges and had also experienced auditory hallucinations encouraging them to leave multiple shelters. A HOT case manager referred the client to a HEAL clinician, as the client was not yet connected to any mental health services, nor were they taking medication to manage their symptoms. It took both staff members more than 1 month of multiple contact attempts to finally conduct a warm handoff for the client. Unfortunately, the client did not yet completely trust the staff members and indicated that they were not willing to receive program services at that point in time. The HEAL clinician continued to attempt follow-up conversations with the client, which required engagement with the HOT case manager for help locating the client. After 2 more months, the client agreed to an appointment with the HEAL psychiatrist. The HEAL team coordinated with the street medicine team to engage the client during the appointment, prescribe and order a long-acting injectable medication, and encourage the client to agree to receive the medication at a future appointment. The medication has a short shelf life and requires a strict dosing schedule to be effective, making it difficult to administer to transient individuals when significant and repeated effort is required to locate the client. However, through close coordination between the HEAL and street medicine teams, the client has successfully been receiving scheduled doses of the medication for about 5 months now. Although the client is still not receptive to entering a shelter, the injections are helping to manage symptoms, and the client is making clinically significant progress, which the program considers a huge success.

CHALLENGES

There are two main challenges that the HEAL program encountered during FY 2023–24:

[48] For more information about Functional Zero for homelessness, see https://community.solutions/built-for-zero/functional-zero/.
[49] See https://www.smcgov.org/ceo/homelessness-dashboard.

- **Clients' resistance to entering housing:** Some clients were reluctant to enter a shelter, preferring to remain on the street in an encampment. Program staff often attribute this resistance to clients' psychosis, paranoia, trauma, or previous negative experiences in shelters. Although the HEAL team does not directly place clients in housing, distrust of shelter services can delay clients' recovery process because their fundamental needs remain unmet. To mitigate this issue, staff continue to engage clients and provide mental and behavioral health support with the goal of eventually reframing the clients' negative perspectives of homeless shelters.
- **Limited availability of housing resources:** The supply of permanent housing resources in San Mateo County remains limited. As discussed above, the HEAL team does not directly place clients in housing. However, inability to secure stable housing puts clients at risk of experiencing delays in their recovery process as their fundamental needs remain unmet.

The following story highlights one client's challenging experience with homeless shelters, providing insight into why a client may choose to remain in an encampment rather than accept an available shelter bed.

Client Challenge Story: A client who identified as LGBTQ+ was placed in a shelter. Currently, there are family shelters available, or individual shelters that are categorized as co-ed, male, or female shelters. However, men and women are still separated in different sections of the co-ed shelters. The client had been placed in a section of the co-ed shelter that aligned with the sex listed on their birth certificate but where they did not feel safe or comfortable because placement in this group did not align with their gender identity. This client added that they chose not to divulge their gender identity because of concern that it might prevent them from being permitted to enter the shelter. They also shared that they had negative shelter experiences in the past, including harassment from other residents. The HEAL program has not encountered many LGBTQ+ clients to date, so staff have not yet developed adequate resources for meeting these individuals' needs.

DEMOGRAPHICS

The following table summarizes the demographic information of the 108 clients who were admitted and actively a part of the HEAL program during FY 2023–24. Most clients were between the ages of 26 and 59 years (73.1%). The majority spoke English as their primary language (81.5%). Most identified as White/Caucasian (28.7%) or a race not listed (12.0%). Most did not identify as Hispanic or Latino (48.1%). A majority of clients were male (59.3%). Most clients identified as straight or heterosexual (58.3%). It is important to note, however, that 33.3% of respondents did not report information on their race, 25.0% did not report information on their ethnicity, and 33.4% did not report on their sexual orientation.

Homeless Engagement Assessment and Linkage Program Client Demographics (N = 108)

	Number of clients	Percentage of total
Age		
0–15 years	0	0.0
16–25 years	8	7.4

	Number of clients	Percentage of total
26–59 years	79	73.1
60 years and older	21	19.5
Primary language		
English	88	81.5
Spanish	8	7.4
Portuguese	2	1.9
Other	1	0.9
Unknown/not reported	9	8.3
Race		
White or Caucasian	31	28.7
Other	13	12.0
Black or African American	11	10.2
Multiple	10	9.3
Native American, American Indian, or Alaska Native	4	2.8
Asian	3	3.7
Unknown/not reported	36	33.3
Ethnicity		
Not Hispanic or Latino	52	48.1
Hispanic or Latino	29	26.9
Unknown/not reported	27	25.0
Gender assigned at birth		
Male	64	59.3
Female	44	40.7
Sexual orientation		
Straight or heterosexual	63	58.3
Lesbian, gay, or homosexual	5	4.6
Bisexual	2	1.9
Declined to state	1	0.9
Another	1	0.9
Unknown/not reported	117	33.4

THE SAN MATEO COUNTY PRIDE CENTER

The Pride Center (35% CSS, 65% PEI) creates a welcoming, safe, inclusive, and affirming space for individuals of all ages, sexual orientations, and gender identities through education, counseling, advocacy, and support. The Pride Center takes a holistic approach to improving the health and well-being of the LGBTQ+ community by providing direct mental health services to individuals living with severe mental health challenges and individuals in the community seeking support groups, resources, community-building activities, and social and educational programming.

In FY 2023–24, the Pride Center served 147 unduplicated individuals in San Mateo County through their clinical component (therapy and case management); 12,140 individuals (duplicated) were also

engaged through various services including peer groups, youth and older adult focused services, training, events, outreach, and other activities.

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

RAVENSWOOD FAMILY HEALTH CENTER

Ravenswood Family Health Center is a community-based federally qualified health center that serves East Palo Alto residents. Ravenswood provides outreach and engagement services and identifies individuals presenting for health care services who 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 PEI.

Ravenswood	FY 2023–24
Total clients served	80
Total cost per client	$226

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

Photo: Felton Institute, Early Psychosis Programs

PREVENTION AND EARLY INTERVENTION

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 seven 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 the following:

- 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 18 months, unless the individual receiving the service is identified as experiencing first onset of SMI or SED with psychotic features, in which case, early intervention services shall not exceed 4 years.
- Prevention programs reduce risk factors for developing SMI and build protective factors for individuals whose risk of developing SMI 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 living with SMI as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by BHRS programs.
- Stigma and discrimination reduction activities reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services.
- Suicide prevention programs are not a required service category. Activities prevent suicide but do not focus on or have intended outcomes for specific individuals at risk of or living with SMI.

PEI EVALUATION

PEI DATA COLLECTION AND REPORTING FRAMEWORK

A PEI Data Collection and Reporting Framework was originally developed in June 2022—through discussions with local MHSA PEI-funded programs—to be in alignment with MHSA requirements and BHRS Office of Diversity and Equity (ODE's) Theory of Change, which engaged clients, families, community partners, BHRS staff, and county departments. The framework focuses on collecting (a) individual demographics data from PEI program participants, (b) referrals provided to BHRS and other health and social services, and (c) individual outcomes that could be analyzed across PEI programs that collect individual-level program data across the following nine PEI outcome domains:

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

Starting in May 2023, non-individual-level programs—those that primarily collect population-level data or duplicated individuals served—were incorporated into the existing framework to allow for a broader assessment of the impact of PEI programs. These programs focus on community awareness campaigns, education, and trainings and include the Parent Project®, HEIs, Mental Health First Aid (MHFA), suicide prevention, and PhotoVoice/storytelling. Standardized questions based on the outcome indicators were identified and embedded into each program's respective evaluation surveys. Newly launched PEI programs such as the Program to Encourage Active, Rewarding Lives (PEARLS) for older adults and allcove® youth drop-in centers are being incorporated in FY 2024–25. See Appendix 6 for updated PEI Data Collection and Reporting Framework.

The most recent version of the PEI framework also refined some of the crosswalks, narrowing and honing them on the basis of clarified written domain definitions for the nine domain areas. Notably, there was a language shift in two of the domain categories: "General mental health" was switched to "general behavioral health" to include both mental health and substance use, and the "cultural identity" category was changed to "cultural responsiveness" to encompass both cultural humility and cultural identity concepts.

PEI ANNUAL AND THREE-YEAR REPORT

MHSA PEI regulations require that counties prepare and submit an Annual PEI report, covered in the following pages, and a Three-Year PEI Evaluation Report. The Three-Year PEI Evaluation Report can be seen in Appendix 7 and covers FY 2021–22 , FY 2022–23, and FY 2023–24.

PEI PROGRAMS – PREVENTION AND EARLY INTERVENTION

The following programs serve children and youth ages 0–25 years exclusively and some combine PEI strategies. MHSA guidelines require 19% of the MHSA budget to fund PEI and 51% of the PEI budget to fund programs for children and youth.

EARLY CHILDHOOD COMMUNITY TEAM

The Early Childhood Community Team (ECCT) aims to provide targeted, appropriate, timely responses to the needs of underserved families with children ages 0–5 years or pregnant mothers in the Half Moon Bay community. ECCT focuses on the parent/child relationship as the primary means for intervention. Team members also focus on child development and strive to individualize services to ensure that each child and family's unique needs are met. Identifying challenges early and providing families with the proper assessments, interventions, and supports can make a difference in a child's earliest years and for many years thereafter. ECCT is made up of three interconnected roles that support the community and families in different ways.

1. The community worker provides case management and parent education to the families, facilitates play and support groups, and develops and maintains community partnerships.

The mental health clinician provides child-parent psychotherapy informed therapeutic support to families and uses other attachment/relationship-based clinical modalities as appropriate. Child-parent psychotherapy is a specific intervention model for children ages 0–5 years who have experienced at least one traumatic event and/or are experiencing challenges related to attachment and/or behavioral problems, including posttraumatic stress disorder. The primary goal of child-parent psychotherapy is to support and strengthen the relationship between a child and his or her caregiver as a vehicle for restoring the child's cognitive, behavioral, and social functioning.

The early childhood mental health consultants provide ongoing support to childcare providers in preschool settings with the goal of establishing a safe and trusting relationship that supports teachers in building their capacity of self-reflection, understanding the child's experience, and fostering an inclusive classroom in which all children can receive high-quality care. Consultation services also provide more intensive case support for children who have been identified with significant needs or who are at risk of losing placement at their site. For this more intensive work, ongoing support is provided for parents in hopes of bridging the child's home and school experience and creating a feeling of continuity of care.

PROGRAM IMPACT

Early Childhood Community Team [a]	FY 2023–24
Clients served (unduplicated)	193
Cost per client	$3,209
Individuals reached (duplicated)	57
Total served	250

[a] Unduplicated clients served are the children/families that participated in individual or group therapy; individuals reached include parent/caregiver groups, teacher consultations, and so on.

Outcome Indicators

Domain	Indicator/question	*n*	%
Connection and	Number of parents/caregivers who improved familial connection and support as measured by improvement in Protective Factors Survey	2 of 2	100

Domain	Indicator/question	*n*	%
support	score		
Improved knowledge, skills, and/or abilities	Due to my engagement in this program, I feel more confident in my parenting (group services).	4 of 4	100
Connection and support	Due to my engagement in this program, I feel more connected to other parents in my community (group).	3 of 3	100
Stigma reduction	I feel more comfortable talking about my and my child's mental health/children in my classroom. (population = groups, teacher consultations, and one-on-one services)	3 of 3	100
	I feel more comfortable seeking out resources for myself and/or my child.	3 of 3	100
Knowledge/access to services	Due to my engagement, I know where to go in my community for resources and support. (population = groups, teacher consultations, and one-on-one services)	3 of 3	100
Self-empowerment	Due to my engagement, I feel more empowered to advocate for myself and my child's needs. (population = group and 1:1)	3 of 3	100
Cultural identity/humility	I feel like my identity is affirmed by this program. (population = groups, teacher consultations, one-on-one services)	3 of 3	100

DEMOGRAPHICS

Early Childhood Community Team Program Client Demographics (N=161)

	Number of clients	Percentage of total
Age		
0–15 years	108	67
16–25 years	6	4
26–59 years	27	17
60–73 years	1	0.1
74 years and older	0	0
Prefer not to answer/unknown	19	12
Primary language		
English	34	21
Spanish	104	65
Another language	0	0
Prefer not to answer/unknown	23	14
Race/ethnicity		
Asian or Asian American	0	0

	Number of clients	Percentage of total
Black or African American	1	1
Native American, American Indian, or Indigenous	0	0
Native Hawaiian or Pacific Islander	0	0
White or Caucasian	16	9
Latino/a/x or Hispanic	117	73
Another race, ethnicity, or tribe	1	1
Prefer not to answer/unknown	26	16
Gender identity		
Female/woman/cisgender woman	74	46
Male/man/cisgender man	58	36
Transgender woman/trans woman/trans-feminine/woman	0	0
Transgender man/trans man/trans-masculine/man	0	0
Questioning or unsure of gender identity	0	0
Genderqueer/gender non-conforming/gender non-binary/neither exclusively female nor male	0	0
Indigenous gender identity	0	0
Another gender identity	0	0
Prefer not to answer/unknown	29	18
Sexual orientation		
Gay or lesbian	0	0
Straight or heterosexual	5	2
Bisexual	0	0
Queer	0	0
Pansexual	0	0
Asexual	0	0
Questioning or unsure of sexual orientation	0	0
Indigenous sexual orientation	0	0
Another sexual orientation	0	0
Prefer not to answer/unknown	158	98
Behavioral health consumer or family member		
Client/consumer	NA	NA
Family member	NA	NA
Both	NA	NA
Neither	NA	NA
Prefer not to answer/unknown	NA	NA

REFERRALS

Mental Health and Substance Use Referrals

Type of referral	FY referrals to programs within your agency	FY referrals to other agencies	FY total
Serious mental illness referrals	0	0	0
Substance use disorder referrals	0	1	1
Other mental health referrals	0	7	7
Total	**0**	**8**	**8**

Referrals to Other Services

Type of referral	FY total	Type of referral	FY total
Emergency/protective services	0	Legal	0
Financial/employment	0	Medical care	0
Food	0	Transportation	0
Form assistance	0	Health insurance	1
Housing/shelter	0	Cultural, nontraditional care	0
Other	4	**Total**	**5**

PROGRAM NARRATIVE

In FY 2023–24, Mental Health Consultation Services were provided to five childcare programs in the Coastside region. Families with less intense needs were provided "Light Touch" services. The consultant met with these families for one to five sessions to provide support and any needed referrals. Families with more intensive needs received "Case Consultation" services that lasted as long as necessary to address the more complex needs. Consultation activities included individual and group mental health consultation with childcare providers and site supervisors, individual meetings with parents, parent workshops, observations of classrooms and individual children, and assistance obtaining needed resources and referrals. This year, consultants facilitated four workshops for parents on topics including child development, inclusion, and the power of relationship. There continues to be a shift to more live services, although the program continues to have a hybrid model to accommodate family preferences.

The mental health clinician provided child-parent psychotherapy informed therapeutic support and/or collateral sessions to 14 children and their caregivers in the Coastside community. When appropriate, clinicians had other collateral contacts such as school observations and participation in IEP meetings.

The community worker provided services to 133 caregivers and (indirectly) their children. Services included assessment of needs, case management, providing activities that support the caregiver/child relationship and the child's development, parent education, and linkage to needed resources.

Mental health consultants, mental health clinicians, and community workers meet as a team a minimum of twice per month to ensure collaboration of shared cases as well as to provide a space in which clients are "held" and teams can brainstorm together on best practices, possible referrals, and how to continue to provide attuned and "in depth" care.

Improves timely access and linkages for underserved populations: ECCT receives referrals from schools, community partners, and other StarVista programs. In addition to outreach efforts that lead to self-referrals, there often are families that self-refer after hearing about supports and services from other families that have worked with ECCT.

When a referral is received, the intake coordinator connects with the caregiver within 2 to 3 business days and completes a detailed phone intake. The phone intake involves listening to the caregiver's immediate concerns, gathering information on what supports/services they are interested in, and identifying any immediate risk factors facing the family. During the phone intake, the family is offered referrals to community resources outside of ECCT. In addition, families with multiple and/or more complicated needs are connected with a community worker who can provide assistance in connecting them to needed resources. When providers' caseloads are full and families are placed on a waitlist, the intake coordinator regularly follows up with the waitlisted families to assess for any changes in needs and to provide additional referrals. By assessing needs and offering referrals at multiple points, beginning within 3 business days of referral, caregivers are offered timely linkages. When families with the greatest needs are offered timely community worker support, confidence that caregivers actually connect to needed resources is greatly increased.

In addition to linkages provided during intake for mental health services, mental health consultants support children identified by teaching staff as needing more intensive services because of behavioral, social-emotional, and/or developmental concerns. Consultants offer timely linkages to services that support not just the child but also the family. At some sites, teachers have been able to identify children even before they start the program, through Ages and Stages Questionnaires (ASQ) screening done at enrollment. This allows for early identification and timely referrals that ensure that the child and family receive the support they need.

Increases number of individuals receiving public health services: In addition to receiving referrals from mental health consultants, ECCT receives referrals from schools, community partners, and other StarVista programs. Outreach efforts lead to self-referrals, and families self-refer after hearing about supports and services from other families that have worked with ECCT. The intake coordinator and community worker regularly communicate with community partners and keep a schedule of upcoming groups, events, and new resources. Families are offered updated resources relevant to their needs, and face-to-face introductions are made when possible and indicated. By regularly assessing needs, making referrals, and assisting families with follow-through on referrals, ECCT ensures that a greater number of families receive needed services.

Reduces disparities in access to care: At the core of ECCT's work is the relationship that staff have with family members. Treating families with respect, with cultural humility, and in their preferred language (whenever possible) is essential. Central to the work is the belief that the relationship between ECCT staff and caregivers parallels the child-caregiver relationship. Beginning at intake, the

intent is to gather information from caregivers and allow their input to guide services, treatment goals, and pace of work, using strengths-based language. Meeting caregivers where they are and allowing their family's needs, concerns, culture, and beliefs to drive the work is at the heart of the ECCT program. For this to occur, open communication and respect are key. ECCT staff remain curious with families and allow the work to follow the family's needs, not predetermined goals. At regular points throughout the work, time is set aside to reflect on progress and challenges, evaluating the caregiver's experience and making adjustments as needed.

It is essential for ECCT to maintain a connection to the community and understand its needs. Knowing community resources, trends, and challenges allows greater understanding of families' daily challenges and enables ECCT staff to provide more holistic support. Many families remain hesitant to connect with some services because of the ongoing political climate and fear of deportation or concerns about green card eligibility. Community workers are available to support families with appointments and help reduce their anxiety.

ECCT's core tenets of flexibility and commitment to understanding multiple perspectives allow for unique tailoring of services for clients and larger systems involved. Consistent mental health staff meetings ensure regular communication about staff needs and those of the children and families they serve. ECCT's culturally sensitive and social justice-oriented framework encourages discussion of issues such as disparity, inequity, systemic oppression, community violence, and immigration trauma, providing a safe space for healing. Consultants and site staff discuss language barriers, cultural differences, and disparities, exploring how these issues impact their connection to children and families. Space is provided for caregivers to explore how their own trauma might impact their work. Within a safe and trusting relationship with the consultant, site staff can explore their implicit biases and how those affect their understanding of children and families. Addressing these deeper issues allows teachers to build solid connections and develop more effective interventions, creating a more inclusive and sensitive classroom environment.

The intake coordinator, mental health clinician, mental health consultants, and community worker are primarily bilingual in Spanish and English. Staff are required to complete a minimum of 8 hours of diversity training annually in order to integrate a more culturally responsive approach.

Recent years have brought uncertainty, challenges, and chronic stress for many teachers. This year, teachers reported high levels of stress, burnout, and fatigue due to illness, short staffing, and children's increased separation anxiety and social-emotional delays. The consultation space proved crucial for processing complex feelings. The framework stems from the belief that when teachers can share their experiences with a trusted mental health professional, they are better able to support children and families. For many, this therapeutic space is their main mental health check-in. Through an attachment lens, ECCT ensures that site staff's needs are met so they can better serve the children under their care.

Consultation services also supported children displaying challenging behaviors, reducing their risk of suspension and expulsion and supporting the school's capacity to sustain these children in their programs. Of the children who were provided with intensive case consultation services, none were expelled or suspended. Consultants and teachers often use consultation meetings to explore possible

meaning behind behavior and to better understand a child's needs. Classroom observations allow consultants to "bear witness" to teachers' experiences, offering a reflective space to discuss challenges and successes. This approach helps teachers become more grounded and intentional, leading to better self-regulation and support seeking.

Last, ECCT works with community partners to ensure comprehensive family services. The team connects families with ongoing support programs and attempts to fill short-term service gaps. Regular conversations with community providers allow for coordinated gap filling and advocacy. The community worker's strong relationships with community members and providers are crucial in connecting families with needed services.

Implements recovery principles: ECCT staff approach substance use from a harm reduction perspective and view substance use without judgment. Staff are aware of the recovery programs and are comfortable discussing use with families. Staff are trained in motivational interviewing strategies and use them, as appropriate, when discussing substance use with families.

Other activities that benefit clients: When parents consent, consultants can conduct classroom observations of a child and meet with teachers and parents to gather information on factors that may be contributing to the child's challenging behavior. Through this process, teachers and families collaborate to complete assessment tools that provide a richer and broader picture of what is happening at home and at school. This deeper understanding of the child allows the consultant, teacher, and parent to develop and implement more attuned strategies for supporting the child's social-emotional development. When indicated, children are referred for mental health services, and collaboration among all parties continues. This collaborative and attuned approach from the multiple caregivers interacting with a child provides a richer and more consistent environment in which the child can flourish.

SUCCESSES

The program successfully filled all open positions for Coastside services. During periods with openings, existing staff covered Coastside needs. With a full staff, this has become much easier. New hiring has extended StarVista's language capacity to include Portuguese.

Mental health staff are attending an 18-month county-provided training on child-parent psychotherapy. This training serves as a refresher for some staff and initial training for others, enhancing fidelity to child-parent psychotherapy concepts.

Clients continue to benefit from the flexibility of receiving either in-person or telehealth services. Although in-person services are encouraged, clients can choose the type that works best for them. In addition, StarVista now has a memorandum of understanding with Coastside Hope, allowing StarVista to use their space to see clients. This collaboration offers more flexibility to clients and strengthens communication and collaboration between the two programs.

ECCT will replace the Child and Adolescent Needs and Strengths (CANS) and the Adult Needs and Strengths Assessment (ANSA) with the Pediatric Symptom Checklist and the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) Self-Rated Level 1 Cross-Cutting

Symptom Measure, respectively. These new measures are easier to administer, are more sensitive to change, and do not require expensive training. They have been entered into the StarVista data system and are ready for implementation in the coming FY. It is anticipated that the new measures will provide more accurate information on treatment effectiveness.

Success Story #1: Manny (pseudonym), a 4-year-old Latino male, was referred for services after witnessing and experiencing domestic violence. His teachers expressed concern about changes in his affect and behavior. Manny had begun having crying bouts, becoming emotionally dysregulated when facing minor challenges, struggling to concentrate, being less cooperative with teachers and peers, and having difficulty voicing his opinions and needs. His peers were unsure how to respond to his unpredictable behavior, and he struggled to make friends.

Therapy focused on helping Manny and his mother regulate emotions and teaching his mother effective ways to support Manny when overwhelmed. This included creating space for them to play and strengthen their bond, modeling effective ways to address challenging behavior, and helping establish structure and routine in their daily life. The StarVista community worker assisted Manny's mother in moving to safe housing and developing a safety plan for potential future threats. The therapist collaborated with Manny's teachers to support him during struggles and ensure consistency between strategies used at school and home.

Manny responded well to the services. His dysregulation significantly decreased, and he became more confident in expressing his wants and needs. He recently started kindergarten, and teachers report that he is adjusting to the changes. His mother has noted positive behavioral changes both at home and at school. Manny now smiles more, plays more freely, and is more engaged with his surroundings.

Success Story #2: Julia (pseudonym), a 4-year-old Latina female living with her parents and three older siblings, was referred to therapy because of behavioral problems at preschool. Teachers reported that she grabbed things from peers, hit them, had trouble listening and following directions, and struggled to express herself verbally. Julia experienced similar difficulties at home.

Initially, Julia's mother was reluctant about therapy but felt obligated because of teacher recommendations. The clinician visited weekly, using play therapy to model parenting skills and offer reflections explaining Julia's behavior, helping her verbalize thoughts and feelings. Observing Julia's positive response, her mother began adopting these strategies independently. As Julia's behavior improved at home, her mother became highly engaged in therapy, gaining parenting confidence and opening up about additional home issues.

Julia's longstanding sleep problems were particularly challenging for her mother after long workdays. The clinician helped Julia's mother communicate her needs to her husband and encouraged her to seek bedtime assistance. Julia's father took over the bedtime routine, to which Julia responded well, largely resolving her sleep issues. Bedtime became valuable bonding time for Julia and her father.

Julia's mother also shared tensions between Julia and her older sister. The clinician helped the mother recognize that Julia's sister might feel ignored because of Julia's behavior needs. Julia's

mother began setting aside one-on-one time with the older sister and shared effective communication strategies. The sister shifted from bickering to supporting Julia, improving their relationship and reducing family conflict.

In addition, the clinician observed Julia in her classroom and shared successful home strategies with teachers. She organized and attended a team meeting with school staff and both parents to identify strategies for consistency and support across settings. School improvements were noted, with teachers commenting that Julia was becoming a peer leader. Although Julia still occasionally struggles, her ability to appropriately name and express feelings, follow directions, and positively engage with peers has greatly improved.

CHALLENGES

During FY 2023–24, Early Childhood Services lost Measure K funding, placing additional stress on staff to meet the larger community's needs. Although Coastside services were not directly affected, the entire team felt the program's stress. The grants team is actively seeking alternative funding sources to maintain staff and restore services previously covered by Measure K funding.

Families continue to struggle with housing and resource disparities as well as financial and food instabilities. Many of the families served experienced employment changes that resulted in an inability to pay rent. In FY 2023–24, there was a great discrepancy between the number of housing resources in the community and the number of families in need. Families faced barriers to attaining needed resources because of documentation requirements for aid. Living within a small community, families sometimes hesitated to seek support, fearing stigma concerning receiving mental health and/or other related services. Finally, the overwhelming stress that many families experienced made it difficult for them to find the time and energy required to seek out and connect with services.

Dyadic work via telehealth platforms continues to be challenging with this age group, despite clinicians' efforts to offer engaging and interactive activities. In-person services are encouraged, but time, space, transportation, and other challenges result in some families opting for telehealth.

Although the program is currently fully staffed, the community worker was out on bereavement leave and then resigned in May 2023. It was the end of June before a new community worker was hired and working. This created periods of interrupted services and challenges in meeting deliverables. Scarcity of qualified applicants and inability to pay a living wage make it difficult to fill open positions. Having open positions places stress on existing staff and prevents them from meeting all expectations placed on the program. The program managers continue to work closely with the executive team and the human resources department to seek creative ways of hiring and retaining staff.

TRAUMA-INFORMED CO-OCCURRING SERVICES FOR YOUTH

Trauma-Informed Co-occurring Services for Youth target youth and TAY ages 15–25 years who are at greatest risk for adverse childhood experiences; children of color and children who grow up in poverty show the greatest risk for adverse childhood experiences. Other groups can include juvenile justice-involved youth, immigrant youth, unhoused youth, and youth in foster care. Trauma-Informed Co-occurring Services for Youth consists of three required components: Group-Based Intervention, Community Engagement, and Social Determinants of Health Screening and Referrals.

- The Group-Based Intervention component uses an evidence-based or promising practice intervention or curriculum to address trauma and substance use issues with youth. Agencies can opt to provide the Mindfulness-Based Substance Abuse Treatment (MBSAT), which was piloted with youth throughout San Mateo County or an alternate culturally relevant intervention/curriculum. Agencies target at least eight youth per cohort, and each cohort consists of at least eight sessions for the intervention and one session for youth engagement opportunities.
- The Community Engagement component addresses community-level challenges that are necessary for positive youth outcomes. Agencies provide at least two foundational trauma-informed trainings for adults who interact with their youth cohort participants (parents, teachers, probation officers, service providers, etc.) to create trauma-informed supports for youth. This component also encourages agencies to connect the youth cohort to leadership opportunities such as the BHRS ODE HAP–Youth (HAP-Y) and the AOD youth prevention programs.
- The Social Determinants of Health Screening and Referrals component acknowledges that social determinants of health (e.g., food insecurity, housing, transportation, medical treatment) can account for up to 40% of individual health outcomes. Agencies screen youth participants to support appropriate referrals and identify community-based social service resources and social needs and/or gaps.

Four agencies provide interventions as follows:

- Project SUCCESS – Schools Using Coordinated Community Efforts to Strengthen Students
  - Puente de la Costa Sur provides two cohorts per year in the southcoast region.
- Mindfulness-Based Substance Abuse Treatment (MBSAT)
  - StarVista provides six cohorts per year in North County and South County.
  - Puente provides two cohorts per year in the southcoast region.
  - YMCA Bureau of San Mateo County provides two cohorts per year in South San Francisco.
- GiraSol (formerly, Panche Be Youth Project)

- The Latino Commission provides two cohorts per year in South County for girls.

Project SUCCESS

Project SUCCESS is an evidence-based program that uses interventions that are effective in reducing risk factors and enhancing protective measures. Project SUCCESS is a Substance Abuse and Mental Health Services Administration model program that prevents and reduces substance misuse and associated behavioral problems among high-risk youth ages 9–-18 years. Project SUCCESS is offered by the local nonprofit Puente de la Costa Sur (hereafter, Puente).

Project SUCCESS is designed for use with youth ages 9–18 years and includes parents as collaborative partners in prevention through parent education programs. Clinical staff trained in culturally competent practices ran all the groups. All of Puente's staff are either licensed or prelicensed by the Board of Behavioral Sciences. Project SUCCESS groups are offered to 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 years, to participate in one or more Project SUCCESS activities. Each academic school year, a passive consent letter explaining the Project SUCCESS curriculum is sent to all parents with children ages 9–18 years. There is an opportunity for parents to have their child opt out with a signature at the bottom of the consent letter. Project SUCCESS activities include the following:

1. Social-emotional learning
2. Psychoeducation workshops with students, parents, and community members
3. Individual and family counseling services
4. Parent and teacher consultation
5. Mental health community awareness and education

PROGRAM IMPACT

Project SUCCESS	FY 2023–24
Clients served (unduplicated) [a]	35
Cost per client	$9,361
Individuals reached (duplicated)	57
Total served	92

[a] Unduplicated clients served are the students who participated in the intervention and individual and family therapy; individuals reached include parent/teacher consultations as well as community awareness and education.

Outcome Indicators

Domain	Indicator/question	*n*	%
Connection and support	Due to this program, I can identify trusted adults in my life and when to tell adults about my mental concerns. (fifth-grade students, *n* = 18)	14	78
Improved knowledge, skills, and/or abilities	Due to participating in this program, I can identify how drugs and alcohol affect the brain. (middle school, *n* = 11)	9	82
	Due to participating in this program, I understand the risks with the use of alcohol and substances. (middle school, *n* = 11)	11	100
	Due to participating in this program, I have many ways to manage my big feelings. (middle school and fifth-grade students, *n* = 29)	14	48
Self-empowerment	Due to this program, I am comfortable asking for help for myself or others with an adult. (fifth-grade students, *n* = 18)	13	72
	Due to participating in this program, I can recognize when I need help. (middle school, *n* = 11)	7	64
General behavioral health	Due to participating in this program, I can identify my emotions and notice how I experience them in my body. (fifth-grade students, *n* = 18)	10	56
	Due to this program, I can identify anxiety and notice how I experience it in my body (middle school, *n* = 11)	8	72

DEMOGRAPHICS

In FY 2023–24, Puente implemented various initiatives to enhance its demographic data collection. The team currently inputs all surveys and questionnaires into designated Excel sheets, with both long and short county questionnaires attached to consent forms for cohorts. However, they observed that several clients have opted out of answering the questionnaire, resulting in limited data. To address this, the Community Mental Health and Wellness (CMHW) team will continue to inform clients that although completing the questionnaire is optional, the information provided helps Puente accurately report the demographics of clients served to grant providers, emphasizing the importance of these data in securing continued support for their programs.

REFERRALS

Mental Health and Substance Use Referrals

Type of referral	FY referrals to programs within your agency	FY referrals to other agencies	FY total
Serious mental illness referrals			

Type of referral	FY referrals to programs within your agency	FY referrals to other agencies	FY total
Substance use disorder referrals			
Other mental health referrals		1	1
Total		**1**	**1**

Referrals to Other Services

Type of referral	FY total	Type of referral	FY total
Emergency/protective services	1	Legal	1
Financial/employment	2	Medical care	3
Food	2	Transportation	1
Form assistance	2	Health insurance	0
Housing/shelter	0	Cultural, nontraditional care	0
Other	0	**Total**	**12**

PROGRAM NARRATIVE

In FY 2023–24, Puente's primary program activities included delivering the Project SUCCESS PEI curriculum to all 18 fifth graders in the school district and a cohort of 11 middle school students. The intervention consisted of individual and family counseling services, parent and teacher consultation, and mental health community awareness and education. The fifth-grade classrooms received six lessons of Project SUCCESS, covering topics such as coping skills and effects on the body. Each academic year, a passive consent letter explaining the Project SUCCESS curriculum is sent to parents/guardians of children ages 9–11 years, whereas high school students ages 12–17 years sign their own consent forms. Parents have the opportunity to opt their child out of the workshops by signing the bottom of the passive consent letter; one student's parents chose this option. In addition, a Project SUCCESS group was offered to all middle school students during a free period, attended by 11 students who received raffle tickets for their participation.

Improves timely access and linkages for underserved populations: Puente's service region is home to San Mateo County's most underserved population. Participants either live or work in Pescadero, La Honda, San Gregorio, or Loma Mar. Many participants face numerous challenges including accessing behavioral health care. The CMHW team offers free counseling to all individuals in Puente's geographic region regardless of an individual's socioeconomic or legal status.

Reduces stigma and discrimination: Project SUCCESS provides opportunities for students ages 9–18 years and their families to engage with trained mental health clinicians in educational workshops and therapeutic sessions. These interactions build relationships that break down the stigma surrounding mental health and substance use issues, reducing barriers to seeking treatment. Puente's CMHW team promotes mental health awareness, provides education in accessible formats, and facilitates easy access to mental health services through a simple referral process. In FY 2023–24, Puente's CMHW team participated in a Farmworker's Convention, where team members presented on mental

health stigma and facilitated a discussion with participants to reduce stigma. All CMHW clinicians are trained in cultural humility and operate within a diversity, equity, and inclusion framework, which helps reduce language barriers and cultural biases.

Increases number of individuals receiving public health services: By providing free services within its geographic region, Puente increases the number of individuals receiving public health services. In addition, Puente offers services to all youth in the district schools that they would otherwise not receive.

Reduces disparities in access to care: Through Project SUCCESS, all La Honda-Pescadero Unified School District students have access to this program. Puente's goal is to eliminate health disparities and improve access to health care services for vulnerable populations on the South Coast, including mental health care. By providing greater access to mental health care services, Puente seeks to improve participants' mental wellness and decrease long-term mental health problems. Puente improves individual and family mental health by providing on-site individual and group mental health services. It significantly reduces the disparities that exist in the mental health system by providing this ease of services.

Implements recovery principles: Project SUCCESS is an early prevention and intervention program that is designed to mitigate the need for recovery services. Puente provides AOD referral services as needed.

Other activities that benefit SUCCESS participants: Given the rise of students arriving from Mexico, as reported by the school, Puente's CMHW team provided a clinical group for middle school students who are newcomers, newly arrived from Oaxaca, Mexico. Two bilingual/bicultural clinicians facilitated a 7-week group series. The goal of the group was for students to build a sense of community and support as they are integrating themselves into a new community. Students were able to share their experiences arriving in a new community and struggles in school and at home.

Puente clinicians facilitated a short-term whole class group for the first and second graders at Pescadero Elementary focusing on self-control and teaching coping skills. Students learned and practiced self-control skills such as understanding when to think or say a thought, understanding body control and respecting one's own and others' personal space, and recognizing and responding when their emotions feel out of control. Students responded positively to the group and were able to remember and put into practice the skills they were learning week to week.

SUCCESSES

FY 2023–24 was filled with many successes for Project SUCCESS. Here are some examples:

- Student engagement and appreciation: The CMHW team has been facilitating Project SUCCESS for several years, and students show appreciation for the CMHW clinicians during the cohort by participating and asking to extend the cohort weeks. During the reported period, a parent shared that at the fifth-grade promotion, a student acknowledged Puente's CMHW team and stated, "Thank you, Puente, for all the fun activities you provided us."

- Wellness and substance education group: Puente therapists facilitated a wellness group with a focus on AOD education and prevention. Students learned about the different classifications of drugs and alcohol and their effects on the body. They also discussed various factors that may lead someone to choose drugs and alcohol as a coping mechanism as well as healthier coping mechanisms. The students asked insightful questions and were curious about the physical and psychological effects of drugs and alcohol. They identified multiple alternative coping tools for stress, such as seeking therapy, participating in enjoyable activities such as sports and reading, and seeking support from friends and family. The students showed empathy and compassion toward individuals struggling with addiction and reflected on how they might respond if offered drugs or alcohol as well as ways they could support themselves and their peers in choosing healthier coping mechanisms.
- Staffing: During the FY 2023–24, Puente welcomed two new clinicians to the CMHW team. On September 18th, Veronica joined the team as a full-time mental health clinician, and on February 5th, Emma joined as a part-time mental health clinician.
- Individual referral: In the previous reporting year, some participants seeking individual therapy services were added to a waitlist because of clinicians' availability. Fortunately, during FY 2023–24, participants who sought individual therapy services were able to be connected to a therapist in a shorter period than before.

CHALLENGES

- Scheduling: A new challenge faced by the program was scheduling Project SUCCESS at one of the locations. One of the groups was scheduled during the students' lunch break because of the teacher's curriculum and instructional minutes. Although students enjoyed participating in the group initially, they lost interest toward the end of the sessions.
- Data collection: New data collection and tracking processes have been implemented by the CMHW director. However, the program has noticed that a small number of clients have chosen to partially complete or not fully complete the demographics survey and assessments.

Mindfulness-Based Substance Abuse Treatment

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

MBSAT—Puente de la Costa Sur

MBSAT is designed for use with adolescents and young adults, ages 15–25 years, and uses adult facilitators as leaders of the group to model authenticity and build healthy relationships. Puente's

CMHW clinical staff, trained in cultural humility and trauma-informed care, facilitate this group. All Puente CMHW staff are either licensed or prelicensed by the Board of Behavioral Sciences. MBSAT is offered to high school students in the La Honda-Pescadero Unified School District as well as young adults in the community.

During FY 2023–24, Puente faced significant challenges in implementing the MBSAT program, primarily because of limited staffing and low student engagement. Despite various recruitment efforts, the program was unable to gather sufficient interest to form a cohort. The CMHW team offered an MBSAT cohort to Pescadero High School students and conducted multiple recruitment strategies, including checking in with previous participants, making schoolwide announcements, collaborating with the school counselor, and offering a raffle incentive. However, student interest remained low. The program was offered during a free period rather than integrated into an existing class, which may have contributed to the lack of participation. Even with the incentive of entering a raffle to win a $100 gift card, no students attended the offered sessions. The limited staffing available to implement the program likely compounded these challenges, restricting the team's ability to conduct more intensive outreach or offer the program at multiple times. To address these issues in the upcoming year, Puente's CMHW team plans to facilitate weekly raffles with age-appropriate prizes, conduct classroom visits for direct invitations, explore integrating the program into existing class schedules, and assess staffing needs to ensure adequate resources for implementation and outreach. These strategies aim to increase student engagement and overcome the implementation challenges faced in FY 2023–24.

MBSAT—StarVista

The StarVista Insights Program offers MBSAT to improve the lives of TAY dealing with substance use, trauma, emotional regulation, family conflict, unhealthy relationships, and other factors limiting their healthy development and overall happiness. The program's mindfulness groups focus on essential life skills such as self-awareness, enhancing emotional well-being, and reducing substance use through healthier coping mechanisms and informed decision making. With the right tools, youth can better manage life challenges in the moment instead of allowing emotions to lead to poor judgment, risky decisions, and eventually negative or dire consequences.

Group facilitators teach participants that mindfulness encompasses practices ranging from formal meditation to making informed, here-and-now decisions in daily life. A key mindfulness tool taught is the TAP acronym: Take a breath, Acknowledge (the situation), and Proceed. This acronym aligns with the popular youth slang "tap in," bridging familiar language with a new practice to support better decision making in risky situations.

The curriculum covers topics including substance use, cravings, triggers, emotional awareness, brain function, family systems, peer systems, and environmental influences on behavior. Each group explores multiple meditation interventions, focusing on specific practices such as meditation of the breath, body, and environment. When youth are provided with space to calmly explore their internal states, they can apply insights to make better choices in everyday life.

The program has adapted to continue providing in-person services with appropriate safety protocols, while also preparing for potential COVID-19 spikes. It emphasizes emotional regulation to help youth cultivate resilience during uncertain times.

To ensure steady yet sustainable growth, the program continually adapts its offerings by working with various CBOs and San Mateo County school districts. It welcomes any TAY (typically ages 15–25 years) to participate and is open to collaborating with organizations serving this population. This flexibility has allowed the program to serve 36 youths, with groups organized by appropriate age ranges (14–17 years and 18–25 years).

As of August 2024, the program is prepared to return to several schools at the request of both students and administrators. Clinicians continue to travel to various sites, aiming to extend services to anyone who can benefit.

PROGRAM IMPACT

MBSAT—StarVista [a]	FY 2023–24
Clients served (unduplicated)	32
Cost per client	$3,039
Individuals reached (duplicated)	2
Total served	34

[a] Unduplicated clients served are the youth who participated in Mindfulness-Based Substance Abuse Treatment (MBSAT) group sessions; individuals reached would include community member trauma-informed presentations to support youth.

Outcome Indicators

Domain	Indicator/question	Number who agree	%
Improved knowledge, skills, and/or abilities	*Because I participated in this program, when I'm worried about something, I make myself think about it in a way that helps me feel better.*	15	100
	When I want to feel better about something, I change the way I'm thinking about it.	15	100
	As a result of participating in this program, I learned that trauma affects physical, emotional, and mental well-being.	15	100
	As a result of participating in this program, I believe that recovery from trauma is possible.	15	100
	Due to my participation in this program, I practice self-care (taking care of my own needs and well-being).	15	100
	As a result of participating in this program, I believe in and support the principles of trauma-informed practice.	15	100

DEMOGRAPHICS

MBSAT StarVista Program Client Demographics (N=19)

	Number of clients	Percentage of total

	Number of clients	Percentage of total
Age		
0–15 years	0	0
16–25 years	19	100
26–59 years	0	0
60–73 years	0	0
74 years and older	0	0
Prefer not to answer/unknown	0	0
Primary language		
English	11	58
Spanish	6	32
Another language/multiple	2	10
Prefer not to answer/unknown	0	0
Race		
Asian or Asian American	0	0
Black or African American	3	16
Native American, American Indian, or Indigenous	1	5
Pacific Islander	3	16
White or Caucasian	1	5
Another race/multiple	10	53
Prefer not to answer/unknown	1	5
Ethnicity		
Latino/a/x or Hispanic	8	42
Caribbean	0	0
Central American	3	16
Mexican/Mexican American/Chicano	4	21
South American	1	5
Another identity or tribe	0	0
Prefer not to answer/unknown	0	0
Not Latino/a/x or Hispanic	11	58
African	2	11
Asian Indian/South Asian	1	5
Chamorro	0	0
Chinese	0	0
Eastern European	0	0
European	1	5
Fijian	0	0
Filipino/a/x	2	11
Japanese	0	0

	Number of clients	Percentage of total
Korean	0	0
Middle Eastern or North African	0	5
Samoan	0	0
Tongan	1	5
Another ethnicity or tribe	0	0
Prefer not to answer/unknown	3	16
Sex assigned at birth		
Male	8	42
Female	11	58
Prefer not to answer/unknown	0	0
Intersex		
Yes	7	37
No	10	53
Prefer not to answer/unknown	2	10
Gender identity		
Female/woman/cisgender woman	11	58
Male/man/cisgender man	8	42
Transgender woman/trans woman/trans-feminine/woman	0	0
Transgender man/trans man/trans-masculine/man	0	0
Questioning or unsure of gender identity	0	0
Genderqueer/gender non-conforming/gender non-binary/neither exclusively female nor male	0	0
Indigenous gender identity	0	0
Another gender identity	0	0
Prefer not to answer/unknown	0	0
Sexual orientation		
Gay or lesbian	0	0
Straight or heterosexual	14	74
Bisexual	2	10.5
Queer	0	0
Pansexual	2	10.5
Asexual	1	5
Questioning or unsure of sexual orientation	0	0
Indigenous sexual orientation	0	0
Another sexual orientation	0	0
Prefer not to answer/unknown	0	0
Disability status		
Yes	1	5
No	18	95

	Number of clients	Percentage of total
Prefer not to answer/unknown	0	0
Veteran status		
Yes	0	0
No	19	100
Prefer not to answer/unknown	0	0

REFERRALS

Mental Health and Substance Use Referrals

Type of referral	FY referrals to programs within your agency	FY referrals to other agencies	FY total
Serious mental illness referrals	1	0	1
Substance use disorder referrals	0	0	0
Other mental health referrals	1	0	1
Total	**2**	**0**	**2**

Referrals to Other Services

Type of referral	FY total	Type of referral	FY total
Emergency/protective services	0	Legal	0
Financial/employment	0	Medical care	0
Food	0	Transportation	0
Form assistance	0	Health insurance	0
Housing/shelter	0	Cultural, nontraditional care	0
Other	0	**Total**	**1**

Improves timely access and linkages for underserved populations: Many clients are the first in their families to access services. StarVista works with partner agencies and participants to determine optimal dates, times, and access points for participation. The program provides an online/at-home format, allowing for greater reach and accessibility for those interested in telehealth services. Through a special grant, StarVista has secured cellular phones with cameras for clients who would most benefit from remote services because of transportation issues but lack their own devices.

Reduces stigma and discrimination: The mindfulness program avoids simply "telling youth what to do and what not to do." This approach helps reduce internalized shame because youth don't feel their choices are being judged as "good" or "bad" or scrutinized for morality. By helping youth understand the influence of personal, familial, societal, and systemic pressures on their decision-making abilities, counselors work with them to identify key moments in which they can exercise agency within various social, political, and economic dynamics. While recognizing their agency, they can also understand that some choices are heavily influenced by external factors. The program focuses on developing

practices for making more informed decisions—ones based on desired long-term outcomes rather than immediate gratification or reactivity.

The program encourages peer engagement, creating deeper rapport, comfort, and safety for participants. Facilitators avoid strict didactic top-down approaches in which the clinician is the sole source of knowledge. This creates a socio-corrective experience that helps reduce stigma; when youth can speak to their life experiences with authority, they begin to take control and feel pride in their self-awareness and future decisions. By working with others in similar situations, youth realize that they're not alone in facing difficulties and can share without the judgment they might expect from those with different experiences. These connections help normalize conversations about motivations for drug use, healthy coping, problem solving, and decision making beyond the program's duration.

The COVID-19 pandemic has normalized conversations around mental health. Many youth involved in juvenile justice, probation, services for unhoused, and foster care have expressed feeling powerless within these systems. This program provides TAY with psychoeducation, skill-building, and decision-making abilities needed to overcome obstacles and find their own solutions, fostering empowerment and self-definition. The program helps participants contextualize their past experiences as results of limited resources rather than character flaws, helping destigmatize their past, present, and future.

Increases number of individuals receiving public health services: Clinicians assess participants' needs throughout treatment and facilitate connections to appropriate public services. StarVista collaborates with partner sites, other StarVista programs, and San Mateo County services to coordinate care. Services are implemented at high schools where youth can easily access them, with screening by school counselors or teachers who identify needs.

Reduces disparities in access to care: By targeting underserved populations and bringing services to participants, the program removes transportation barriers. The online platform offers flexible scheduling to accommodate various work, home-life, and school commitments. StarVista provides phones to youth needing devices for remote participation. Staff encourage and normalize accessing safety net programs throughout the lifespan.

Implements recovery principles: Through emphasizing awareness and acceptance as core elements of mindfulness, individuals can implement critical recovery principles. The practice encourages self-actualized, self-directed factors identified through the recovery process, rooted in holistic, strengths-based, person-centered approaches.

Other activities that benefit clients: Clinicians provide case management services outside of group sessions to assess and connect clients with appropriate resources. They also work with participants' parents to access resources such as medical and mental health counseling, recognizing the connection between parent and youth success in the program.

SUCCESSES

Client Success Story: The MBSAT group that was held at Terra Nova High School was set up to provide a safe space to learn about mindfulness and how it could be used and incorporated into

clients' everyday lives. This group offered a significant amount of valuable insight from different group members and allowed the clients to work through personal challenges individually and with their peers. One particular client who comes to mind when discussing a success story is that of a 15-year-old female, referred to as Sarah (name changed to protect confidentiality). Sarah was referred to the mindfulness group at Terra Nova High School by the main general counselor for a history of depressive symptoms and having a difficult time adjusting to numerous aspects of high school. For the first 4 weeks of the mindfulness group, Sarah was more reserved, removed, and quiet and would answer in only one or two words when questions were prompted.

As the group continued building a healthy and safe space to share, the clinicians were able to witness Sarah becoming more open about her present-day challenges with school and her grades. For the following 4 weeks, the clinicians started incorporating more hands-on activities to provide the clients with opportunities to actively practice mindfulness when working through challenges. By Week 5, Sarah was verbalizing how she "loves the activities and looks forward to seeing what each mindfulness task is next." Sarah was then able to hold conversation, share in a safe and trusted space, practice vulnerability, and even provide feedback and supportive language to her peers who were struggling with some similar experiences. By the end of the scheduled group, Sarah approached both clinicians and shared that she never thought she would be able to talk about many of the topics covered in the sessions and was "grateful" that she had that group. Sarah also verbalized that she was "excited to join group again next year."

CHALLENGES

During the first phases of the groups, some members were sensitive to the presence of other members who had a different demeanor or personality style. If active, outspoken members were present, the more timid or quiet participants felt encouraged to open up and speak, but if they were absent, the others tended to be more reserved, resulting in lower engagement. To improve engagement, clinicians took time to balance rapport building and the curriculum to increase comfort in the group to express feelings, thoughts, and experiences from all members. Another challenge that clinicians managed was difficulty engaging a particular group that had a mixture of members who were participating in the group a second time (they were familiar with the content) and those who were in their first round of group. Clinicians were able to use the familiarity of the more seasoned participants as a strength by providing some leadership roles that allowed these youth to help with small tasks to keep everyone appropriately engaged.

Although much of the outreach done with new programs and schools indicated that many individuals were interested and would move forward with implementation, many schools and programs were dealing with the challenges of returning to in-person instruction and staff shortages. The Wellness Teams at various sites often were very busy and did not have time to coordinate to launch the mindfulness groups. The process for outside contractors to provide services can be quite extensive and time consuming. In addition, communication is sometimes intermittent, and if many people are involved, it can become fragmented. Sites were enthusiastic about adding this service to their campus but were just strapped for time and thus unable to follow through. The team hopes to start

coordinating with the Wellness Teams at the sites sooner in the year to make sure they have ample time. They will continue to remain flexible to the sites' needs.

On a very different front, some clients come to group with a lack of clarity and/or ambivalence about mindfulness topics and how to use the practices in their day-to-day lives. The team is working through this, but as of now, clients see it as something very foreign to their own experience. One solution found was to focus on mindfulness versus strict meditation, which is what most people think of when they hear the word "mindfulness." Most often, clients do not understand that mindfulness can be practiced in various settings and have not had the opportunity to learn without worrying about doing it "right." As mentioned before, at its most basic, mindfulness means to be present to whatever is unfolding with an attitude of nonreactivity and nonjudgment. This produces a state of equanimity, which all life experiences can benefit from.

Last, facilitators do not yet have a consistent group of youth showing up to sessions every week. Group members have varied throughout, and this means that sometimes it dips down to one member. Having to plan group activities and anticipate a flux is a bit difficult, but clinicians are working on having a variety of activities that will work well even if just one student participates in a given week. Clinicians plan to work toward greater consistency in group members in the future by working with point persons at the sites to provide reminders and incentives to youth.

MBSAT—YMCA

The Youth Service Bureau (YSB) of the YMCA provides mental health services at two South San Francisco high school campuses: South San Francisco High School and El Camino High School. The YSB's focus is on adolescents ages 14–18 years who are enrolled in high school. The services provided by YSB School Safety Advocates (SSAs) are free of charge and accessible to all students on campus.

High School SSAs deliver a diverse array of services and groups including the First Stop group. This group employs the MBSAT curriculum, designed for youth engaging with school-based services for both prevention and substance use concerns. Referrals to these services stem from various sources, including school staff, administrators, counselors, and parents. The flexible nature of the MBSAT curriculum and interventions allows for their delivery either in group settings or individually, effectively meeting each student's unique needs.

Services provided by High School SSAs on campus include the following:

- Crisis intervention and mediation
- Risk and mental health assessment
- On-campus First Stop groups, using MBSAT curriculum
- On-campus Girls United empowerment groups (dependent on need and SSA capacity)
- On-campus emotion regulation Controlling Anger and Learning to Manage (CALM) groups (dependent on need and SSA capacity)

- On-campus sexual violence prevention group, for any youth who may be exhibiting emerging problematic sexual behaviors such as harassment and other boundary-crossing behaviors
- Referrals for further individual and family counseling at the YSB/YMCA clinics or with other appropriate services in the county
- Family case management, including parent support and psychoeducation

The YSB High School SSA program's main objective is to increase high school students' access to mental health services, concentrating on early intervention and prevention, while addressing crucial safety concerns. Collaborating closely with school personnel, SSA staff contribute to fostering secure environments within campuses. Their roles include conflict intervention, employing restorative justice methods for conflict resolution, and proactively countering potential instances of bullying, self-harm, suicide, and substance abuse. Furthermore, the program aims to offer alternatives that help high school students steer clear of involvement in the criminal justice system.

Through the therapeutic framework used by SSAs, they cultivate relationships that empower youth to collaborate with a trustworthy adult figure. This relationship facilitates the learning of problem-solving skills and techniques to navigate challenges, within both the school environment and the home setting.

The overarching goals of the program include the following:

- Reduce youth violence, gang participation, substance abuse, and involvement in the criminal justice system
- Identify any risk to self or others and secure appropriate services to ensure youth' safety
- Change at-risk youth' behaviors to increase personal responsibility, risk avoidance, protective behaviors, and resiliency
- Provide developmental inputs to promote positive behavioral change: safe environments, supportive adults, and a variety of programs and interventions matched to youth' risk levels
- Measure the impacts of those developmental inputs as indicators of positive behavioral change

The YSB High School SSA team engages with students on campus through a diverse range of activities and interventions. Students identified as requiring a higher level of care can be directed to the YSB of the YMCA for individual or family therapy on an outpatient basis. A large part of the YSB High School SSAs' work with referred students revolves around case management. YSB SSAs handle a substantial number of referrals and, via thorough assessments, determine the most appropriate approach based on each student's individual needs. Moreover, the possibility of directing students to outside agencies or resources is also considered.

In addition, YSB High School SSA staff provide outreach and education activities with schools to enhance strategies for reducing risk factors and substance use through discussions with students, workshops, and parent workshops.

PROGRAM IMPACT

MBSAT—YMCA [a]	FY 2023–24
Clients served (unduplicated)	11
Cost per client	$2,809
Individuals reached (duplicated)	50
Total served	61

[a] Unduplicated clients served are the youth who participated in Mindfulness-Based Substance Abuse Treatment (MBSAT) group sessions; individuals reached would include community member trauma-informed presentations to support youth.

Outcome Indicators

Domain	Indicator/question	Number who agree	%
Improved knowledge, skills, and/or abilities	*Because I participated in this program, when I'm worried about something, I make myself think about it in a way that helps me feel better.*	3 of 3	100
	When I want to feel better about something, I change the way I'm thinking about it.	2 of 3	67
	As a result of participating in this program, I learned that trauma affects physical, emotional, and mental well-being.	45 of 50	90
	As a result of participating in this program, I believe that recovery from trauma is possible.	43 of 50	86
	Due to my participation in this program, I practice self-care (taking care of my own needs and well-being).	36 of 50	72
	As a result of participating in this program, I believe in and support the principles of trauma-informed practice. (mental health providers only)	13 of 20	65

DEMOGRAPHICS

MBSAT YMCA Program Client Demographics (N=19)

	Number of clients	Percentage of total
Age		
0–15 years	1	9
16–25 years	10	91
26–59 years	0	0
60–73 years	0	0
74 years and older	0	0

	Number of clients	Percentage of total
Prefer not to answer/unknown	0	0
Primary language		
English	11	100
Spanish	0	0
Another language/multiple	0	0
Prefer not to answer/unknown	0	0
Race		
Asian or Asian American	2	18
Black or African American	1	9
Native American, American Indian, or Indigenous	3	28
Pacific Islander	1	9
White or Caucasian	2	18
Another race/multiple	0	0
Prefer not to answer/unknown	2	18
Ethnicity		
Latino/a/x or Hispanic	6	55
Caribbean	0	0
Central American	0	0
Mexican/Mexican American/Chicano	1	9
South American	0	0
Another identity or tribe	5	45
Prefer not to answer/unknown	0	0
Not Latino/a/x or Hispanic	5	45
African	0	0
Asian Indian/South Asian	0	0
Chamorro	0	0
Chinese	0	0
Eastern European	0	0
European	0	0
Fijian	0	0
Filipino/a/x	4	36
Japanese	0	0
Korean	0	0
Middle Eastern or North African	0	0
Samoan	0	0
Tongan	0	0
Another ethnicity or tribe	1	9
Prefer not to answer/unknown	0	0

	Number of clients	Percentage of total
Sex assigned at birth		
Male	6	55
Female	5	45
Prefer not to answer/unknown	0	0
Intersex		
Yes	0	0
No	0	0
Prefer not to answer/unknown	11	100
Gender identity		
Female/woman/cisgender woman	5	45
Male/man/cisgender man	6	55
Transgender woman/trans woman/trans-feminine/woman	0	0
Transgender man/trans man/trans-masculine/man	0	0
Questioning or unsure of gender identity	0	0
Genderqueer/gender non-conforming/gender non-binary/neither exclusively female nor male	0	0
Indigenous gender identity	0	0
Another gender identity	0	0
Prefer not to answer/unknown	0	0
Sexual orientation		
Gay or lesbian	0	0
Straight or heterosexual	8	73
Bisexual	0	0
Queer	0	0
Pansexual	0	0
Asexual	0	0
Questioning or unsure of sexual orientation	0	0
Indigenous sexual orientation	0	0
Another sexual orientation	0	0
Prefer not to answer/unknown	3	27
Disability status		
Yes	0	0
No	4	36
Prefer not to answer/unknown	7	63
Veteran status		
Yes	0	0
No	11	100
Prefer not to answer/unknown	0	0

PROGRAM NARRATIVE

Throughout the academic year, YMCA High School SSAs manage a significant volume of student referrals for various reasons. Each referred student undergoes a comprehensive assessment to determine the most appropriate course of action. A key advantage of the High School SSA program is that students are of an age at which they can independently consent to services. Although parental or caregiver involvement is encouraged, it's not mandatory for accessing on-campus services promptly.

When students require additional services or resources, SSAs can quickly initiate necessary connections. Outpatient therapy referrals are typically directed to the YMCA clinic, which accepts Medi-Cal and offers fee-based options on a sliding scale, providing financial assistance to those in need.

In cases in which external support is deemed beneficial, SSAs facilitate appropriate referrals. They can also guide students to Care Solace, a resource that connects students with community-based mental health care providers through the school district. The YMCA, in collaboration with school partnerships, works diligently to reduce disparities in care access.

The YMCA Community Resource Center plays a crucial role in offering essential services such as food assistance, housing and shelter resources, homelessness aid, and short-term financial support for rent, deposits, mortgages, and utility bills. These services are available to residents of South San Francisco, San Bruno, and Brisbane. When a student's family needs basic resources or referrals to these core services, the linkage process is initiated swiftly and efficiently.

The YSB of the YMCA High School SSA program helps destigmatize mental health concerns through its integration within the school community and close collaboration with the counseling team. This integration often enhances trust building, particularly among students who find comfort in the YSB SSAs' affiliation with an external agency. The presence of a reliable adult figure on campus, capable of providing individual and group support, normalizes mental health services and lays the foundation for lifelong help-seeking habits.

The absence of traditional therapeutic services provided by SSAs on campus enhances accessibility while reducing disparities in accessing essential services. Notably, the alignment of YSB SSAs' cultural backgrounds with those of the student and family communities they serve fosters heightened engagement and connection, effectively countering stigma and discrimination.

The YSB's MBSAT program and curriculum promote mindfulness practices and self-awareness, aiming to facilitate healthier choices. Within this framework, recovery principles of empowerment and peer support motivate young individuals to actively participate in their journey by making informed decisions and setting meaningful goals. The adaptable MBSAT curriculum offers rich psychoeducational content in both group and individual settings, ensuring tailored services that effectively address each youth's specific needs.

The YMCA is committed to operating as a trauma-informed system, underpinned by cultural humility and the promotion of racial equity within its workforce and training programs. The trauma-informed system framework is based on a comprehensive understanding of trauma, recovery, sociocultural

trauma, and structural oppression. This approach extends to interactions with students, clients, families, and community partners.

Recognizing that individual and systemic racism, along with oppressive structures, can perpetuate trauma, the YSB of the YMCA takes proactive measures to address power and privilege dynamics, confront racism, and champion anti-racist practices. These actions aim to curtail discrimination while valuing and nurturing the distinctive strengths and resilience of students navigating historical and present-day traumas.

The YMCA continues its pursuit of racial equity through collaboration with consultants, focusing on leadership coaching, staff training, and ongoing professional development. In addition, the YSB is integrating Healing Centered Engagement practices, which offer a strengths-based, holistic perspective on healing, emphasizing the role of culture and identity in personal well-being.

These initiatives aim to enhance staff retention and recruitment, ultimately improving support for students served by the YMCA. The organization prioritizes hiring staff members who resonate with the student population, particularly those from historically marginalized Black, Indigenous, and People of Color communities. This effort aims to amplify engagement and bolster students' self-esteem while fostering a workplace that fully embraces and upholds racial equity.

SUCCESSES

Several programmatic successes were achieved during FY 2023–24, including expanded outreach activities. The YSB of the YMCA High School SSAs facilitated outreach events at both campuses. One event took place during a parent night at South San Francisco High School, whereas the other was held at El Camino High School during an evening workshop facilitated by the High School SSA. These events provided psychoeducation about trauma, resilience, and strengths that can be used to work toward healing.

The event held at South San Francisco High School during a parent night welcomed nine parents/caregivers. The El Camino High School event was a drop-in workshop that attracted 41 individuals. Both events featured attendance by mental health providers who worked either on campus or in the community. The outreach and engagement models used were well received overall, and every effort will be made to replicate the process for the upcoming FY.

The following quotations were taken directly from surveys provided to the attendees at the event hosted at El Camino High School. All responses are anonymous as surveys do not capture any demographic data.

"*This is important information, and I appreciate as someone who works with students with emotional disturbance.*"

"*It didn't change much for me, but it did reinforce/remind me of things I had already had awareness around.*"

"*Thank you, Ms. L. The presentation is very informative!*"

"*Succinct and salient.*"

The following account is a brief narrative provided by the YSB SSA at El Camino High School for FY 2023–24. Names and identifying details have been changed or removed to protect client confidentiality. The described intervention involved the use of the MBSAT curriculum in a group setting. This narrative highlights key themes such as accessing substance abuse services, reducing stigma, and implementing recovery principles.

"During the school year I had the pleasure of running the First Stop curriculum. This year a couple of students showed up and contributed greatly to the space. One student stuck out particularly from the beginning, creating personal goals to stick to and reach for the duration of the First Stop group. This student was able to stick to and reach their biggest goal upon agreeing to participate in the curriculum. This student excelled in reflecting on and processing their feelings around substance use and their history with it. Each week they came in with a positive attitude, eager, engaged, and more mindful than the previous week. At the end of the 10-week meetings this student was proud of themselves and expressed 'feeling more confident and braver.'"

The following quotations are from participants of the MBSAT First Stop group at South San Francisco High School during FY 2023–24. The quotations are anonymous and contain no identifying information to protect the confidentiality of participants.

"*Ms. V was very nice and helpful to me, and she made me feel comfortable talking about my feelings.*"

"*This program/experience has been very helpful and very calming. This program opened me and made me realize a lot that I should have known better.*"

CHALLENGES

Programmatic challenges persisted in FY 2023–24, particularly regarding referrals to the MBSAT First Stop group. The YSB of the YMCA High School SSAs managed large caseloads with consistently high-needs clients. Despite numerous student suspensions at both high schools due to on-campus substance use, these incidents rarely translated into MBSAT First Stop program referrals.

Low referral rates may stem from school personnel's lack of awareness about available services. Students enrolled in on-campus MBSAT First Stop groups generally engage well and report positive experiences. Efforts continue to improve referral processes from the Alternatives To Suspension program, a partnership between the YSB of the YMCA and San Francisco Unified School District. Whereas Alternatives To Suspension offers brief interventions for substance use-related suspensions, the MBSAT First Stop group provides more comprehensive prevention and education support.

FY 2023–24 proved exceptionally challenging for the YSB of the YMCA. Early in the 2023–24 academic year, an influx of state and government funding for expanding mental health services on school campuses created uncertainty and instability within the organization. The future of the YSB of the YMCA's school-based programs became uncertain, with slow-coming answers affecting the entire system. This uncertainty significantly impacted school-based clinicians' morale, integral to school communities. Effects included worry, diminished communication, and lack of transparency. The

school climate became nearly intolerable for some, with burnout and overwhelm reaching very high levels.

The YSB of the YMCA High School SSAs, who typically manage high caseloads year-round, faced additional systemic stressors. The challenging school environment in FY 2023–24 created numerous obstacles for SSAs and their colleagues. The YSB of the YMCA experienced an unprecedented number of staff clinicians leaving the agency in the past two quarters. Many remaining clinicians opted not to return to their assigned school sites for FY 2024–25.

Consequently, El Camino High School and South San Francisco High School will have new YSB of the YMCA SSAs on campus for FY 2024–25.

GiraSol

The Latino Commission is the one agency that proposed an alternate culturally relevant intervention/curriculum, GiraSol. The GiraSol curriculum debuted at The Latino Commission's San Bruno location in spring 2023 serving female-identified youth in the South Bay Area. The spring cohort was successful across many areas, primarily in the area of increasing and strengthening youth participants' ability to cope with, manage, and transform mental health symptoms and intersecting adversity, through culturally rooted protective factors, skill and knowledge development, and enhancing their trust and use of healthy peer, adult/family, and community support systems. Youth participants engaged in 14 consecutive educational and skill-building sessions of an integrative, unique, and culturally rooted curriculum and were offered 60 hours of culturally rooted educational workshops. Program outcomes contributed to and nurtured youth participants' emotional, social, and psychological development, fostering a sense of belonging, security, and well-being rooted in strong values, culture, community, and healthy relationships.

PROGRAM IMPACT

Program outcomes, activities, and data were not provided for FY 2023–24 and therefore cannot be reported. Following a competitive Request for Proposals process, this program will not receive MHSA funding in FY 2024–25.

HEALTH AMBASSADOR PROGRAM–YOUTH

HAP-Y engages youth (ages 16–24 years) in training and workshops on behavioral health and mental wellness. HAP-Y aims to train participants as mental health ambassadors in their communities to help reduce stigma, increase mental health awareness, and share resources. Youth participants engage in an extensive 14-week training program that focuses on psychoeducation and suicide prevention workshops, to prepare them to support their peers. Some of the topics included as part of the curriculum are as follows:

- Introduction to Mental Health and Stigma
- Be Sensitive, Be Brave (BSBB) for Mental Health and for Suicide Prevention
- WRAP (offered through One New Heartbeat)

- Storytelling Through PhotoVoice
- Mood and Personality Disorders
- Consent and Healthy Relationships
- Self-Care
- Substance Use Prevention
- Careers in Mental Health
- Sexual Orientation, Gender Identity, and Expression (SOGIE) + Pronouns 101
- Mental Health and the Justice System

Youth participants are required to complete three community involvement activities in which they educate their peers, share resources, and share personal lived experiences (when appropriate), to encourage them to be active advocates. The community presentation that ambassadors conduct entails a brief introduction to mental health, discussing stigma and how it plays a role in whether individuals seek support for their mental health. The presentation also focuses on depression, stress, anxiety, and healthy coping skills to address those symptoms. The presentation concludes with a suicide prevention portion—recognizing the signs, helpful things to say, and resources available.

PROGRAM IMPACT

Health Ambassador Program–Youth [a]	FY 2023–24
Clients served (unduplicated)	47
Cost per client	$6,408
Individuals reached (duplicated)	1,167
Total served	1,214

[a] Unduplicated clients served are the youth health ambassadors; individuals reached include the broader community receiving training and education from the ambassadors.

Outcome Indicators

Domain	Indicator/question	*n*	%
Self-empowerment	Due to participating in HAP-Y, I think more positively about challenges in my life. (cohort)	18 of 37	49
Stigma reduction	I feel comfortable discussing topics related to mental health. (cohort)	16 of 37	43
	I feel comfortable discussing topics related to mental health. (audience)	162 of 634	26
	I feel comfortable seeking mental health services. (audience)	248 of 634	40
Access to services	I know who to call or access online if I need mental health services. (audience)	335 of 634	53%
Community advocacy	After participating in HAP-Y, I am able to contribute to other	37 of 37	100%

	people's learning about mental health. (cohort)		
Improve knowledge, skills, and/or abilities	HAP-Y provided me with knowledge and skills that I continue to use. (cohort)	37 of 37	100%

DEMOGRAPHICS

HAP-Y Program Client Demographics (N=50)

	Number of clients	Percentage of total
Age		
0–15 years	0	0
16–25 years	50	100
26–59 years	0	0
60–73 years	0	0
74 years and older	0	0
Prefer not to answer/unknown	0	0
Primary language		
English	49	98
Spanish	1	2
Another language	0	0
Prefer not to answer/unknown	0	0
Race		
Asian or Asian American	22	44
Black or African American	1	2
Native American, American Indian, or Indigenous	2	4
Pacific Islander	1	2
White or Caucasian	5	10
Another race/multiple	19	38
Prefer not to answer/unknown	0	0
Ethnicity		
Latino/a/x or Hispanic	16	32
Caribbean	1	2
Central American	2	4
Mexican/Mexican American/Chicano	9	18
South American	4	8
Another identity or tribe	0	0
Prefer not to answer/unknown	0	0
Not Latino/a/x or Hispanic	34	68
African	1	2
Asian Indian/South Asian	7	14
Chamorro	0	0
Chinese	8	16
Eastern European	1	2

	Number of clients	Percentage of total
European	4	8
Fijian	0	0
Filipino/a/x	8	16
Japanese	0	0
Korean	2	4
Middle Eastern or North African	0	0
Samoan	0	0
Tongan	1	2
Another ethnicity or tribe	1	2
Prefer not to answer/unknown	0	0
Sex assigned at birth		
Male	6	12
Female	44	88
Prefer not to answer/unknown	0	0
Intersex		
Yes	0	0
No	46	92
Prefer not to answer/unknown	4	8
Gender identity		
Female/woman/cisgender woman	39	78
Male/man/cisgender man	6	12
Transgender woman/trans woman/trans-feminine/woman	0	0
Transgender man/trans man/trans-masculine/man	0	0
Questioning or unsure of gender identity	0	0
Genderqueer/gender non-conforming/gender non-binary/neither exclusively female nor male	1	2
Indigenous gender identity	0	0
Another gender identity	2	4
Prefer not to answer/unknown	2	4
Sexual orientation		
Gay or lesbian	3	6
Straight or heterosexual	30	60
Bisexual	8	16
Queer	2	4
Pansexual	0	0
Asexual	0	0
Questioning or unsure of sexual orientation	1	2
Indigenous sexual orientation	0	0
Another sexual orientation	1	2
Prefer not to answer/unknown	5	10

	Number of clients	Percentage of total
Disability status		
Yes	8	16
No	35	70
Prefer not to answer/unknown	7	14
Veteran status		
Yes	NA	NA
No	NA	NA
Prefer not to answer/unknown	NA	NA

REFERRALS

Mental Health and Substance Use Referrals

Type of referral	FY referrals to programs within your agency	FY referrals to other agencies	FY total
Serious mental illness referrals	0	0	0
Substance use disorder referrals	0	0	0
Other mental health referrals	0	0	0
Total	**0**	**0**	

Referrals to Other Services

Type of referral	FY total	Type of referral	FY total
Emergency/protective services	0	Legal	0
Financial/employment	0	Medical care	0
Food	0	Transportation	0
Form assistance	0	Health insurance	0
Housing/shelter	0	Cultural, nontraditional care	0
Other	0	**Total**	**0**

PROGRAM NARRATIVE

The primary goal of HAP-Y for its audiences (ambassadors and community members) is to work toward stigma reduction around mental health and help-seeking services to support mental health. Education and conversations support this goal by normalizing topics that are highly stigmatized, such as suicide prevention, substance use prevention, mental health illnesses, and help seeking. The educative conversations help clarify and demystify any misconceptions about mental health. HAP-Y programming continuously highlights that stigma serves as a barrier for individuals who may need support but are hesitant to reach out because of it. HAP-Y attempts to measure program success through an exit survey completed by ambassadors at the end of their participation in programming and through an audience survey that is administered by ambassadors after their community presentations. The data gathered through the surveys help support the effectiveness of HAP-Y.

The conversations and workshops hosted during the 14 weeks (about 3 months) of HAP-Y give participants a safe place to learn and remove any negative preconceptions surrounding mental health that can lead to discrimination against communities and individuals living with behavioral health challenges. By the end of programming, participants feel empowered and ready to bring the conversation to their community. Here are direct quotations from the HAP-Y exit survey (completed by ambassadors at the end of programming) that capture the impact of the program and of the community involvement requirement of HAP-Y:

"Something that I feel so blessed to have gotten from HAP-Y was being able to share my personal experiences with my peers and letting them know that they are not alone. Hearing everyone talk about their mental health made it feel like an extremely safe place."

"Overall, it [HAP-Y] was an amazing learning experience. I gained so much knowledge on the topics regarding mental health. The cohort group was so supportive too; it was overall great."

"My experience with presentations was greatly beneficial to myself, being able to show facts to others and enlighten not only them but myself is a great experience. Before I was unsure, but after I was more confident about my ability to share this knowledge."

"I was so excited to present what I had learned through HAP-Y and share all the new information I had gathered through my training. I felt very proud and as if I was contributing a positive thing for the environment."

HAP-Y's goal to reduce stigma goes beyond the three cohorts that take place each year; HAP-Y has a community-wide impact made possible by community events led by the ambassadors, events in which the ambassadors bring recognition to topics related to behavioral health challenges. An audience of 1,167 was reached just in FY 2023–24. Some of the community activities hosted by HAP-Y ambassadors include the following:

- Community presentation—can be viewed here
- PhotoVoice exhibit at San Carlos Library for Suicide Prevention Month
- Mental Health Jeopardy game during the annual Orgullo y Educacion (OYE) conference
- Instagram Live—can be viewed here
- Teen wellness video created by ambassadors—can be viewed here
- Stop the Violence hosted by PART Program (Positive Alternative Recreational Teambuilding Impact)

The impact of youth-led community educational presentations is immeasurable. Survey responses show that HAP-Y's presentation has been successful in raising awareness of mental health, normalizing the conversation, and sharing resources to encourage help-seeking behaviors. The majority of audience members (92%) said that they found the presentation to be helpful. Audience members shared that the presentation was effective in building empathy toward individuals with behavioral health challenges, sharing resources, and in some instances, helping audience members

accept that healing and recovery are possible. More important, audience members felt seen and validated through the presentation. Here are some direct quotations from audience member responses on surveys:

"It [presentation] states that I have the possibility of getting help and knowing where I can get support, whether it's through a hotline or meeting with someone."

"It helped me understand that I am not alone on my journey and that there are others around who are willing to help me."

These powerful quotations help us understand the power of youth-led community presentations and how they help increase confidence in talking about mental health and encourage community members to reach out for support.

The HAP-Y curriculum places an emphasis on recovery and maintaining wellness. Through the support of One New Heartbeat (a small, local nonprofit), the ambassadors were led through 8 weeks of WRAP. Through this workshop, ambassadors were asked to reflect on recovery and wellness: what it means to them, what it looks like for them, and how they can reach it when life stressors take them out of recovery and wellness. By the end of the 8 weeks, ambassadors each have their own personalized action plan to help them stay well, which helps them regain and maintain control of their lives.

HAP-Y staff and programming do an outstanding job in introducing participants to what mental health is and introducing behavioral health as a future career option for participants—70% of ambassadors who participated in HAP-Y FY 2023–24 said that their participation in the program has led them to consider a career in behavioral health. Having guest speakers with diverse career backgrounds within behavioral health has contributed to fostering a rewarding and exciting experience for professional behavioral health.

SUCCESSES

In-person cohort: During summer 2024, HAP-Y hosted its first in-person 14-week (about 3 months) program. This was the first time HAP-Y had the opportunity to host an in-person cohort since 2019. To keep its promise of being accessible to communities in San Mateo County that have been underserved, the program hosted the summer 2024 cohort in Pacifica. Although there were fewer participants compared with virtual cohorts, nine youth successfully completed the 14 weeks of HAP-Y training. Below are a couple of pictures from the HAP-Y summer 2024 cohort. All in all, the in-person cohort was a success.

PhotoVoice workshop: Each cohort participates in a PhotoVoice workshop in which participants of the current cohort share their stories in ways that are healing, empowering, and inspiring. Every cohort has a successful PhotoVoice workshop. The following is a PhotoVoice created by an ambassador. This PhotoVoice spotlights the immense impact that HAP-Y has on the lives of participants. In their PhotoVoice, the ambassador explains that through their time in HAP-Y, they were able to learn to validate their own experiences, prioritize their own mental health, and build compassion and understanding for the behavioral health challenges of their loved ones.

Resource Sharing

Finding ways to best capture the resources created by HAP-Y ambassadors has been an ongoing challenge. However, this past FY, HAP-Y staff have worked with ambassadors to better track some of the referrals. Since starting their journey with HAP-Y,
23 ambassadors have shared resources with friends and family; 17 of them reported sharing one to three different resources, and six of them reported sharing four to six different resources.

Validity

Throughout my whole life, my problems have felt like a mere drop in the ocean that is my brother's mental health struggles.
My constant anxiety and stress overachieving perfect grades seemed insignificant next to his depression and lack of motivation, and the impact it had on my mother. Although it was usually masked by frustration and anger, I could still see my mother's immense disappointment at every failed test and "forgotten" homework assignment, and I knew I couldn't let her down too. As a young mother who didn't have the chance to finish college, I know a part of her dreams live on through our academic achievements and success. If she couldn't see those dreams fulfilled through my brother, I felt it was my responsibility to make sure she could experience them through me.
During my parents' divorce, one of the hardest times of my life, I felt trapped in my own suffering. I couldn't bring myself to reach out, feeling like how I felt paled in comparison to my brother's struggles as he not only had to go through my parents' separation but also battle depression and severe social anxiety. So, I struggled in silence, developing unhealthy ways to cope with how I was feeling.
However, these feelings of invalidity began to change when I began my time at HAP-Y. Through the program I began to understand that everyone's feelings, everyone's battles, are valid no matter what. I began to practice self-care more often, I began to open up more to those around me, and I began to feel more confident in my own mental health than ever.
-You are Valid

CHALLENGES

A challenge that HAP-Y faced toward the end of the FY was the low number of youth enrolled in the final cohort of the year. Hosting HAP-Y's summer cohort in person was exciting, and the youth who participated seemed to enjoy the conversations and discussions during the in-person meetings. However, although there was a lot of interest in HAP-Y at the beginning, of the 22 youths who submitted applications and interviewed for the summer cohort, only 11 agreed to participate with the commitment of attending all in-person sessions. HAP-Y staff acknowledges that an all-in-person cohort does not make the program accessible to all youth. Moving forward, HAP-Y will follow a hybrid model: 12 weeks virtually and 2 weeks in person.

BRIEF INTERVENTION MODEL – INSPIRE

INSPIRE – Innovative Strategies for Prevention and Intervention through Restorative Education provides is an alternative to suspension program that allows youth to learn about the effects of their substance use to recognize triggers and create a plan to address it. The program is offered by the Daly City Youth Health Center for Jefferson Union High School District students.

Youth who are identified as using substances (marijuana, alcohol, tobacco, vapes, etc.) on school campuses can face disciplinary action. These youth have the option to attend INSPIRE, which helps students have an in-depth understanding of the dangers of their use, optimize decision-making skills, develop better communication skills, increase emotional control and self-awareness. This program utilizes three 30-45 minute sessions, including brief interventions, that help to assess the students' readiness to change.

INSPIRE will be included in the PEI framework for data collection and reporting this FY 2024-25 to ensure individual-level data can be collected and shared for the youth participating in the program.

YOUTH CRISIS RESPONSE

The Youth Stabilization, Opportunity, and Support (Youth S.O.S.) team was a program under StarVista's Crisis Center, in partnership with San Mateo County BHRS, that provided over-the-phone and/or in-person response to youth (ages 0–25 years) living in San Mateo County. The Youth S.O.S. program sunset as planned on August 31, 2024. The new San Mateo County Mobile Community Response Team (MCRT) provides non-law enforcement behavioral health crisis intervention services to adults, older adults, children, youth and families.

Youth S.O.S. responded to youth who were experiencing an escalation in mental health symptoms ranging from suicidal ideation to undiagnosed mental health disorders. The Youth S.O.S. team was staffed with mental health clinicians and family partners (and one youth peer partner). Together, those roles provided comprehensive suicide and crisis assessment, psychoeducation, brief individual counseling, and case management for family needs. In addition, the Youth S.O.S. team provided San Mateo County schools assistance with suicide assessments and/or crisis intervention.

This program prioritized marginalized ethnic, linguistic, and cultural communities in San Mateo County. This included youth who had experienced abuse, were currently or had formerly been in foster care, experienced unstable housing/homelessness, and belonged to the LGBTQ+ community. The Youth S.O.S. team was also responsible for in-person mobile crisis response for the California Family Urgent Response System to support current and former foster youth as well as their caregivers when crisis occurred. The California Family Urgent Response System program states that it "is a coordinated statewide, regional, and county-level system designed to provide collaborative and timely state-level phone-based response and county-level in-home, in-person mobile response during situations of instability, to preserve the relationship of the caregiver and the child or youth."

The overall goals of the Youth S.O.S. team were to decrease youth psychiatric emergency services (PES) visits, decrease hospitalization for self-harm, decrease emergency calls to law enforcement for youth in crisis, and improve family/caregivers' ability to navigate crisis and increase access of services. As the mobile responders for the California Family Urgent Response System, the team's goal also strove to maintain and support stability of youth in foster care placement and improve trust between youth and caregivers.

PROGRAM IMPACT

Youth Stabilization, Opportunity, and Support [a]	FY 2023–24
Clients served (unduplicated)	147
Cost per client	$6,505
Individuals reached (duplicated)	10
Hotline phone calls	11,448
Total served	11,605

[a] *Unduplicated clients served are youth served by the mobile crisis response; individuals reached include the family members or caregivers of youth served and/or individuals reached through outreach/education.*

Crisis Hotline Outcomes

	Total
24/7 crisis hotline	
Total number of calls	11,448
Average length of calls (in minutes)	7.5
Number of follow-up requests	176
Number of follow-ups provided	249
Number of 988 texts received (NEW)	585
Number of 988 texts answered (NEW)	518
Number of 988 chats received (NEW)	240
Number of 988 chats answered (NEW)	213
Percentage of callers who received service linkages and referrals to service providers as appropriate	100
Teen crisis services (web-based services, text suite pilot)	

	Total
Total number of chats	33
Total number of texts	21
Total site views	7,371
Suicide prevention presentations and outreach	
Total number of tabling events	22
Total number of contacts at tabling events	3,843
Total number of presentations	34
Number of adults served	396
Number of youth served	882
Number of youth requesting follow-up	23
Number of youth who received follow-up	0
Youth Stabilization, Opportunity, and Support	
Total number of referrals	157
Total number of in-person responses	10
Total number of youth served with in-person response	9
Response time	
Immediate (1 hour)	24
Delayed (3 hours)	0
Follow-up (24+ hours)	4
Phone consultations/de-escalation	
School/community provider	1
Youth	3
Caregiver/family member	9
Percentage of youth deferred from psychiatric hospitalization through means of safety plan	100
Total number of youth deferred from use of psychiatric emergency services through means of safety plan	NA
Total number of youth referred to psychiatric emergency services after in-person crisis response	3
Total number of youth whose in-person crisis response resulted in incarceration	0
Family Urgent Response System	
Total number of referrals	8
Total number of in-person responses	7
Total number of youth served with in-person response	2
Response time	
Immediate (1 hour)	6
Delayed (3 hours)	0
Follow-up (24+ hours)	1
No in-person response occurred	1

Currently, StarVista does not have the data to assess outcomes for this program. Although outcome tracking was a key priority, the necessary data were not collected to provide a comprehensive evaluation. The Youth S.O.S. program closed on August 31, 2024, and there was no plan for the

agency to begin collection of data given this closure. As a result, no outcome data were collected in FY 2023–24, and no further data collection occurred before the program ended.

Outcome Indicators

Domain	Indicator/question	*n*	%
Improved knowledge, skills, and/or abilities	Number of youth who learned a new coping strategy to increase mental, emotional, and relational functioning	NA	NA
Connection and support	Number of youth who can identify and feel safe reaching out and contacting at least one adult when they are experiencing emotional distress during a follow-up session	NA	NA
Self-empowerment	Number of youth who can identify and feel confident accessing emergency mental health services when their emotional distress is high	NA	NA
Knowledge and access to services	Number of caregivers or family members who received psychoeducation and resources to increase youth' community and relational support (population = family members/caregivers of youth)	NA	NA
Utilization of emergency services	Youth diverted from use of psychiatric emergency services (population = youth who received Youth Stabilization, Opportunity, and Support services) Youth who did not require law enforcement intervention (population = Youth Stabilization, Opportunity, and Support services)	NA	NA

DEMOGRAPHICS

Similarly to the outcome data, demographic information for program participants was not collected in FY 2023–24. Although gathering demographic data was recognized as valuable for understanding the population served, the necessary systems were not implemented. Given the program's closure on August 31, 2024, and the decision not to initiate new data collection efforts, no demographic information was gathered during this period or in the program's final months of operation.

REFERRALS

Mental Health and Substance Use Referrals

Type of referral	FY referrals to programs within your agency	FY referrals to other agencies	FY total
Serious mental illness referrals	0	0	0
Substance use disorder referrals	0	0	0
Other mental health referrals	1	7	8
Total	**1**	**7**	**8**

Referrals to Other Services

Type of referral	FY total	Type of referral	FY total
Emergency/protective services	0	Legal	0
Financial/employment	0	Medical care	1
Food	0	Transportation	0
Form assistance	2	Health insurance	2
Housing/shelter	0	Cultural, nontraditional care	0
Other (SMART, FAST, etc.)	16	**Total**	**21**

PROGRAM NARRATIVE

Throughout its operational years, including FY 2023–24, the Youth S.O.S. team provided telephone de-escalation and in-person response to youth and families in crisis, addressing all concerns through trauma-informed de-escalation strategies. Clinicians consistently assessed the need for higher level interventions during initial crises and provided follow-up care as needed or requested by youth and families. The multidisciplinary team offered appropriate resources to youth and families at the time of response and through follow-up, which included the following:

- Linkage to existing services
- Coordination with physicians and/or psychiatrists
- Basic needs assessment
- Other community supports

These interventions enhanced awareness and knowledge of services among underserved populations and supported families in understanding and accessing public health services. Family partners worked alongside families, offering psychoeducation about mental health and mental health services. Many families entering S.O.S. services had significant stigmas about receiving support from systems of care. Family partners consistently worked to break down these stigmas nonjudgmentally and offered support services to families not already connected to care.

Improves timely access and linkages for underserved populations: The team provided appropriate resources to youth and families at the time of response and through follow-ups, including basic needs, community support, and therapeutic support.

Reduces stigma and discrimination: The team prioritized the needs of marginalized communities by providing culturally competent, confidential, and nonjudgmental services. They educated caregivers and community members about mental health challenges, helping to normalize these issues and reduce stigma in the community over time.

Increases number of individuals receiving public health services: Family partners supported families with psychoeducation about mental health and assessed their needs. They worked to break down

stigmas nonjudgmentally and offered support services to families not already connected to care. They assisted families in connecting to public health services and other community resources.

Reduces disparities in access to care: Family partners supported families with psychoeducation about mental health and assessed their needs. They worked to break down stigmas nonjudgmentally and offered support services to families not already connected to care. They assisted families in connecting to public health services and other community resources.

Implements recovery principles: The program centered on using the least invasive interventions, highlighted by the following recovery principles:

- Self-direction: Clients, with clinician support, determined their own path to their safety plan.
- Individualized and person centered: Clients received responses, resources, and safety plans tailored to their unique strengths, needs, preferences, experiences, and cultural backgrounds.
- Empowerment: Clients chose among options and participated in all decisions affecting them.
- Nonlinear: Suicidality was recognized as a multistep process involving continual growth, occasional setbacks, and learning from experiences.
- Strengths based: Focus was placed on building on clients' strengths.
- Peer support: Clients, with clinician assistance, examined their support systems.
- Responsibility: Consumers were responsible for their own self-care and recovery journeys.

Other activities that benefit clients: The program provided crisis services following suicides in school communities. Staff and students benefited from rapid response to schools during these critical times.

SUCCESSES

Client Story: The clinician responded with a family partner and met a client who was hyperverbal, with pressurized speech and loose associations and demonstrating flight of ideas. The clinician tracked the client's verbiage and used reflective listening, empathy, and unconditional positive regard. The clinician tried to ask questions, and there was some indication the client may have been experiencing a manic episode. The clinician tried to join with the client and validate his thoughts and emotions. When it became apparent that hospitalization was needed, the clinician requested that parents contact SMART (San Mateo Assessment and Referral Team) so that they could transport the youth and for there to be a soft response (no sirens, no police car). The clinician went back inside to de-escalate the client while law enforcement and medical teams responded. After all parties arrived and discussed the next course of action, all parties agreed that it would be best for the client to go with parents to the hospital to lessen any potential traumatic experiences or responses. The clinician kept in constant contact with parents to ensure that the client was hospitalized, which he was, on a 5585 hold, because of homicidal ideation and, later, suicidal ideation statements at the hospital. The clinician also created a safety plan with parents to help prepare for the son's release. The client was

already connected to mental health support, and parents were advised to set an appointment as soon as the son was discharged.

CHALLENGES

There was a significant number of third-party callers who were both educators (14%) and counselors/clinicians (20%) from the school districts calling regarding a client. However, requests for an in-person response were a fulfillable service only if the clients themselves requested the support or if a parent/legal guardian of the minor in crisis had been the one requesting an in-person response, because of the limitations of the Youth S.O.S. program. Unfortunately, because the Youth S.O.S. program ended, there is no current plan to mitigate these challenges in the future.

PEI PROGRAMS – PREVENTION

TRAUMA-INFORMED 0–5 SYSTEMS

In FY 2023–24, First 5 San Mateo County continued its multisector initiative to transform the service sector for young children and their families. The Trauma- and Resiliency-Informed Systems Initiative (TRISI) is a countywide effort to integrate a comprehensive commitment to address trauma and promote resiliency into local programs, structures, and culture with a long-term goal of embedding trauma- and resiliency-informed policies and practices at every level. The strategies and targets for the initiative include the following:

- Training and support for child- and family-serving organizations to embed trauma-informed practices in their internal operations,
- Training and resources on trauma-informed practices for professionals working with children and families, and
- Education for parents to help recognize the signs and symptoms of trauma.

The current initiative focus is primarily on the first level shown previously: training and support for child- and family-serving organizations to embed trauma-informed practices in their internal operations.

Through an extensive planning process with cross-sector partners, the initiative has established the following areas of focus:

- Systems strengthening: focused on system leaders, organizational leaders, and policymakers
- Practice improvement: focused on organizational leaders, managers, and all staff
- Initiative evaluation: to measure strides made by organizations to become more trauma- and resiliency-informed

Progress to date prior to this reporting period includes the following:

- *Online resource hub:* Development of a local online resource hub targeted at providers and other interested community members.
- *Market assessment survey:* Creation, dissemination, and analysis of an online market assessment survey designed to gauge the interest of local stakeholders in family-serving organizations in trauma-informed training and stages of organizational readiness.
- *Countywide trauma convening:* Hosting of a full-day Culture of Care Convening focused on supporting trauma-informed organization (TIO) practices for child- and family-serving organizations attended by more than 150 individuals and more than 40 agencies.
- *Organizational assessment tool:* Identification of an organizational assessment tool to determine stages of readiness and areas for growth for child- and family-focused organizations interested in furthering their TIO practices; outreach/education to publicize the tool for first tranche of organizations; and linkage and support for completing the tool and disseminating results internally for said organizations.
- *TIO cohorts and coaching:* Support the deepening of TIO practices for an initial round of organizations by offering ongoing training, support, and action plans through group work in cohorts and specific agency-focused goals through coaching.
- *Development of TRISI 2.0:* Planned for and designed the second phase of the assessment, cohort, and coaching model with and for three of the largest child- and family-serving public agencies in San Mateo County.
- *TRISI 2.0 initial implementation:* Launched three offerings for the three participating agencies: TIO assessments, trauma-informed agency coaching, and cross-agency cohort.

In FY 2023–24, the primary goal for this work was to support the implementation of the second round of TRISI (2.0), which began more than a year ago. It focused on supporting three of the largest child- and family-serving public agencies/departments in San Mateo County that collectively support nearly 1,000 employees and serve an untold number of children and families through their work. The partner agencies include the San Mateo County Office of Education, San Mateo County Health: BHRS, and Child and Family Services within the San Mateo County Human Services Agency.

This past year, TRISI evolved as a result of the cycle of continuous quality improvement. Input from agency leaders and the TRISI Core Team the previous year resulted in prioritizing agency-specific coaching with a focus on alignment with existing initiatives and priorities. The coaching was intentionally prioritized over the multiagency cohorts, given the resources required to bring such large public agencies on board with concepts that are new to many. Feedback from participants from the previous year indicated that the cross-agency work would be more effective if sequenced to take place after each agency is further along with embedding TIO practices independently.

PROGRAM IMPACT

Trauma-Informed 0–5 Systems	FY 2023–24
Total clients served [a]	446
Total cost per client	$277

[a] For the purposes of this project, the clients served are, most directly, the staff and providers working within the target agencies that serve children and families in San Mateo County. In this context, the MHSA intended outcomes would be sought for providers within our community that work to serve the public.

In the first year of TRISI 2.0, staff from the three target agencies completed the Trauma-Informed Organizational Practices Assessment Tool. Although the TIO Assessment Tool does not ask specific questions about the mental health status or outcomes for agency staff, the overarching intention of building a community of TIOs is consistent with supporting positive mental health practices and outcomes for staff of child- and family-serving organizations.

The following data reflect information collected from those who completed the Assessment Tool in FY 2022–23, although they did not receive the TIO Agency Summary for each department until the beginning of FY 2023–24. These reports detailed the agency's aggregate score in each domain rated by staff who completed the survey as well as high-level comments or themes from the comment sections for each domain area. The reports are intended to provide vital information to the agency about growth opportunities and areas of strength related to trauma-informed agency practices.

Each agency has taken different approaches to integrating the results into planning and goal setting. At least one agency has explicitly used the findings from the assessment to update their agency workplan focused on equity, diversity, and healing. Others are committed to using the assessment findings to guide their priorities for their TIO-focused work moving forward.

The high-level summary data gathered from the 446 participants within the three agencies who completed the TIO Assessment Tool in the 2022–23 grant year are included next. To note, these data do not include the previous data set from the first round of TIO Assessment with the first round of agencies (346 staff participants within seven of the eight agencies). The combined data could be combined and assessed collectively in the future if desired.

High-level aggregated results of the TIO Assessment (all results are on a 4-point scale):

Domain Averages:
Safety: 3.05
Trustworthiness and Transparency: 2.97
Peer Support: 2.9
Collaboration and Mutuality: 2.84
Empowerment, Voice, and Choice: 2.65
Cultural, Historical, Race, and Gender Awareness: 3.05
Administrative and Policy Support: 2.75

Overall Average: 2.9
Percentage of respondents reporting that their organization is at a given Stage of Organizational Development for Trauma-Informed Practices:
Stage 1: 41%
Stage 2: 28%
Stage 3: 19%
Stage 4: 13%

SUCCESSES

The primary success of FY 2023–24 was that three of the county's largest child- and family-serving agencies remained involved and committed to exploring and implementing TRISI, despite the work being difficult by nature. The exposing and undoing of harmful or toxic workplace practices is difficult, messy, slow moving, and nonlinear. Experts in the field would maintain that if the work feels hard, that likely means progress and growth are happening. Given this reality, the commitment of high-level leaders in each participating agency and department should not be understated.

Along similar lines, the fact that all three large agencies are committing to this work in partnership with each other and using that joint commitment to learn from each other in their agency journeys and to hold each other accountable is even more powerful. Leaders of the three agencies met monthly with the First 5 San Mateo County program manager and deputy director to provide each other with updates and to co-plan a retreat with key members of their staff to take place in August 2024.

As noted above, the strategy for this past year centered on the desire of each agency to pursue its own TIO path in ways that felt aligned and responsive to the feedback from staff participants and leadership. It was the right decision to support agency engagement and sustainability. The following are a few additional successes by agency:

BHRS: For the first half of the year, BHRS used the support of an organizational coach to update an existing plan focused on multicultural organizational development with a more trauma-informed overlay. In the second half of the year, the work of the coach has been spent supporting the dissemination of the updated multicultural organizational development plan with new leaders and alongside Race, Equity, Diversity, & Inclusion (REDI) efforts so that the work is comprehensive and aligned rather than seen as just another short-term initiative. The coaching has been targeted to a

small group of agency leaders and change-makers in this phase, with an eye toward broader agency expansion in the future.

Child and Family Services: The Child and Family Services team took the basis of trauma-informed learning from the past year and decided to go deeper in two specific TIO implementation areas without the support of an agency coach provided by First 5 San Mateo County. The primary focus of their TIO work this year has been to participate in a statewide offering to help their department take up the practice of reflective supervision. Reflective supervision is designed to improve the quality of intervention by helping providers develop critical competencies and manage powerful emotions that often accompany the work. This modality is particularly supportive for providers who are likely to have a high incidence of vicarious trauma, such as those working in the child welfare system. Child and Family Services workers and supervisors across the state had a unique opportunity this year to receive training in this modality, which was covered by the state. Staff see this as a way of mitigating vicarious trauma and sustaining them in the work. In addition, staff organically started a support group among themselves to care for each other and particularly to address vicarious trauma.

San Mateo County Office of Education: This past year, the San Mateo County Office of Education spent dedicated time rolling out their recently completed strategic plan to staff and the public. This effort took priority during the year alongside deeper equity-focused work; therefore, the TRISI-focused work at the San Mateo County Office of Education did not use a coach until the second half of the year. Because of internal transitions and medical leave for key San Mateo County Office of Education leaders, the work experienced a significant delay and is requiring a restart to refresh staff, align the work to the strategic plan, and integrate with the support of staff. The assigned TRISI coach and leadership met in spring 2024 to develop some goals, to set a work plan to support the upcoming year of funding, and to avail themselves of the coaching resource.

CHALLENGES

As noted previously, the decision to decentralize elements of the TRISI process in service of prioritizing individual agency-specific priorities and alignment was important to sustaining engagement and buy-in for agency participants. Although this certainly was a necessary shift, decentralizing also has had its challenges. As agencies pursue their own paths toward a more trauma-informed future, approaches, dosage, and consistency across agencies have varied considerably.

Maintaining consistent engagement and keeping TRISI visible as a priority with other competing forces such as leadership changes and multiple other initiatives are challenging at times. The differences in approach and focus also can prove challenging when determining evaluation strategy and process. Thankfully, with the support of Susan Wolfe as the TRISI evaluator, evaluation is taking shape and promises to be a rich experience with results planned to be shared out in the coming year.

SUBSTANCE USE PREVENTION

MHSA funding is supporting the implementation of the recommendations from three community-led assessments conducted to better understand the unique substance use needs, contributing factors, and prevention opportunities within historically underrepresented communities. Implementation activities for the community assessment follow-up include:

- Identification of community health topics to address.
- Research to determine best practices and proposal for at least one mid- to long-term effort as prioritized by the community.
- 7 community educational presentations.
- Quarterly community gathering events are conducted to bring the community together for health education, strategic conversation, and/or implementation of a health improvement program.

Following is a summary of the assessments and recommendations:

- **African American community assessment coordinated by Bay Area Community Health Advisory Council (BACHAC):** The first-ever community assessment by and for Black/African Americans in San Mateo County gathered input from 441 participants (371 surveys, 59 focus group participants, 11 key informant interviews). While most reported no substance use, those who did cited isolation, racism, financial hardship, and stress as primary reasons. Recommendations include developing culturally-centered mentorship programs, strengthening community connections, implementing cultural competency training, expanding outreach services, and creating youth leadership opportunities designed by and for Black community members.
- **Latinx community assessment coordinated by Ayudando Latinos A Soñar (ALAS):** This assessment gathered input from 598 participants (481 surveys, 117 in focus groups and interviews) to identify factors influencing substance use, mental health, and wellbeing in the Latino/e/a community. Five key recommendations emerged: addressing financial challenges, providing outreach for culturally informed services, decreasing substance abuse, supporting youth-driven and family-centered programs, and building capacity for existing providers to serve more Latino youth and families.
- **Tongan community assessment coordinated by Taulama for Tongans:** Data from 400 participants (353 surveys, 12 interviews, 2 focus groups) revealed that cost of living and housing affordability create significant stress, substance use is viewed as a social norm among

adults while youth use it as an escape, and community members lack awareness of available services. Protective factors included the central role of churches and strong community support. Recommendations focused on increasing County-Tongan organization collaboration, creating educational pathways to improve Pacific Islander representation in County employment, and addressing economic challenges through living wage opportunities and affordable housing.

This program will be included in the PEI framework for data collection and reporting this FY 2024-25 to ensure program impact information can be collected and shared in future annual updates.

OFFICE OF DIVERSITY AND EQUITY (ODE)

The MHSA provided dedicated funding to address cultural competence and access to mental health services for underserved communities; in San Mateo County, this led to the formal establishment of the ODE in 2009. The 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, the ODE works to promote cultural humility and inclusion within BHRS and in partnerships with communities through the following programs:

- Health Equity Initiatives
- Health Ambassador Program
- Adult Mental Health First Aid
- Digital Storytelling and PhotoVoice
- Parent Project
- Stigma Free San Mateo—Be the ONE Campaign
- San Mateo County Suicide Prevention Committee

PROGRAM IMPACT

The ODE measures progress along five indicators. These definitions are influenced by (a) public health frameworks and (b) the ODE's mission, values, and strategy.

Office of Diversity and Equity (across all programs)	FY 2023–24
Individual clients served (unduplicated)	2,002
Individuals reached (duplicated)	28,497
Total individuals reached	30,499

- Self-empowerment—enhanced sense of control and ownership of the decisions that affect one's life
- Community advocacy (or community empowerment)—increased ability of the community to influence decisions and practices of a behavioral health system that affect their community

- Cultural humility—heightened self-awareness of community members' culture impacting their behavioral health outcomes; heightened responsiveness of behavioral health programs and services for the diverse cultural communities served
- Access to treatment/prevention programs (reducing barriers)—enhanced knowledge, skills, and ability to navigate and access behavioral health treatment and prevention programs despite potential financial, administrative, social, and cultural barriers
- Stigma discrimination reduction—reduced prejudice and discrimination against those with mental health and substance use conditions

HEALTH EQUITY INITIATIVES

In 1998, San Mateo County's BHRS workforce employees began to have serious conversations about racial and ethnic gaps within the department's services, including the lack of diversity and cultural sensitivity within the clinical work that the county offered. From these conversations, the staff realized that there was a need to address the access and quality of care issues among underserved, unserved, and inappropriately served communities within the county.

Over time, several priority communities were identified, including African Americans, Chinese residents, Filipinos, Latino/a/x people, Native and Indigenous people, Pacific Islanders, and LGBTQIA+ people. Out of both opportunity and great need, BHRS created nine HEIs that have become vehicles to promote cultural humility and community empowerment. Each of the nine HEIs addresses health disparities, inequities, and stigma by working collaboratively to bring together mental health professionals, residents, clinicians, organizations, and stakeholders on a regular basis to provide outreach, programs, and advocacy toward meaningful solutions for our communities. HEIs implement activities that are intended to

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

ODE provides oversight to nine HEIs representing specific ethnic and cultural communities that have been historically marginalized. The following is a high-level statement of purpose for each initiative:

- The AACI aims to be a known resource and support system for African American community members facing challenges with finding and using mental health services while addressing inequalities faced by African Americans in the county.
- The CHI works with the community to empower and support better outcomes for prevention, outreach, and referrals, while also advocating for services to be in the appropriate language and culturally relevant to community members.
- The FMHI seeks to connect and empower Filipinos toward mental health and social services and reduce stigma, while advocating for culturally appropriate services through provider collaboration.

- The LC promotes holistic practices that integrate Latino/a/x heritage, culture, spirituality, and family values to destigmatize mental health services and treatments in the community.
- The NIPI was created to bring a comprehensive revival of Native American community in San Mateo County through awareness, health education, and outreach that honors culturally appropriate, traditional, Native healing practices.
- The PII aims to address health disparities experienced by Pacific Islander families and to help change systems and policies to better meet community needs through awareness, prevention, capacity building, and leadership.
- Using an interdisciplinary and inclusive approach, the PI seeks to support and advocate for the well-being of LGBTQQI communities across the county.
- The SI works to build opportunities for community members, families, and providers to collaboratively explore, increase awareness of, and support spirituality and its relationship to health and well-being.
- The DEC is an advisory board to ensure that BHRS policies are designed and implemented in a manner that strives to decrease health inequalities and increase access to services.

PROGRAM IMPACT

HEIs hosted various events, trainings, and presentations as forms of intervention. Overall, HEIs held **12** community-driven events, **29** presentations/ trainings related to behavioral health, and **19** outreach activities (e.g., supporting community efforts, tabling, etc.) throughout the fiscal year.

Health Equity Initiatives (HEIs) [a]	FY 2023–24
Individuals reached (duplicated) through HEI monthly meetings	1,262
Individuals reached (duplicated) through HEI trainings, events, and other activities	8,231
Total individuals served	9,493
Total cost per client	$4

[a] Unable to report unduplicated clients; HEIs focused on broad community awareness and system change strategies (presentations, events, and trainings).

Events:

- **AACI:** Black History Month; Juneteenth Celebration
- **CHI:** Lunar New Year Celebration
- **LC:** Annual Health Forum “¡Sana, Sana, Colita de Rana!”; Cesar Chavez event in collaboration with Voices of Recovery San Mateo County (VORSMC)
- **NIPI:** Native Heritage Month; Native Heritage Gathering
- **PII:** Journey to Empowerment: Arts and Voices Exhibit
- **PI:** Pride Celebration and Parade; Trans Action Day of Change

- **SI:** Interfaith National Day of Prayer; May Mental Health Month Healing Connections: Open Mic event

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 toward these goals by providing support and information about mental health and recovery services to BHRS clients and residents.

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

- Awareness: Increase overall community awareness and involvement of community members in the AACI.
- 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 MHFA, PhotoVoice, and Applied Suicide Prevention.
- Employment: To advocate for the staffing of at least one African American clinician or peer-support provider (licensed marriage and family therapist, licensed clinical social worker, and other providers) in each service area of BHRS.
- Research: To provide feedback and inform San Mateo County BHRS regarding African American community as result of surveying through the OCFA, 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 the AACI and to reach out to the African American community.
- Partnership: Partner with other organizations and HEIs from the ODE to support AACI and African American clients and professionals as well as other diverse groups; link and collaborate with other entities that work in various capacities with African American community members.

Highlights and accomplishments: To reduce disparities in access to care, the AACI sought to foster deep relationships and connection among African American residents. One of those efforts was illustrated in this year's Black History Month celebration, which centered around the theme "African Americans and the Arts Wellness Event." The program included live singing of the Black National Anthem; a presentation on "Art and Behavioral Health: Promoting Mental Wellness Through Art in the African American Community"; spoken word from a local East Palo Alto poet; spirit dancing; resource tabling from several health agencies across the county; intimate talks concerning health, wellness, and Black behavioral health; and a proclamation honoring East Palo Alto African American residents and their many contributions to their communities. The AACI also participated in organizing and hosting the following events:

- Black History Month Celebration
- Juneteenth Celebration

Total individuals reached in FY 2023–24:

- HEI monthly meetings: 135
- Trainings, events and other activities: 201

Black History Month Celebration 2024—Event Overview and Outcomes

The AACI co-hosted a Black History Month Celebration with VORSMC San Mateo County. The event theme was "African Americans and the Arts Wellness Event." Held at East Side College Preparatory in East Palo Alto, the gathering attracted more than 65 participants.

Data collection:

- 83 demographic and event evaluation sheets collected
- Evaluation method: Virtual and paper copies
- Incentive: Lunch ticket for completing evaluation

Participant feedback: Participants rated their experience on a scale ranging from 1 to 10 (1 = *strongly disagree*, 5 = *neutral*, 10 = *strongly agree*).

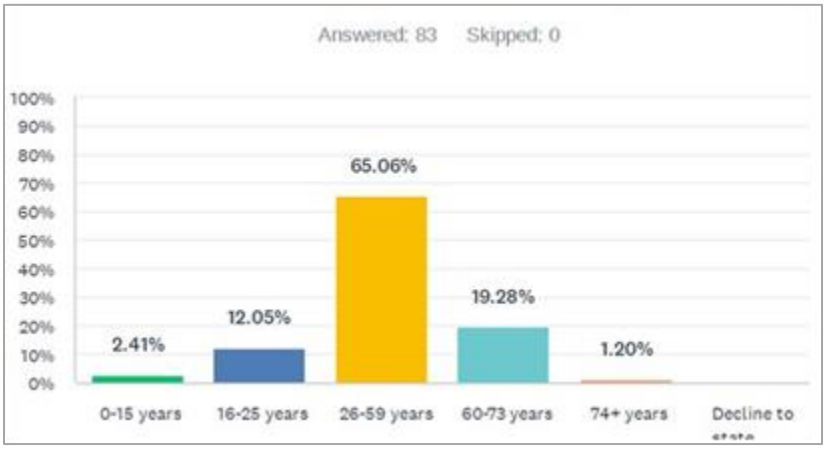
Key outcomes (highest to lowest average rating):

- This program/training/event affirmed that people with mental illness are capable and able to make positive contributions to society. (average rating: 8.68)
- Through my participation in this event/program/training, I have learned knowledge and skills that I can use to access behavioral health services. (average rating: 8.35)
- I feel like my identity, cultural background, and experiences (race, ethnicity, gender, religion, etc.) were affirmed by this program/training/event. (average rating: 8.29)
- Due to my participation in this program/training/event, I feel more confident in my ability to create change in my community. (average rating: 8.29)

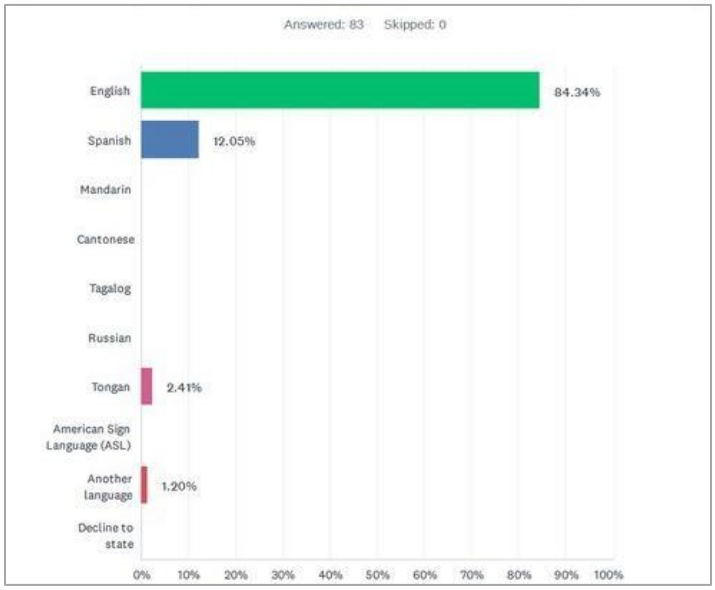
- Due to my participation in this program/training/event, I am more confident in my ability to advocate for the behavioral health needs of myself and/or my child/ren and/or another family member. (average rating: 8.29)
- Due to this program/training/event, I feel more comfortable talking about my mental health and/or substance use. (average rating: 8.12)

Sample event demographics:

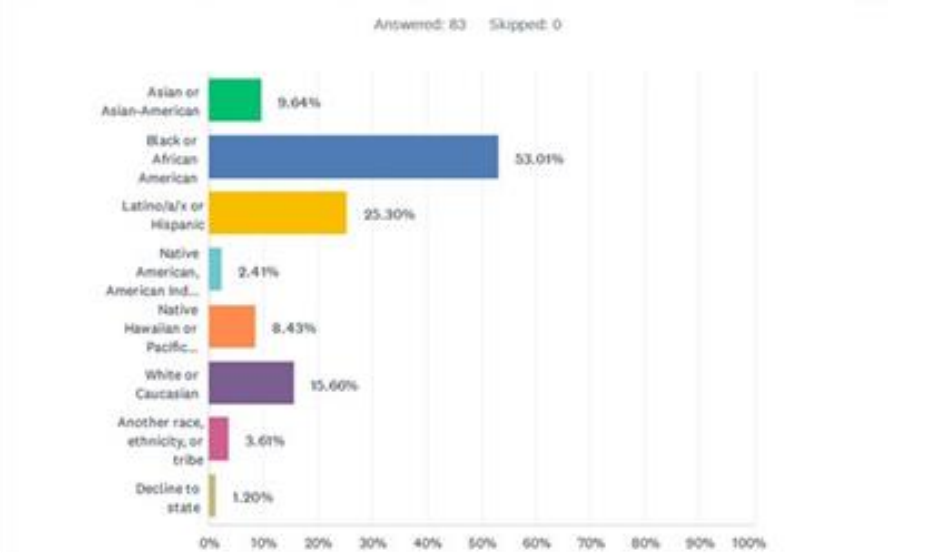
Question 1—What age range are you under (check one)



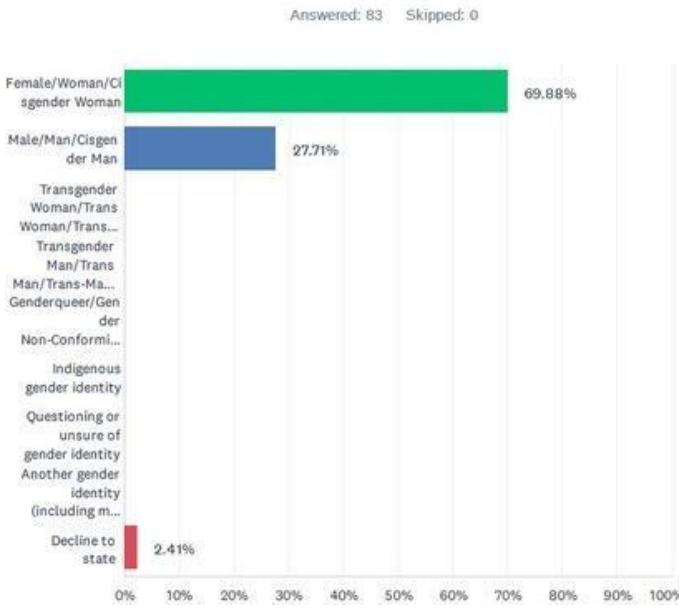
Question 2—What is your primary language spoken at home (check one)



Question 3—What race(s)/ethnicities(s) do you identify with (check ALL that apply)



Question 4—What is your gender identity (check one)



Diversity and Equity Council (DEC)

The DEC works to ensure that topics concerning diversity, health disparities, and health equity are reflected in the work of San Mateo County's mental health and substance use services. The formation of the DEC can be traced back to 1998 when staff members formed the Cultural Competence Committee. This committee later became the Cultural Competence Council in 2009, which played an integral role in the formation of the ODE and met the Department of Health Care Services (DHCS) Cultural Competence Plan Requirements (per California Code of Regulations, Title 9, Section 1810.410).

Mission, vision, and objectives: The council serves as an advisory board to ensure that BHRS policies are designed and implemented in a manner that strives to decrease health inequalities and increase access to services.

Highlights and accomplishments: In FY 2023–24, the DEC, with the support of ODE consultant Tania Perez, was able to dive deeper into strategic planning and overall alignment with HEI strategies/vision. DEC members had the opportunity to be part of an input process to prioritize activities and areas of work. This information will be used to create a comprehensive long-term workplan for the DEC and, more immediately, support the upcoming activities for FY 2024–25. Other highlights for this year included ongoing support for the Cultural Stipend Internship Program (CSIP) intern and inclusion in BHRS and county policy review/community feedback opportunities.

The results of the input process highlighted the following: WET on (a) Compassionate Leadership Training, (b) Understanding Trauma: Effects and Recovery, and (c) SOGIE training. In addition, members gave priority to

- Establishing a platform to showcase available services for community members.
- Exploring language access for behavioral health services (e.g., suicide prevention hotline in Chinese).
- Implementing trauma-informed practices within existing systems.
- Developing collaborative projects that prioritize information creation that focuses on access to services in underserved communities.
- Reviewing services/programs with respect to health equity issues in the county.

Total individuals reached in FY 2023–24:

- HEI monthly meetings: 262
- Trainings, events and other activities: 37

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 San Mateo County Health. 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 CHI has three key goals: (a) establishing a peer support network where members can learn and find support; (b) increasing membership and partnerships; and (c) bringing awareness of the needs and gaps of Chinese residents in San Mateo County. The CHI has accomplished this by harnessing the co-chairs' expertise and passion for serving the Chinese community, engaging members, and forging key partnerships within BHRS and with CBOs. It has been extremely beneficial to have the two co-chairs bring different skills to the CHI and have the

combination of one chair working within the county and one leading a CBO with a similar mission to that of the CHI.

Highlights and accomplishments: The CHI co-chairs took a proactive step in understanding members' needs by creating a survey. The feedback was invaluable, guiding them to continue with online meetings while also providing in-person opportunities to network and learn. The survey also helped identify different workshop topics that members were interested in, which have since been incorporated into monthly meetings. Specific accomplishments include the following:

- "What I Wished My Parents Knew About Mental Health" workshop in collaboration with Chinese Community Association of Belmont, Redwood Shores, and San Carlos
- "Love Does Not Hurt: Domestic Violence Awareness Seminar" workshop conducted by CORA and StarVista
- Lunar New Year in-person meeting
- March 2024 Board of Supervisors meeting to advocate for more awareness in the Chinese community
- Co-chairs engage as advisory members of the Music Therapy grant for North East Medical Services
- Collaboration with StarVista for an online behavioral health support group for residents
- Innovative workshops, trainings, and other community opportunities for members to participate outside of the monthly meetings

Total individuals reached in FY 2023–24:

- HEI monthly meetings: 152
- Trainings, events and other activities: 179

"What I Wish My Parents Knew" Workshop—Event Overview and Outcomes

The CHI, a part of San Mateo County BHRS's ODE, hosted a family and community workshop titled "What I Wish My Parents Knew." This event was organized in collaboration with valued partner agencies and community members. Held in Redwood City, the workshop attracted more than 50 participants.

Data collection:

- 12 demographic sheets collected
- 9 event evaluation sheets collected
- Evaluation method: virtual and paper copies

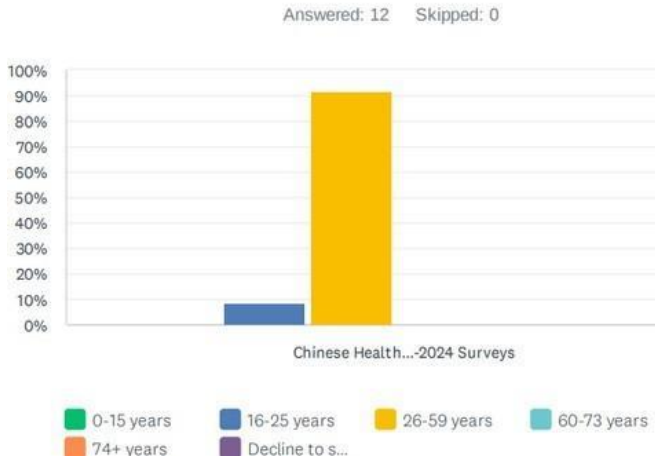
Participant feedback: Participants rated their experience on a scale ranging from 1 to 10 (1 = *strongly disagree*, 5 = *neutral*, 10 = *strongly agree*).

Key outcomes (highest to lowest average rating):

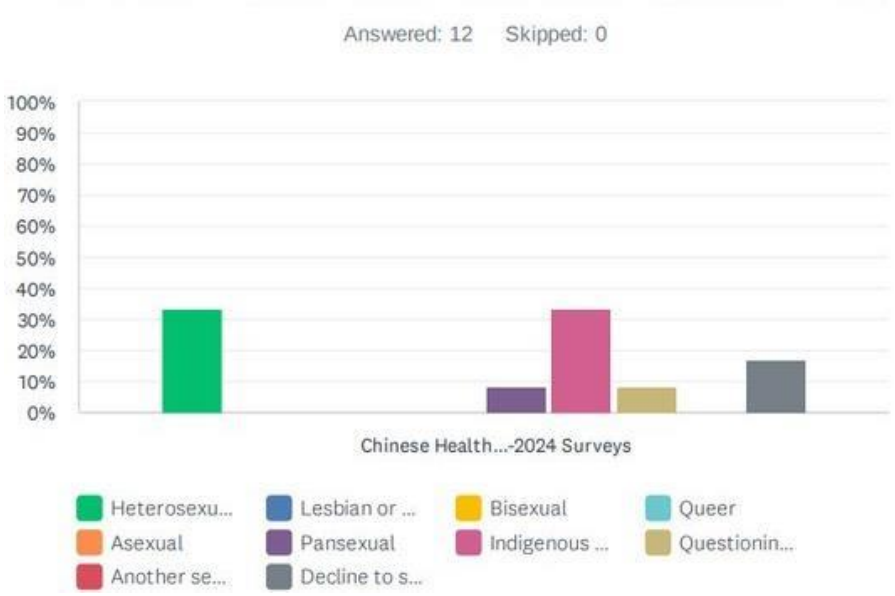
- Through my participation in this event/program/training, I have learned knowledge and skills that I can use to access behavioral health services. (average rating: 8.78)
- I feel like my identity, cultural background, and experiences (race, ethnicity, gender, religion, etc.) were affirmed by this program/training/event. (average rating: 8.78)
- Due to my participation in this program/training/event, I am more confident in my ability to advocate for the behavioral health needs of myself and/or my child/ren and/or another family member. (average rating: 8.78)
- This program/training/event affirmed that people with mental illness are capable and able to make positive contributions to society. (average rating: 8.67)
- Due to this program/training/event, I feel more comfortable talking about my mental health and/or substance use. (average rating: 8.11)
- Due to my participation in this program/training/event, I feel more confident in my ability to create change in my community. (average rating: 7.89)

Sample event demographics:

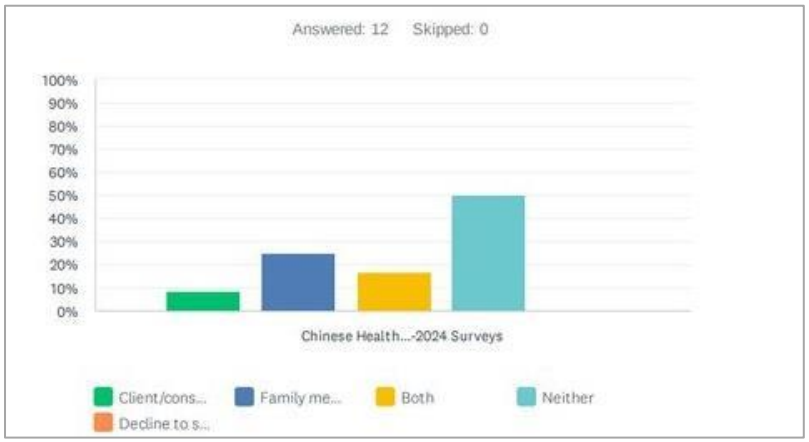
Question 1—What age range are you under? (check one)



Question 5—What is your sexual orientation? (check one)



Question 6—Do you identify as behavioral health client/consumer or family member? (check one)



Filipino Mental Health Initiative

The FMHI began as an informal gathering of Filipino clinicians from BHRS North County Clinic and local CBOs in the 1990s with the intent to support and elevate the needs of Filipino families and provide mental health outreach and education. A series of focus groups was conducted in 2005 by San Mateo County BHRS. During these focus groups, community members, providers, and staff members discussed issues pertaining to mental health, stigma, and barriers to accessing care among Filipinos living in San Mateo County. Following these focus groups, in 2006 interested members formed a group with funds made available from MHSA to support Filipino families not yet connected to services. In 2010, FMHI was formally established as one of the ODE's nine HEIs.

Mission, vision, and 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 and accomplishments: In FY 2023–24, the FMHI focused on creating more in-person opportunities for members and the broader community to gather, connect, and share resources. In those spaces, the FMHI successfully integrated culturally affirming practices including *kuwentuhan* (storytelling) in two Kapwa Soul Sessions that happened during key months—Filipinx-American History Month in October and Mental Health Month in May. Members were able to bravely share their experiences, participate in mindfulness practices, learn about various resources, and externalize stress due to sociopolitical and global stressors that have collectively impacted many communities.

As co-chairs of the FMHI and co-directors of KKC and Café, they continue to respond to the needs of the community by creating safe and brave spaces for people to have a dialogue about some of the most distressing issues of our time. The FMHI continues to embrace and promote diverse mental health support options: acknowledging the significance of traditional resources, while recognizing the importance of holistic approaches for the community. They respect participants' self-determination, particularly elders who may not be comfortable with psychotherapy. The FMHI emphasizes hope and healing through community, connection, and culture.

Total individuals reached in FY 2023–24:

- HEI monthly meetings: 66
- Trainings, events and other activities: 266

Latino/A/X Collaborative

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

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

- Creating stronger, safer, and more resilient families through holistic practices.
- Promoting stigma-free environments.

- Providing fair access to health and social services, independent of health insurance coverage.
- Appreciating and respecting traditional practices.
- Recognizing and incorporating Latino/a/x history, culture, and language into BHRS.

Highlights and accomplishments: In FY 2023–24, the LC increased its focus to centralize community input and become a hub of information sharing. In doing so, the LC has had consistent attendance with its members this year and increased the promotion of resources and services for Latinx communities to help fill the health disparity gap among Latinx communities in the county. The following are several highlights for the LC for the FY:

- The LC participated in several tabling opportunities (e.g., Black History Month, Cesar Chavez Day, ¡Sana, Sana, Colita de Rana!, May Mental Health Month) to provide information about culturally appropriate BHRS services and resources to community members. This proved to be valuable to the community, especially those who experience challenges with immigration, language/communication, and extreme economic despair.
- Opportunities were provided for guest speakers to engage with and offer additional educational and health resources to community members (Dr. Estela Garcia, Dr. Maria Lorente-Foresti, BHRS, Dr. Padilla, and other HEI co-chairs, such as NIPI), highlighting cultural and community connection. The LC has been compassionate and respectful of cultural backgrounds in providing these services to the community.
- Opportunities continue to be provided to decrease behavioral health stigma and empower community members to advocate for the needs of themselves and their family and community.
- The LC promoted cultural humility opportunities, community gatherings/events, monthly meetings, and planning meetings with appropriate language translation and interpretation as a means to reduce health disparities and achieve language access.
- The LC saw an increase in engagement in monthly meetings from community members, CBOs, stakeholders, and BHRS staff; for the past 6 months, the average monthly engagement was 24 individuals.

Total individuals reached in FY 2023–24:

- HEI monthly meetings: 183
- Trainings, events and other activities: 227

¡Sana, Sana, Colita de Rana! 2023—Event Overview and Outcomes

The LC, a part of San Mateo County BHRS's ODE, hosted a family and community event titled "¡Sana, Sana, Colita de Rana! 2023." This event was organized in collaboration with valued partner agencies and community members. Held in South San Francisco, the gathering attracted more than 150 participants.

Data collection:

- 143 demographic sheets collected
- 58 event evaluation sheets collected
- Evaluation method: virtual and paper copies
- Incentive: lunch ticket for completing evaluation

Participant feedback: Participants rated their experience on a scale ranging from 1 to 10 (1 = *strongly disagree*, 5 = *neutral*, 10 = *strongly agree*).

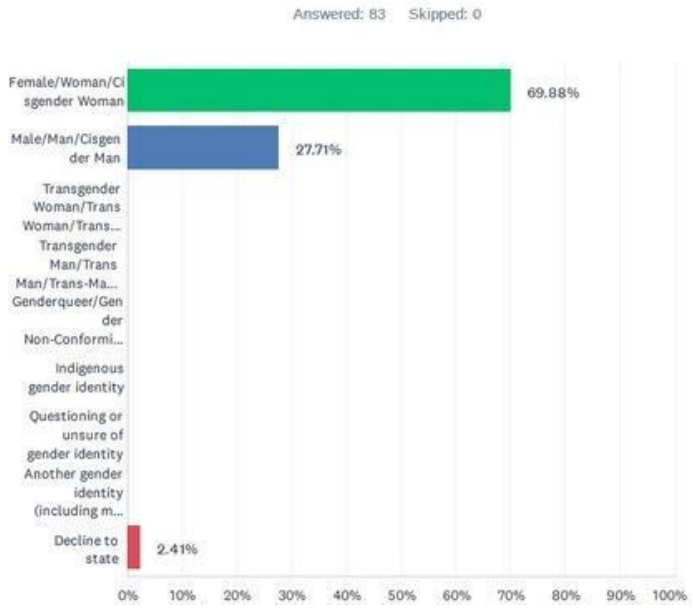
Key outcomes (highest to lowest average rating):

- I feel like my identity, cultural background, and experiences (race, ethnicity, gender, religion, etc.) were affirmed by this program/training/event. (average rating: 9.79)
- Due to my participation in this program/training/event, I am more confident in my ability to advocate for the behavioral health needs of myself and/or my child/ren and/or another family member. (average rating: 9.22)
- Through my participation in this event/program/training, I have learned knowledge and skills that I can use to access behavioral health services. (average rating: 8.98)

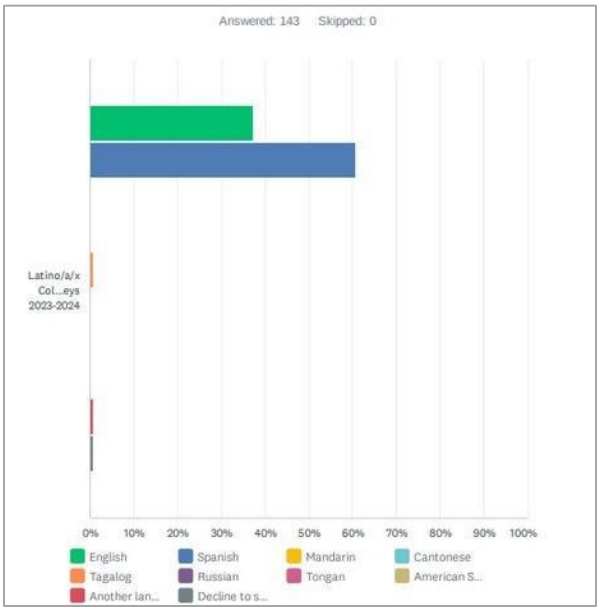
- This program/training/event affirmed that people with mental illness are capable and able to make positive contributions to society. (average rating: 8.78)
- Due to my participation in this program/training/event, I feel more confident in my ability to create change in my community. (average rating: 8.47)
- Due to this program/training/event, I feel more comfortable talking about my mental health and/or substance use. (average rating: 8.31)

Sample event demographics:

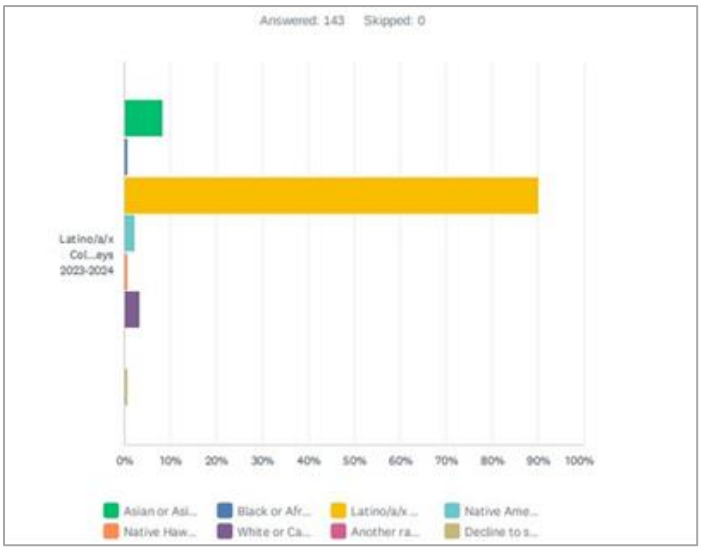
Question 4—What is your gender identity? (check one)



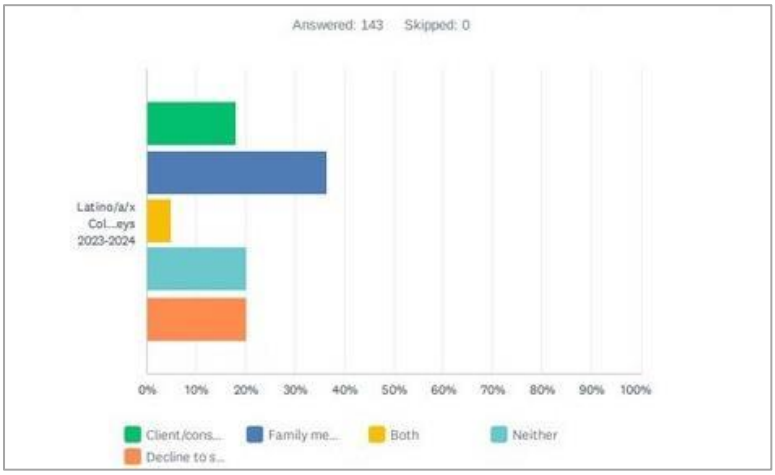
Question 2—What is your primary language spoken at home? (check one)



Question 3—What race(s)/ethnicities(s) do you identify with? (check all that apply)



Question 6—Do you identify as behavioral health client/consumer or family member? (check one)



Cesar Chavez Celebration—Event Overview and Outcomes

The LC co-hosted a Cesar Chavez Celebration with Voices of Recovery San Mateo County. The event theme was “Beyond the Fields.” Held at East Palo Alto Academy, the gathering attracted more than 65 participants.

Data collection:

- 42 demographic sheets collected
- 22 event evaluation sheets collected
- Evaluation method: virtual and paper copies
- Incentive: dinner ticket for completing evaluation

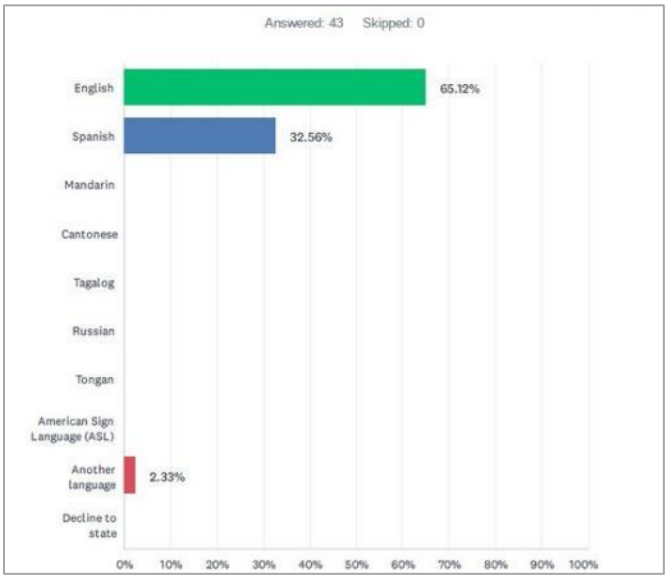
Participant feedback: Participants rated their experience on a scale ranging from 1 to 10 (1 = *strongly disagree*, 5 = *neutral*, 10 = *strongly agree*).

Key outcomes (highest to lowest average rating):

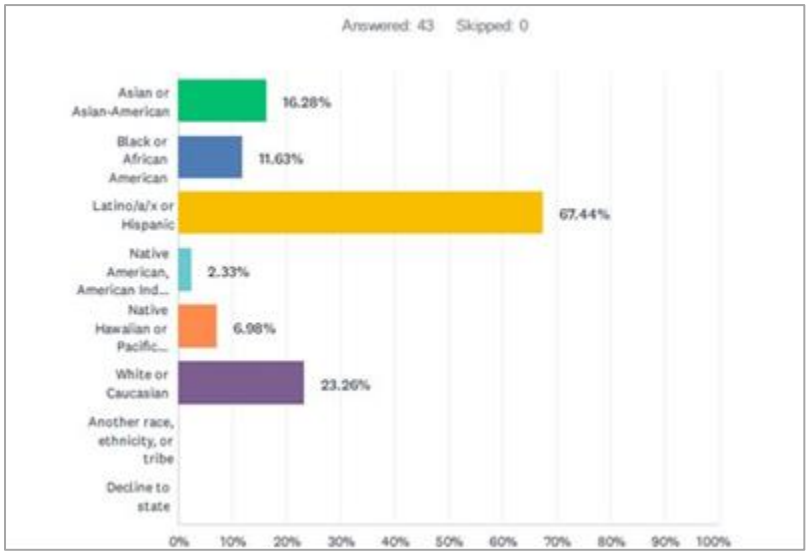
- Due to this program/training/event, I feel more comfortable talking about my mental health and/or substance use. (Average rating: 6.91.)
- I feel like my identity, cultural background, and experiences (race, ethnicity, gender, religion, etc.) were affirmed by this program/training/event. (Average rating: 6.64.)
- Due to my participation in this program/training/event, I am more confident in my ability to advocate for the behavioral health needs of myself and/or my child/ren and/or another family member. (Average rating: 6.5.)
- Due to my participation in this program/training/event, I feel more confident in my ability to create change in my community. (Average rating: 6.36.)
- Through my participation in this event/program/training, I have learned knowledge and skills that I can use to access behavioral health services. (Average rating: 6.14.)
- This program/training/event affirmed that people with mental illness are capable and able to make positive contributions to society. (Average rating: 6.14.)

Sample demographics:

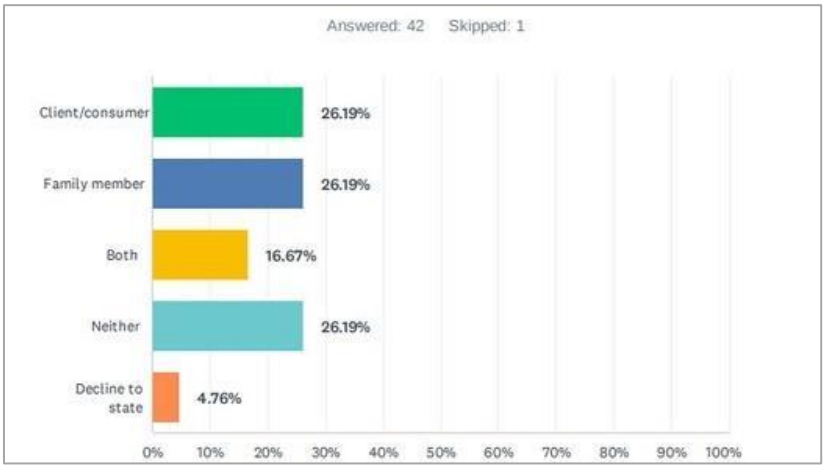
Question 2—What is your primary language spoken at home? (check one)



What race(s)/ethnicities(s) do you identify with? (check all that apply)



Question 6— Do you identify as behavioral health client/consumer or family member? (check one)



Native and Indigenous Peoples Initiative

The NIPI is one of the newer HEIs, 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, and objective: The 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 that honor culturally appropriate traditional healing practices. The NIPI's vision is to provide support and build a safe environment for the Native American and Indigenous communities. The NIPI's goal is to appreciate and respect Indigenous history, culture, spirituality, 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 to better serve Indigenous communities.
- Welcome and support: welcome community members, clients, consumers, and family. Assist individuals in accessing and navigating San Mateo County Health.
- Strengthen our community: provide opportunities for Native Americans and Indigenous people to strengthen their skills and create collaboration for guidance, education, and celebration of Indigenous communities.

Highlights and accomplishments: Since the NIPI's official launch in 2012, its impact within the county has been steadily growing. The NIPI has worked on increasing awareness of prevalence and risks of behavioral health disorders in the Native American/Indigenous communities and in identifying barriers to Native and Indigenous communities seeking treatment at San Mateo County clinics. The NIPI is working on teaching differences between community-defined and evidence-based practices, engaging participants in exercise and examples of traditional healing practices. The NIPI provided a workshop using sound bath in a clinical setting as well as medicinal drumming to best meet the needs of the community. The NIPI has ongoing collaboration with San Mateo County Libraries for presentations for Native Heritage Month such as historical trauma/generational trauma.

Total individuals reached in FY 2023–24:

- HEI monthly meetings: 40
- Trainings, events and other activities: 115

Pacific Islander Initiative

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

Mission, vision, and objectives: The PII's mission is to raise awareness of mental health issues in the Pacific Islander community to address the stigma associated with mental illness and substance use. The PII envisions a healthy community that feels supported by service providers, is accepting of individuals experiencing mental illness or substance use challenges, and is knowledgeable of the various resources and services that are available to address mental and behavioral health needs. The goals and objectives of the PII are organized according to four pillars identified by members:

1. Service Accessibility
2. Sustainability and Funding
3. Mental Health Career Pipeline
4. Community Partnership

Highlights and accomplishments: In 2023–24, the PII continued to focus on reducing stigma and increasing awareness and resources about behavioral health and suicide prevention in Pacific Islander communities. The PII experienced several immediate changes that impacted the initiative and community:

- Transition of PII co-chairs in 2023, which initiated new leadership through the nonprofit and CBO, Samoan Solutions. New co-chairs from Samoan Solutions and an interim county co-chair began leading the initiative in March 2024.
- Strategic planning with a consultant was conducted, beginning in spring 2024, which outlined the initiative's work plan for the next 2 years. There were opportunities for the community to engage in the strategic plan and have their voices heard at the Journey to Empowerment exhibit opening event for Arts and Voices 2024.
- Creating systems of work to move sustainably, to include "legacied" methods, and remove barriers to the initiative's productivity and success—for instance, establishing a standardized sponsorship process and promoting opportunities for data generation via community input.

Total individuals reached in FY 2023–24:

- HEI monthly meetings: 66
- Trainings, events and other activities: 227

Journey to Empowerment: Arts and Voices Exhibit—Event Overview and Outcomes

The PII, a part of San Mateo County BHRS's ODE, hosted a community event titled "Journey to Empowerment." This event was organized in collaboration with valued partner agencies and community members. Held at Samoan Solutions in Burlingame, the gathering attracted 44 participants.

Data collection:

- 33 demographic sheets collected
- 19 event evaluation sheets collected

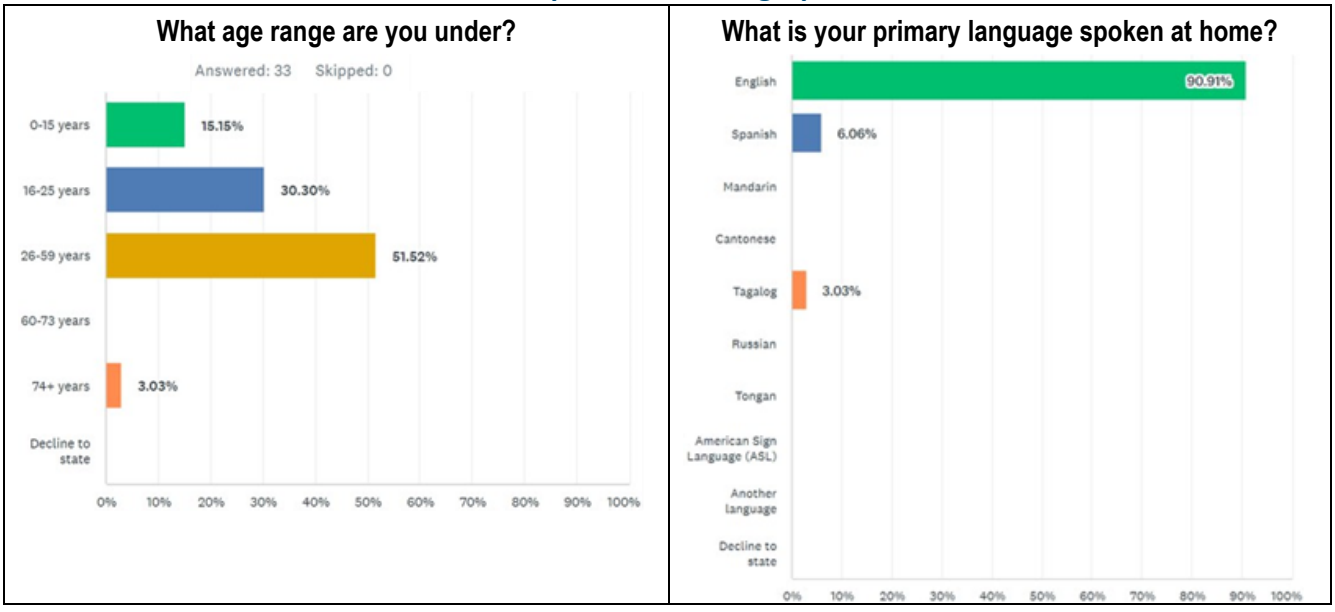
- Evaluation method: virtual and paper copies
- Incentive: dinner ticket for completing evaluation

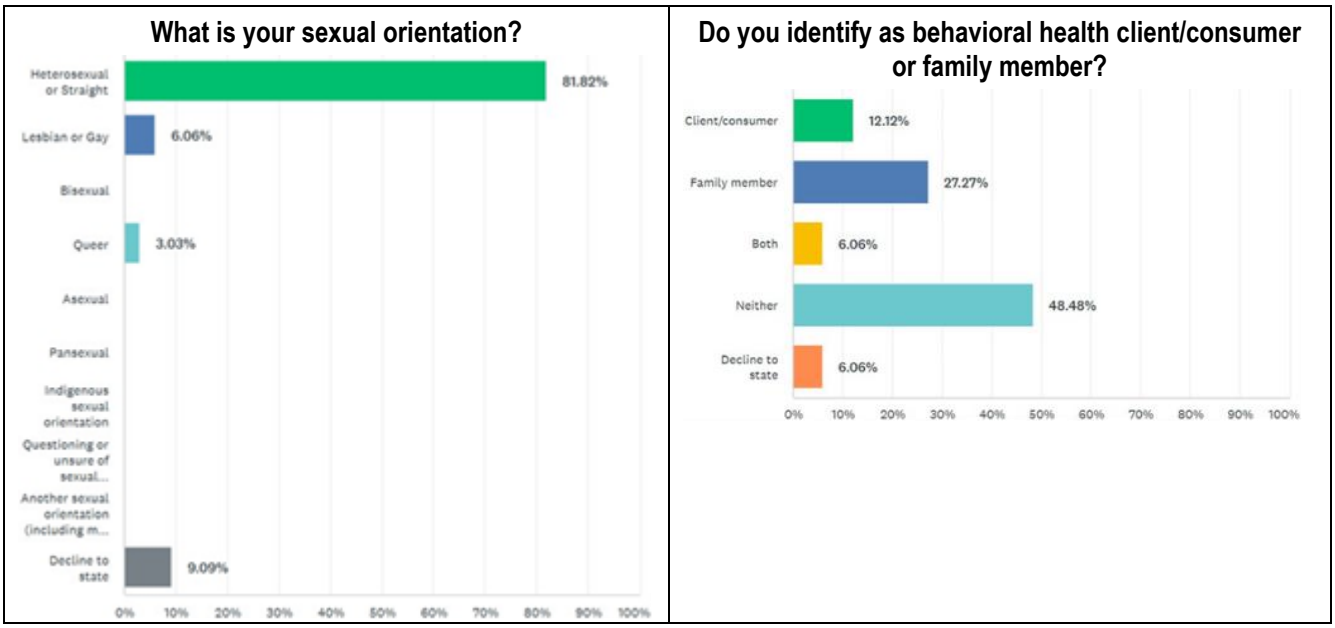
Participant feedback: Participants rated their experience on a scale ranging from 1 to 10 (1 = *strongly disagree*, 5 = *neutral*, 10 = *strongly agree*).

Key outcomes (Highest to lowest average rating):

- This program/training/event affirmed that people with mental illness are capable and able to make positive contributions to society. (Average rating: 8.16.)
- Through my participation in this event/program/training, I have learned knowledge and skills that I can use to access behavioral health services. (Average rating: 7.84.)
- Due to my participation in this program/training/event, I am more confident in my ability to advocate for the behavioral health needs of myself and/or my child/ren and/or another family member. (Average rating: 7.58.)
- Due to my participation in this program/training/event, I feel more confident in my ability to create change in my community. (Average rating: 7.53.)
- Due to this program/training/event, I feel more comfortable talking about my mental health and/or substance use. (Average rating: 7.47.)
- I feel like my identity, cultural background, and experiences (race, ethnicity, gender, religion, etc.) were affirmed by this program/training/event. (Average rating: 7.42.)

Sample event demographics





PRIDE Initiative

The PI was founded in April 2007 and was one of the first LGBTQ-focused efforts in San Mateo County. The initiative comprises individuals concerned about the well-being of LGBTQQI.

Mission, vision, and objectives: The PI has defined its mission as being committed to fostering a welcoming environment for the 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 that services are sensitive and respectful of LGBTQ+ issues. The PI envisions an inclusive future in San Mateo County grounded in equality and parity for LGBTQ+ communities across the county. PI objectives have been defined as follows:

- 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 and accomplishments: In FY 2023–24, the PI experienced two key highlights related to work around the Pride Parade and Celebration and a change to the standing meeting agenda. Concerning the Pride Parade and Celebration, the PI's reach into the community has never been greater, which was exemplified by the fact that the Board of Supervisors contributed $37,500 to the event. The parade tripled in size over its first year with more than 383 participants in the parade. The celebration grew by a third with nearly 6,000 people attending the event this year. This represents 2,000 more attendees over the previous year. The reach of Pride Parade and Celebration events has grown significantly. Survey data demonstrate that more races/ethnicities were represented than ever before with an increase in previously underrepresented populations. There was an increase in attendance by transgender men and women, which is incredible considering safety issues for this population. There was an increase of participants from within the county for every region except for

the South County region and East Palo Alto, which were only slight declines, whereas participation from throughout the Bay Area increased significantly. Two thirds of the attendees were consumers, family members, or both.

Concerning the change to the PI's agenda, the initiative modified the agenda to have program time because the initiative has been perceived as mostly focused on the Pride Parade and Celebration. The program time is meant to provide the opportunity for CBOs to present to the initiative to learn what Pride-oriented services are available in the community and which organizations support the LGBTQIA+ community in order to inform members so that they can, in turn, inform their constituents. This has been so interesting that BHRS is considering doing the same at their Leadership Team or All Staff meetings. Examples of presentations include a service overview, especially as related to the LGBTQIA+ community, from CORA and their extensive services to those in abusive, intimate relationships, to a presentation by a CBO that convinced the initiative to market the Pride Parade and Celebration as a smoke-free event.

Total individuals reached in FY 2023–24:

- HEI monthly meetings: 195
- Trainings, events and other activities: 6,506

Pride "Love at Our Core, 2024" Event and Parade—Overview and Outcomes

The PI, a part of San Mateo County BHRS's ODE, hosted a family and community event titled "Love at Our Core, 2024" event and parade. This event was organized in collaboration with valued partner agencies and community members. Held in San Mateo, the gathering attracted an estimated 6,000 participants.

Data collection:

- 454 participants provided feedback through surveys

Participant feedback: Participants rated their experience on a scale ranging from 1 to 10 (1 = *strongly disagree*, 5 = *neutral*, 10 = *strongly agree*).

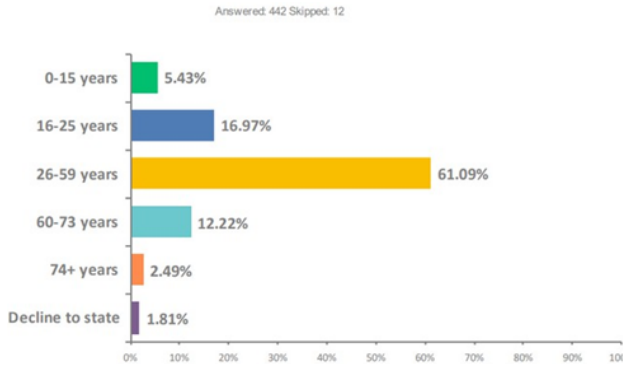
Key outcomes (highest to lowest average rating):

- I feel like my identity, cultural background, and experiences (race, ethnicity, gender, religion, etc.) were affirmed by this program/training/event. (Average rating: 9.1)
- This program/training/event affirmed that people with mental illness are capable and able to make positive contributions to society. (Average rating: 8.9)
- Due to my participation in this program/training/event, I am more confident in my ability to advocate for the behavioral health needs of myself and/or my child/ren and/or another family member. (Average rating: 8.9)
- Due to my participation in this program/training/event, I feel more confident in my ability to create change in my community. (Average rating: 8.8)

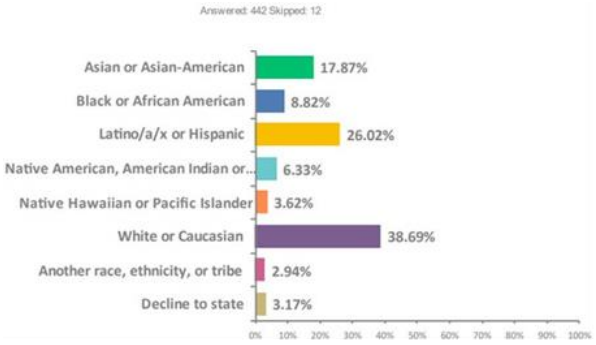
- Through my participation in this event/program/training, I have learned knowledge and skills that I can use to access behavioral health services. (Average rating: 8.7)
- Due to this program/training/event, I feel more comfortable talking about my mental health and/or substance use. (Average rating: 8.7)

Sample event demographics

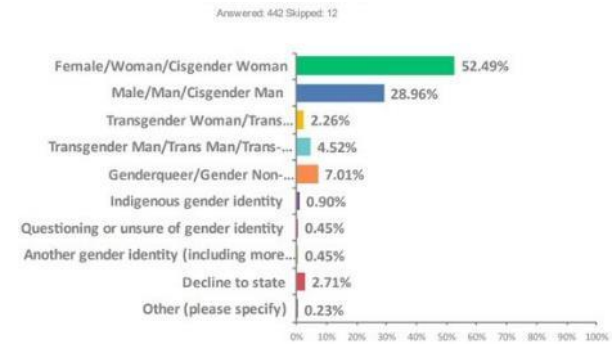
What age range are you under?



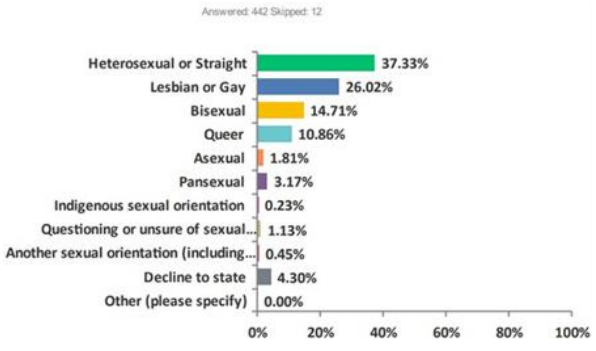
What race(s)/ethnicities(s) do you identify with?



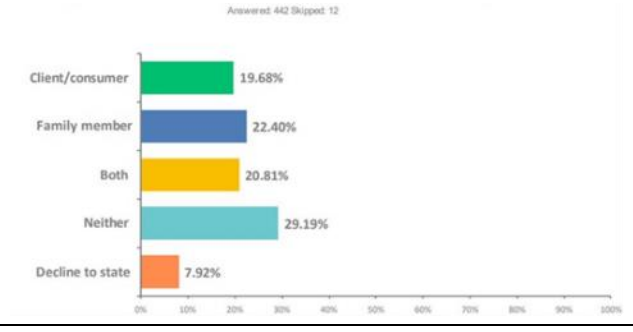
What is your gender identity?



What is your sexual orientation?



Do you identify as behavioral health client/consumer or family member?



Spirituality Initiative

The SI began in 2009 and works to foster opportunities for clients, providers, and community members to explore the relationship between spirituality and mental health, substance use, and treatment.

Mission, vision, and objectives: The SI envisions a health system that embraces and integrates spirituality when working with clients, families, and communities. It has defined three core principles that guide its work:

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

Highlights and accomplishments: In FY 2023–24, the SI continued to provide support to its members, other HEIs, and beyond to embody hope in the county. Over the course of the FY, the initiative consulted and worked with a professional regarding a 2-year strategic plan. In addition, the initiative has contributed to a substantial amount of work within the community as the strategic plans are being finalized. The co-chairs continue to open and close each meeting with a healing poem, prayer, or wellness quote, which places the focus squarely on spirituality from the outset of the meeting. Additional elements of the initiative are described as follows:

- Monthly presenters are asked to describe "how spirituality influences their programming and service delivery" for monthly presentations to initiative members.
- As an independent contractor/consumer, the SI ensures that the consumer perspective is incorporated in the initiative leadership.
- The SI offered the first annual "Telling Our Own Stories" training focusing on recovery as a spiritual journey. This training will lead to members sharing their stories as a monthly component of each meeting.
- Both co-chairs attend the monthly California Mental Health and Spirituality Meetings throughout the year.
- The SI organized a Healing Connections Open Mic Event, which was the signature event for the county during May Mental Health Month.
- The SI invited a community organization to participate in its current schedule of monthly meetings. In this way, it demonstrates its desire to work closely with CBOs. It has continued to deepen its relationships with other HEIs and community partners by participating in their event planning committees.
- SI members played active roles in planning and presenting a successful annual Interfaith National Day of Prayer.

Total individuals reached in FY 2023–24:

- HEI monthly meetings: 163
- Trainings, events and other activities: 473

Interfaith National Day of Prayer—Event Overview and Outcomes

The SI, a part of San Mateo County BHRS's ODE, hosted a community event titled "Interfaith National Day of Prayer." This event was organized in collaboration with valued partner agencies and community members. Held at the County Center in Redwood City, the gathering attracted approximately 110 participants.

Data collection:

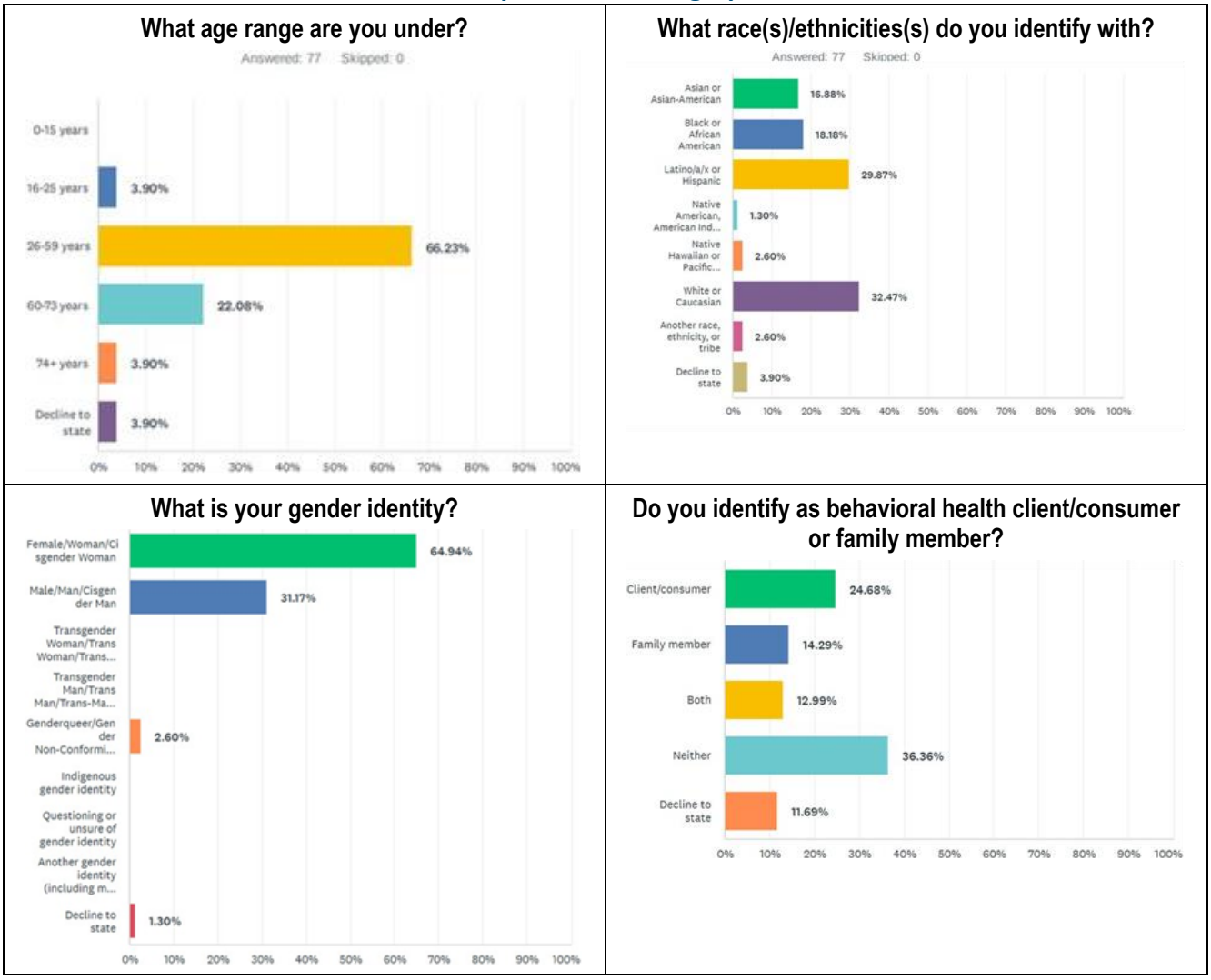
- 77 demographic sheets collected
- 25 event evaluation sheets collected
- Evaluation method: virtual and paper copies

Participant feedback: Participants rated their experience on a scale ranging from 1 to 10 (1 = *strongly disagree*, 5 = *neutral*, 10 = *strongly agree*).

Key outcomes (Highest to lowest average rating):

- This program/training/event affirmed that people with mental illness are capable and able to make positive contributions to society. (Average rating: 8.24)
- Through my participation in this event/program/training, I have learned knowledge and skills that I can use to access behavioral health services. (Average rating: 8.08)
- I feel like my identity, cultural background, and experiences (race, ethnicity, gender, religion, etc.) were affirmed by this program/training/event. (Average rating: 7.96)
- Due to this program/training/event, I feel more comfortable talking about my mental health and/or substance use. (Average rating: 7.96)
- Due to my participation in this program/training/event, I am more confident in my ability to advocate for the behavioral health needs of myself and/or my child/ren and/or another family member. (Average rating: 7.88)
- Due to my participation in this program/training/event, I feel more confident in my ability to create change in my community. (Average rating: 7.48)

Sample event demographics



SUCCESSES

Staffing Changes

In March 2023, the ODE hired a senior community engagement specialist to oversee and coordinate the HEIs. This role transitioned in October 2023, with a new program coordinator joining in December 2023. The new coordinator, with a background in psychological services and clinical management, has developed trusting relationships with co-chairs and initiative members. They also serve as interim county co-chair for both the LC and the PII.

Strategic Planning

A major success for the HEIs was working with a consultant to develop strategic plans outlining 2-year goals for each initiative as well as universal work plans for all nine HEIs. For instance,

- The AACI completed their strategic planning goals with community involvement through surveys during Black History Month.

- The DEC benefited from one-on-one meetings and consideration of broader alignment with BHRS and upcoming state policies.

Community Engagement and Leadership

Several HEIs reported increased community engagement and leadership:

- The FMHI saw members taking on leadership roles, including co-facilitating meetings and managing outreach efforts.
- The SI acknowledged a community member's consistent contributions in event support and regular meditation provision.
- The NIPI noted significant community influence in traditional/medicinal healing practices.

Partnerships and Recognition

HEIs are increasingly recognized as community leaders, building stronger partnerships:

- CHI co-chairs, both San Mateo County residents with lived experiences as Chinese immigrants, bring expertise from nonprofit and health system backgrounds.
- The DEC strengthened partnerships by acting as an information hub and expanding relationships with the county's Office of Racial and Social Justice.
- AACI leadership has increased community awareness and access to health resources.

Inter-initiative Collaboration

HEIs are building unity through collaboration. Here are some examples:

- The FMHI, CHI, and PII received a proclamation establishing May 10th as Asian American, Native Hawaiian, Pacific Islander Mental Health Day in San Mateo County.
- The LC collaborated with the NIPI during an event, providing a land honoring ceremony.
- The SI deepened relationships with other HEIs and community partners by participating in event planning committees.

These collaborations have fostered deeper connections and mutual support among diverse communities, demonstrating solidarity and leadership.

CHALLENGES

HEIs support underserved, unserved, and inappropriately served communities in the county. A core challenge is building trust and empowering HEIs to be a voice for their communities. HEIs were intended to bridge the county, its workforce, and community members by encouraging collaboration. Some HEIs have strong relationships with the county, tapping into their full potential, whereas others struggle because of historical harms. This requires stable ODE staffing to build trust as well as policies that meet HEIs' unique needs as they implement culturally humble interventions.

Another challenge is leveraging HEI members' talents to enhance sustainability. There is a growing need for leadership pipelines within HEIs to support emerging leaders. Many co-chairs find the work

unsustainable as responsibilities have increased with larger events, administrative duties, intern management, and pressing community needs. Some express frustration at lacking time to fulfill their roles effectively. With compensation based on 4–5 hours weekly, co-chairs struggle to deliver results while balancing their full-time jobs. Reassessing time commitments and updating policies could improve effectiveness and clarify roles and expectations.

The AACI has demonstrated a thoughtful leadership transition model. Previous co-chairs selected new ones through a vetting process and then prepared them by sharing work context, administrative practices, and community needs. They co-facilitated monthly meetings before fully transitioning out. This approach better prepared the new co-chairs to lead with a future vision.

Social media and online outreach remain challenging for HEIs. Although some have established social media presence, many struggle with gray areas. For instance, the PII lost access to their accounts for years after a co-chair transition. A guide on social media navigation and clarifying ODE and HEI roles in this area would be beneficial.

Last, HEIs face challenges in meeting community needs. Virtual meetings have increased accessibility for some but created barriers for those lacking technology or reliable internet. Linguistically appropriate materials remain an issue for CHI, PII, and FMHI communities. For example, despite Tagalog being a threshold language in San Mateo County, FMHI lacks consistent translation services, relying on members for interpretation assistance.

HEALTH AMBASSADOR PROGRAM–ADULT

The BHRS Health Ambassador Program (HAP) was created in 2014 out of a desire for community members, who are committed to helping their families and neighbors, to improve their quality of life, continue learning, and increase their involvement in community services. To become a health ambassador, community members must complete five of the 11 courses offered: The Parent Project®, MHFA and/or Youth MHFA, WRAP, NAMI Family to Family, NAMI Basics, Applied Suicide Intervention Skills Training, PhotoVoice Project, Digital Storytelling, Stigma Free San Mateo, and the LEA. The BHRS HAP was created in recognition of the important role that community members serve in effectively reaching out to others. HAP goals include the following:

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

PROGRAM IMPACT

Health Ambassador Program (HAP) [a]	FY 2023–24
Clients served (unduplicated)	96
Cost per client	$1,653
Duplicated clients served (number of participants in HAP workshops/trainings	192
Individuals reached (duplicated)	187
Total individuals served	475

[a] Unduplicated clients served include only the health ambassadors who were engaged during the fiscal year (FY); individuals reached include the community that received training, education, workshops, and so on.

Outcome Indicators

Domain	Indicator/question	*n*	%
Connection and support	Due to my participation in HAP [Health Ambassador Program] courses and/or activities, I feel more connected to my family.	41 of 44	93
Cultural identity/humility	I feel like my identity, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion, etc.) were affirmed by HAP courses.	42 of 44	95
Community advocacy	Due to my participation in HAP courses and/or activities, I am more confident in my ability to create change in my community.	41 of 44	93
Self-empowerment	Due to my participation in HAP courses and/or activities, I am more confident in my ability to advocate for myself and/or advocate for my child/children.	43 of 44	98
Stigma reduction (help seeking)	Due to my participation in this course, I feel more comfortable seeking mental health and/or substance use services for myself and/or my family.	42 of 44	95
Improved knowledge, skills, and/or abilities	Through my participation in this course, I've learned knowledge and skills that I can use to access mental health and/or substance use health services.	44 of 44	100
Access to services	Through my participation in this course, I and/or my family have been connected to mental health and/or substance use services/resources that have been helpful.	38 of 44	86

DEMOGRAPHICS

Health Ambassador Program Client Demographics (N=96)

	Number of clients	Percentage of total
Age		
0–15 years	0	0
16–25 years	4	4
26–59 years	84	88
60–73 years	6	6
74 years and older	0	0
Prefer not to answer/unknown	2	2
Primary language		
English	7	7
Spanish	60	62
Multiple	24	25
Another language	2	2
Prefer not to answer/unknown	2	2
Race/ethnicity		
Asian or Asian American	2	2
Black or African American	1	1
Native American, American Indian, or Indigenous	0	0
Native Hawaiian or Pacific Islander	0	0
White or Caucasian	1	1
Latino/a/x or Hispanic	89	93
Another race, ethnicity, or tribe	0	0
Prefer not to answer/unknown	3	3
Gender identity		
Female/woman/cisgender woman	79	82
Male/man/cisgender man	15	16
Transgender woman/trans woman/trans-feminine/woman	0	0
Transgender man/trans man/trans-masculine/man	0	0
Questioning or unsure of gender identity	0	0
Genderqueer/gender non-conforming/gender non-binary/neither exclusively female nor male	0	0

	Number of clients	Percentage of total
Indigenous gender identity	0	0
Another gender identity	0	0
Prefer not to answer/unknown	2	2
Sexual orientation		
Gay or lesbian	2	2
Straight or heterosexual	74	77
Bisexual	1	1
Queer	0	0
Pansexual	0	0
Asexual	0	0
Questioning or unsure of sexual orientation	0	0
Indigenous sexual orientation	0	0
Another sexual orientation	0	0
Prefer not to answer/unknown	19	20
Behavioral health consumer or family member		
Client/consumer	14	14
Family member	23	24
Both	19	20
Neither	25	26
Prefer not to answer/unknown	15	16

SUCCESSES

Amplifying Impact: HAP Expands Certification Pathway With Four New Courses

In FY 2023–24, HAP expanded its certification pathway this FY by adding four new courses, bringing the total number of available courses to 15. The new workshops include Know the Signs; NAMI-TAY; Be Sensitive, Be Brave for Mental Health; and Be Sensitive, Be Brave for Suicide Prevention.

Know the Signs, part of the state's Take Action for Mental Health campaign, focuses on suicide prevention. This workshop aims to reduce mental health stigma and raise awareness about support services. Participants learn three key steps: recognizing suicide warning signs, engaging in conversations with someone experiencing suicidal thoughts, and connecting individuals to community resources.

The NAMI-TAY workshop, “How to Support My Teenager in Transition to Adulthood,” serves parents and caregivers of youth ages 14–18 years. This session provides essential knowledge, tools, and support for navigating common challenges faced by TAY and their families.

The BSBB workshops for mental health and for suicide prevention incorporate cultural awareness and diversity throughout their curricula. The mental health training helps participants identify when someone is struggling with mental distress, empowers them to offer help, and increases awareness of available resources. It also provides practical tools for building resilience and maintaining mental well-being. The suicide prevention workshop trains community members to recognize suicidal distress, confidently discuss suicide concerns, and connect individuals with appropriate support. Both workshops focus on reducing stigma, enhancing cultural sensitivity, and enabling health ambassadors to effectively address mental health and suicide prevention needs in their communities.

Greater Impact, Growing Reach: HAP Graduates 21 New Champions of Change in FY 2023–24

During this past FY, the program achieved a record-breaking 21 new health ambassador certifications, bringing the total number of graduates to 81 since its inception. To earn certification, community members must complete at least five of the 15 behavioral health-related courses, gaining vital knowledge, skills, and resources.

Program graduates serve essential roles in addressing county mental health and substance use challenges. They raise awareness about resources, promote health and well-being, provide compassionate support, facilitate access to services, share mental health and recovery knowledge, and advocate for their communities. Many graduates extend their impact by participating in community events, engaging in HEIs, pursuing additional training, or becoming facilitators. This creates a ripple effect of positive transformation throughout the community. With this year’s increased number of graduates, the program’s influence continues to expand, helping to build stronger, healthier, and more resilient communities.

HAP graduates report that the program equipped them with resources to support their families and communities while fostering their own personal development and resilience. The following are direct quotations from graduates:

“Going through this program has helped me to understand and manage my mental health, and I learned a lot about how to talk to my granddaughter who is going through a very complicated and challenging time. I thank everyone who participates in giving these trainings that are very important for the Latino community and to all in general.”

“For me, it is a great achievement to have graduated as a health ambassador because it has been a great learning experience for me personally and my community. It has helped me to better understand myself and those around me. I feel like a better human being than before.”

“I feel blessed to have taken the classes in this program and to have obtained this accomplishment and the wonderful training I received, which has served me well in my daily life. I have been able to share my knowledge and care with those who need me the most, including my family and part of my community with whom I interact. Thank you so much to this great health ambassadors program and the entire team!”

“Personally, I am very happy to have finished this program. It has contributed to my self-development, as a woman and as a human being. It has helped me understand my fellow community members more, to not judge anyone, and to always move forward. Thank you very much to all of you who make all this possible.”

“I have learned resilience.”

“For me it was very helpful to learn how to face the challenges in life in a more positive way, whether in a personal, family, or community setting. All of the trainings have been very impactful for our community. Thank you to all the facilitators who shared their stories and their patience to answer many of our questions as part of the learning process. We want to have healthy families and a safe community.”

“I feel much admiration, respect, and gratitude to BHRS HAP for the unconditional support and encouragement provided with love and trust. I feel proud to have completed all the courses that accredit me as health ambassador in San Mateo County, and grateful to begin this path, with all the responsibility that it represents. Success is the sum of small repetitive efforts day after day.”

“I am proud to be a health ambassador. It is something wonderful in my life to be able to have more knowledge because of the courses HAP gave us and thus be able to educate myself more for my loved ones and above all to be able to help with all my heart the community that sometimes thinks that there is no help or resources. I am very happy with this stage in my life and to be able to grow and learn more to help myself and to be of support to my community. With all my heart thank you very much to BHRS HAP for giving us such valuable information. God bless you and let’s go for more. Thank you, thank you!”

CHALLENGES

As HAP grows to include 81 ambassadors and 115 prospective candidates, staffing limitations affect the ability to support key program components. These include planning training workshops, assisting with community events, providing graduate support through advanced training, and addressing individual ambassador needs. Limited staff also impacts data collection, database maintenance, and program evaluation, making it harder to assess community needs and improve services.

The program continues to face challenges in finding effective tools to track and report health ambassadors' community impact, including their work connecting people to mental health, substance use, and other county services.

The program team remains committed to working with leaders to find practical solutions. Plans include reengaging a contractor to help develop better data collection tools and processes. This will help the program understand participants, gain insights into community needs, evaluate impact, and identify ways to improve.

PARENT PROJECT®

The Parent Project® (the program or the course) is a free, 12-week course provided by San Mateo County's ODE targeted for caregivers with children and adolescents who display challenging behavior(s). Classes meet weekly for 3 hours, and the course is offered in both English and Spanish in virtual, in-person, and blended models.

The Parent Project® course was created for anyone who cares for a child or adolescent and wants to learn how to respond to children's behaviors in a way that decreases unhealthy or dangerous behaviors while strengthening family relationships in a culturally informed manner. Throughout the course, parents and caregivers learn parenting skills and get information about resources and other support available in their communities. They learn specific prevention and intervention strategies and practice effective parenting skills such as appropriate ways to discipline, preventing or stopping alcohol and drug use, improving communication skills, and improving school attendance and performance. The BHRS ODE works in partnership with other community organizations to facilitate Parent Project® courses. Between July 2023 and June 2024 (FY 2023–24), the BHRS ODE contracted with StarVista and One East Palo Alto.

In addition to completing the Parent Project® course offerings, participants complete four surveys throughout the program to assess course outcomes. These surveys collect demographic and contact information and evaluate outcomes by assessing participants' perceptions of their parenting skills, their children's behavior and school performance, relational dynamics, parental concerns, and parent-child communication.

In FY 2023–24, course instructors provided three Parent Project® courses to a total of 50 participants. Course participants include community members from a variety of backgrounds. According to the applications submitted, about two thirds of respondents identified as Latinx or Hispanic, with the remainder identifying as other races and ethnicities, including Asian or Asian American, Native

Hawaiian or Pacific Islander, and White or Caucasian. Primary languages were evenly split between Spanish and English. The majority of respondents were between the ages of 26 and 59 years, identified as female, and identified as straight or heterosexual. More than two thirds of survey respondents reported having more than one child, and a large portion reported living in San Mateo or East Palo Alto. Most respondents did not identify as clients/consumers of behavioral health services or family members, and before this year, most participants had not taken parenting classes, such as the Parent Project® course or other classes.

PROGRAM IMPACT

Parent Project®	FY 2023–24
Clients served (unduplicated): program participants	50
Cost per client	$2,392
Individuals reached (duplicated)	NA
Total served	50

Outcome Indicators

Domain	Indicator/question	*n*	%
Access to services	Through my participation in the Parent Project® course, I have learned knowledge and skills that I can use to access behavioral health services.	20 of 26	77
Cultural identity/humility	I feel like my identity, cultural background, and experiences (race, ethnicity, gender, religion) were affirmed by taking the Parent Project® course.	18 of 24	75
Stigma (self-internalized)	Due to this program, I feel more comfortable talking about *my* mental health and/or substance use.	18 of 27	67

Course participants learn through the Parent Project® how to respond to children's behaviors in a way that decreases unhealthy or dangerous behaviors while strengthening family relationships. Participants learn specific prevention and intervention strategies and practice effective parenting skills such as discipline strategies, preventing or stopping alcohol and drug use, improving communication skills, and improving school attendance and performance.

The Parent Project® aims to positively change participants' parenting behaviors to also influence their children's behaviors. The post program survey asked respondents to report on their relational practices and dynamics between them and their children, their parenting skills, and their worries. In addition, the post program survey asks parents to report on their child's behavior, such as the frequency with which they engage in risky behaviors.

Note that most data presented are from aggregates of the pre/post assessments, which means the data changes in responses (more or less favorable) cannot be directly attributed to the class. A few pieces of presented data are from individual respondents matched pre/post assessments, which does show changes from the class. However, the sample size for matched data is so small ($n < 15$ and often < 5) that it is not representative or generalizable to all course participants.

For relational practices and dynamics between parents and their child(ren), 25 of 29 post assessment respondents (86%) expressed that they are somewhat or very satisfied with their relationship with their child(ren), compared with 16 of 23 preassessment respondents (70%). Furthermore, 27 of 29 respondents (93%) reported that they often or always show love and affection to their child(ren), compared with only 15 of 22 preassessment respondents (68%). In addition, 26 of 29 post assessment respondents (90%) express their feelings to their children, compared with only 15 of 22 preassessment respondents (68%).

For parenting skills, 26 of 29 post assessment respondents (90%) reported satisfaction with their parenting skills, compared with only 14 of 22 preassessment respondents (64%). Moreover, 24 of 28 post assessment respondents (86%) reported that they often or always define clear expectations for their child(ren), compared with 17 of 23 preassessment respondents (74%). As for additional strengths of the course, 26 of 27 respondents (96%) reported learning about community resources while participating in the Parent Project® course, and 20 of 26 respondents (77%) reported that they have learned knowledge and skills to access behavioral health services through the course. Finally, three fourths of respondents reported that they felt like their identity, cultural background, and experiences were affirmed by taking the Parent Project® course.

Although there were many strengths of the Parent Project® course, some opportunities for improvement involve parent-child communication, parental worries, and discussing behavioral health. Nearly one in five respondents, in both the pre- and post assessments, indicated that it is somewhat or very difficult to communicate with their child(ren). More specifically, whereas four participants' responses indicated an increase in ease from their pre- to post assessments, three respondents' answers indicated a decrease in ease from pre- to post assessment. For parental worries, approximately one third of respondents, in both the pre- and post assessment, expressed that they feel moderately or very worried about their child(ren)'s mental health, alcohol use, and cannabis use as well as gangs and teen pregnancy. Last, in the course evaluation, nearly one in five respondents disagreed or strongly disagreed that they are more comfortable talking about their mental health and/or substance use because of the Parent Project® course.

Responses suggest that participants would benefit from additional focus on ways to make communication between caregivers and their child(ren) easier, and instructors should focus on strategies for discussing mental health and substance use to support participants to feel more comfortable talking about these challenges.

DEMOGRAPHICS

Parent Project® Program Client Demographics (N=40)

	Number of clients	Percentage of total
Age		
0–15 years	0	0
16–25 years	1	1
26–59 years	23	58
60–73 years	2	1
74 years and older	0	0
Prefer not to answer/unknown	16	40
Primary language		
English	10	25
Spanish	10	25
Another language	1	2
Prefer not to answer/unknown	19	48
Race/ethnicity		
Asian or Asian American	2	5
Black or African American	0	0
Native American, American Indian, or Indigenous	0	0
Native Hawaiian or Pacific Islander	4	10
White or Caucasian	1	2
Latino/a/x or Hispanic	13	33
Another race, ethnicity, or tribe	0	0
Prefer not to answer/unknown	20	50
Gender identity		
Female/woman/cisgender woman	19	48
Male/man/cisgender man	3	7
Transgender woman/trans woman/trans-feminine/woman	0	0
Transgender man/trans man/trans-masculine/man	0	0
Questioning or unsure of gender identity	0	0
Genderqueer/gender non-conforming/gender non-binary/neither exclusively female nor male	0	0
Indigenous gender identity	0	0
Another gender identity	0	0
Prefer not to answer/unknown	18	45
Sexual orientation		
Gay or lesbian	0	0
Straight or heterosexual	16	40%
Bisexual	1	2

	Number of clients	Percentage of total
Queer	0	0
Pansexual	0	0
Asexual	0	0
Questioning or unsure of sexual orientation	0	0
Indigenous sexual orientation	0	0
Another sexual orientation	0	0
Prefer not to answer/unknown	23	58
Behavioral health consumer or family member		
Client/consumer	2	4
Family member	4	8
Both	0	0
Neither	13	26
Prefer not to answer/unknown	31	62

REFERRALS

Mental Health and Substance Use Referrals

Type of referral	FY referrals to programs within your agency	FY referrals to other agencies	FY total
Serious mental illness referrals	NA	NA	NA
Substance use disorder referrals	NA	NA	NA
Other mental health referrals	NA	NA	NA
Total	**NA**	**NA**	**NA**

Referrals to Other Services

Type of referral	FY total	Type of referral	FY total
Emergency/protective services	NA	Legal	NA
Financial/employment	NA	Medical care	NA
Food	NA	Transportation	NA
Form assistance	NA	Health insurance	NA
Housing/shelter	NA	Cultural, nontraditional care	NA
Other [a]	NA	**Total**	**NA**

[a] "Other" category consisted of school-based referrals/supports, general educational development classes, and gender support.

PROGRAM NARRATIVE

Improves timely access and linkages for underserved populations: In addition to teaching parents/caregivers parenting skills, the Parent Project® course is designed to connect participants to

resources and other support available in their communities. The goals of communicating and linking participants to resources are to empower parents and community members to share and receive support as well as meet the needs of their own families. As a result, the Parent Project® seeks to improve timely access and linkages for parents/caregivers in San Mateo County, which represent a variety of backgrounds, identities, and lived experiences (see demographics in the previous section). In FY 2023–24, almost all survey respondents (96%, *n* = 26) who completed the post program survey reported learning about community resources while participating in the Parent Project® course. The most common resources learned about by respondents (*n* = 26) were the San Mateo County Information Handbook (65%), AOD/substance use services (62%), HAP (62%), and StarVista services (62%). In addition, more than three fourths of respondents (77%, *n* = 20) reported that through the course, they have learned knowledge and skills to access behavioral health services.

Reduces stigma and discrimination: The Parent Project® curriculum is divided into two parts: (a) Laying the Foundation for Change and (b) Supporting Change and Improving Relationships. The first part, Laying the Foundation for Change, focuses on parenting behaviors and skills, and the second part, Supporting Change and Improving Relationships, builds on those foundational topics to sustain behavior change and promote family unity. Within both parts of the curriculum, the Parent Project® course incorporates discussion around mental health, substance use, trauma, and other topics that are often associated with stigma. Through these conversations, the Parent Project® course is working to reduce stigma and discrimination within the home and in the community. According to the post program survey, about two thirds of survey respondents (67%, *n* = 18) reported feeling more comfortable talking about their mental health and/or substance use after the Parent Project® course, which points to a reduction in stigma among some class participants.

Survey respondents also noted that one of the most helpful parts of the Parent Project® course, in addition to connecting participants to resources and working to reduce stigma, was listening to and sharing parenting experiences. Survey respondents emphasized how important and valuable it is to learn from other parents who share similar experiences. Hearing from other parents on how they parent their children and navigate challenges enhances the curriculum taught in the course because participants can learn from real-life examples. The following is a quotation from a survey participant that exemplifies this sentiment:

- *"Hearing from other parents what they experience with their children and how they handle it, even though the class explains it step by step . . . it is better to hear it from someone who lives it." —survey respondent, 2024*

SUCCESSES

In FY 2023–24, the Parent Project® is proud to have successfully connected participants to resources and opportunities, created a safe space that fosters a sense of community, and adapted its curriculum to be culturally responsive and build trust with historically underserved communities. There are three examples to note that illustrate these three successes. First, most of the Parent Project® courses featured guest presenters who presented on various resources available in the county for behavioral health and other needs. Presenters included San Mateo County BHRS AOD, StarVista counseling services, the BHRS Call Access Center, and the San Mateo County Pride Center. In

addition, BHRS ODE also presented and detailed all the free programs available, upcoming events, and HAP. At the end of the classes, participants were interested in seeking out BHRS resources as well as pursuing ODE trainings and becoming health ambassadors.

Second, the Parent Project® course encourages participants to build a strong sense of community among one another, which can be a source of needed support. This was evident in the course delivered by StarVista in February 2024, during which participants shared openly about their struggles. This group dialogue and support are often lost through Zoom/virtual classes. Notably, the participants expressed that they felt the ODE and the StarVista facilitators were a team, which contributed to their comfort in asking questions about resources and sharing stories.

- *"I'm thankful for this amazing program, with wonderful facilitators . . . love the group of great parents sharing with each other about our parenting experiences. I learned so much." —survey respondent, 2024*

Last, in FY 2023–24, the Parent Project® successfully adapted its curriculum to be culturally responsive to specific communities and build trust. For example, one of the contractors, One East Palo Alto, offered an in-person Parent Project® course that was responsive to Pacific Islander community members' needs. The course was facilitated in English, Samoan, and Tongan, and the surveys were translated and adapted so that content was culturally relevant. Instructors provided examples that they felt would be applicable to Pacific Islander community members.

CHALLENGES

In FY 2023–24, there were some challenges related to data collection that impacted this year's reporting. First, San Mateo County BHRS ODE collaborated with RDA Consulting to update the surveys administered to program participants, including (a) an application, (b) a preprogram survey, (c) a post program survey, and (d) a follow-up survey (administered 3–6 months after the course). The new surveys were finalized during the fall semester, so the Parent Project® class delivered by StarVista in September 2023 received their pre-course assessment after they had already started the course. As a result of the timing, questions that referenced behaviors prior to the course caused confusion for participants.

In addition, virtual classes contributed to lower survey completion rates. For virtual Parent Project® courses, participants submit survey responses online, which can create barriers based on participants' digital literacy, level of experience with online surveys, and/or technical challenges with the online platform. Together, these barriers and challenges can contribute to lower survey response rates.

Last, the translation of surveys into Samoan and Tongan could be improved in future courses. Participants expressed that the translations were too literal, and many participants did not feel comfortable completing the surveys or providing personal information to the county. Stigma and Discrimination Reduction

EARLY ONSET OF PSYCHOTIC DISORDERS

The (re)MIND® (formerly, PREP) program is a coordinated specialty care model that specializes in early intervention for schizophrenia spectrum disorders. (re)MIND® delivers comprehensive assessment and treatment grounded in wellness, recovery, and resilience to youth and young adults experiencing early symptoms of psychosis with evidence-based and culturally responsive interventions. The (re)MIND®/Bipolar Disorder Early Assessment and Management (BEAM) aftercare program—(re)MIND® Alumni—was developed to provide program graduates and caregivers with a specialized safety net to sustain gains achieved through engagement in psychosis early intervention.

The (re)MIND® and BEAM programs serve the following, regardless of insurance status:

- Residents of San Mateo County *and*
- Individuals between the ages of 14 and 35 years *and*
- Those 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*
- Individuals who have developed symptoms of psychosis for the first time in the past 2 years.

In addition, (re)MIND® Alumni serves individuals who have graduated from (re)MIND®/BEAM and elect to receive active support to maintain engagement in educational or vocational activities and further develop skills to self-navigate community resources.

(re)MIND® provides a wide array of services designed to wrap around the individual and their family members involved in treatment. Services start with an outreach and education campaign that helps members of the community and providers detect early warning signs and reduce the stigma associated with psychosis. When a youth or young adult has been identified and referred to the program, they receive a comprehensive, research-validated diagnostic assessment to determine their diagnosis with a high degree of accuracy and their eligibility for early intervention services. Following assessment, individuals participate in assessment feedback session(s), where they receive psychoeducation on diagnosis and treatment options. Besides early diagnosis, program services include up to 2 years of:

- Cognitive behavioral therapy (CBT) psychosis
- Algorithm-guided medication management
- Individual peer and family support services
- Psychoeducational multifamily groups
- Supported employment and education using the individual placement and support model

- Strengths-based care management
- Community-building activities such as program orientation for new participants and their families

Upon completion of services, either by reaching 2 years in the program or by achieving treatment and recovery goals early, program participants take part in a graduation ceremony to acknowledge their accomplishments and positive transitions. After graduating, participants are offered an opportunity to extend care with their (re)MIND®/BEAM treatment team at a lower intensity of services for up to a total of 4 years through the (re)MIND® Alumni program, to maintain treatment progress, successfully transition to higher levels of education and employment advancement, and empower social supports to sustain the participant's recovery.

PROGRAM IMPACT

(re)MIND® [a]	FY 2023–24
Clients served (unduplicated)	79
Cost per client	$7,390
Individuals reached (duplicated)	54
Total served	133

[a] *Unduplicated clients served are individuals who received early psychosis treatment and aftercare; individuals reached include families and caregivers.*

Outcome Indicators

Domain	Indicator/question	n	%
General behavioral health	Improvement engagement in meaningful activities (employment, academic placement/progression, volunteerism) for participants and alumni	75 of 79	95
General behavioral health	Child and Adolescent Needs and Strengths—psychosis (improvement in score by at least one point or maintenance in score of 1 from initial to follow-up for participants and alumni)	76 of 79	96
Utilization of emergency/crisis services	Reduction in hospitalizations (both number of days and number of episodes) for participants and alumni	75 of 79	95
Self-empowerment	"Due to this program, I can take control of aspects of my life"—agree; agree strongly for participants and alumni	25 of 27	93
Stigma (self-internalized)	"Due to this program, I am able to understand myself better"—agree; agree strongly for participants and alumni	5 of 5	100
Other-satisfaction	"I am satisfied with the services I have received at (re)MIND®/BEAM program"—agree; agree strongly for participants and alumni	25 of 27	93

DEMOGRAPHICS (*N* = 79)

Early Psychosis Program Client Demographics (N=79)

	Number of clients	Percentage of total
Age		
0–15 years	6	7
16–25 years	55	70
26–59 years	18	23
60–73 years	0	0
74 years and older	0	0
Prefer not to answer/unknown	0	0
Primary language		
English	78	99
Spanish	1	1
Another language	0	0
Prefer not to answer/unknown	0	0
Race		
Asian or Asian American	7	9
Black or African American	9	11
Native American, American Indian, or Indigenous	1	1
Pacific Islander	16	20
White or Caucasian	17	22
Another race	23	29
Prefer not to answer/unknown	6	8
Ethnicity		
Latino/a/x or Hispanic	24	30
Caribbean	0	0
Central American	3	4
Mexican/Mexican American/Chicano	18	23
South American	3	4
Another identity or tribe	0	0
Prefer not to answer/unknown	0	0
Not Latino/a/x or Hispanic	55	70
African	4	5
Asian Indian/South Asian	0	0
Chamorro	0	0
Chinese	6	8
Eastern European	2	2
European	8	10
Fijian	0	0
Filipino/a/x	16	20
Japanese	0	0
Korean	0	0

	Number of clients	Percentage of total
Middle Eastern or North African	0	0
Vietnamese	1	1
Tongan	0	0
Another ethnicity or tribe	0	0
Prefer not to answer/unknown	18	23
Sex assigned at birth		
Male	39	49
Female	38	48
Prefer not to answer/unknown	2	3
Intersex		
Yes	0	0
No	79	100
Prefer not to answer/unknown	0	0
Gender identity		
Female/woman/cisgender woman	31	39
Male/man/cisgender man	39	49
Transgender woman/trans woman/trans-feminine/woman	0	0
Transgender man/trans man/trans-masculine/man	4	5
Questioning or unsure of gender identity	0	0
Genderqueer/gender non-conforming/gender non-binary/neither exclusively female nor male	5	6
Indigenous gender identity	0	0
Another gender identity	0	0
Prefer not to answer/unknown	0	0
Sexual orientation		
Gay or lesbian	3	4
Straight or heterosexual	56	71
Bisexual	7	9
Queer	4	5
Pansexual	0	0
Asexual	0	0
Questioning or unsure of sexual orientation	4	5
Indigenous sexual orientation	0	0
Another sexual orientation	3	4
Prefer not to answer/unknown	2	2
Disability status		
Yes	4	5
No	73	92
Prefer not to answer/unknown	2	3
Veteran status		
Yes	0	0
No	79	100
Prefer not to answer/unknown	0	0

REFERRALS

Mental Health and Substance Use Referrals

Type of referral	FY referrals to programs within your agency	FY referrals to other agencies	FY total
Serious mental illness referrals	0	6	6
Substance use disorder referrals	0	0	0
Other mental health referrals	0	17	17
Total	**0**	**23**	**23**

Referrals to Other Services

Type of referral	FY total	Type of referral	FY total
Emergency/protective services	2	Legal	0
Financial/employment	2	Medical care	3
Food	0	Transportation	0
Form assistance	0	Health insurance	15
Housing/shelter	2	Cultural, nontraditional care	0
Other [a]	2	**Total**	**22**

[a] "Other" category consisted of school-based referrals/supports, general educational development classes, and gender support.

PROGRAM NARRATIVE

Improves timely access and linkages for underserved populations: The (re)MIND® program incorporates elements of the stepped model of care, designed to detect signs and risk states for SMI at the earliest stages. Program eligibility includes individuals at risk for developing SMI (prevention) and those with recent onset of symptoms (early intervention). This allows staff to intervene early, limiting the duration of untreated mental illness and preventing symptom worsening by working with individuals and their families toward recovery and illness remission. State timely access standards are upheld to expedite intake and services.

Reduces stigma and discrimination: The program equips mental health providers and the community to identify early warning signs of psychosis through targeted outreach and educational presentations. This achieves two major goals: (a) emphasizing the importance of early intervention in preventing SMI from limiting an individual's potential and (b) broadening community understanding of psychotic experiences as existing on a continuum of common human experiences rather than as a purely pathological condition. During the COVID-19 pandemic, outreach was adapted to digital formats, supplementing in-person activities. Participation in community-sponsored committees such as the DEC, SOGI Collaborative, and school-based initiatives increased to further reduce stigma and discrimination both digitally and in person.

Increases number of individuals receiving public health services: (re)MIND® and (re)MIND® Alumni collaborate with public partners such as the BHRS Youth Transition Assessment Committee (YTAC) network to support youth transitioning out of high school-based services who might otherwise lose contact with the public mental health system. These partnerships help youth maintain a safety net

within the mental health system until they can access public benefits and necessary services directly, ensuring a seamless care continuum and preventing youth from falling through the cracks during the transition to adulthood.

Reduces disparities in access to care: PEI services for psychosis are not yet widely available, and common barriers exist. The (re)MIND® and (re)MIND® Alumni programs address two key barriers: (a) Insurance status is not a factor for accessing care, eliminating barriers to specialized treatment at the earliest point possible, and (b) services are offered in conveniently accessible community locations, addressing potential transportation barriers.

Implements recovery principles: In (re)MIND® and (re)MIND® Alumni, participants' goals, dreams, and aspirations guide treatment. The multidisciplinary team uses a holistic, strengths-based approach to instill hope, empower participants' voices, and develop plans centered around their identified goals. The (re)MIND® Alumni program enables graduates and their families to become role models and peers for new cohorts through group activities, participation in graduations, and community outreach.

SUCCESSES

Client Success Story: A 26-year-old of Chinese American descent entered the program 4 years ago experiencing grandiosity, impulsivity, and depression that was causing them to have trouble finding a job even though they had graduated from college a year earlier with high marks. They had a series of therapists and a peer counselor who helped them along their recovery journey and to whom they wrote a letter upon their graduation from the Alumni program. Here is their story in their own words (quotation used with permission):

"Though not trained as a clinician, [Peer] Phil had an uncanny and intuitive sense of helping me reframe unhelpful scripts and thought patterns into a more balanced way of looking at things. . . . Because we've worked so long and intimately together, he really got to know my story and, during times I felt down, he reminded me of my many strengths as a person: resilience, motivation, creativity, determination. . . . Phil was never afraid to challenge me when he thought I needed to be pushed into a new way of approaching an issue (i.e., being more assertive with those around me), and I'll admit, there were times when I was annoyed at being pushed, though I thanked him later for it.

Nicole was my first therapist . . . devoted to combating the stigma, both external and internal, surrounding the bipolar diagnosis, and learning how to not over-identify with the bipolar label. . . . She helped me see the beginnings of what bipolar really was—a devastating diagnosis that takes a lot of hard work to manage, but is possible to heal from. The recovery can only begin when one has the will to get stable, and that was the first step for me—to want stability more than anything else. More than the highs, the chaos, the thrill. More than some of the gifts that hypomania and mania bear.

My second therapist was Philip, who admittedly, was not a great fit [style] therapist for me. But even he served a purpose during our brief time working together. He had a background in working with substance use disorders, and at the time, I had gotten into vaping and was working hard at quitting the habit. He offered psychoeducation on why we turn to substances to cope with challenges, and

the psychological detriment that substance use causes (it takes away the opportunity to tackle challenges on your own, which deprives you of the chance for personal growth).

Arie grabbed a shovel, jumped in the trenches with me, and helped me dig. I had gotten better at the behavioral coping skills, but still struggled to radically accept bipolar as a part of me, and harbored resentment surrounding the perceived limitations that the illness posed on my life. I cried a lot in our sessions together. We explored core beliefs, particularly the 'I am not lovable because I am bipolar' one, and slowly worked on chipping away at it.

Marissa was my final therapist at Felton. . . . In my final year with Felton, I did not speak much about bipolar during therapy sessions. This showed me that my bipolar was now tamed, managed, and controlled, and I could now turn my attention to other facets of my life without bipolar as the leading role. A big hurdle I faced in my recovery was fear of disclosure of my diagnosis to people I was dating, but the more I disclosed to people, the more I realized that most people don't really care as much about it as I thought they would. . . . And as Marissa reminded me during our final session together, I will have more challenges ahead. But none that I can't overcome.

With the bipolar expertly managed, I am now free to dream big, once again. I am currently writing a memoir about my recovery journey, which I hope to get published in the next 1–1.5 years. I am teaching yoga, dance, and fitness at community and corporate gyms, as well as high schools. . . . I am leading a full life and have such a bright future ahead. It's an ongoing journey, but I will carry everything I've learned these past 4 years into the rest of my life. Thank you for giving me my life back. I am forever indebted to you all."

CHALLENGES

The biggest challenge that the program encountered this year was the turnover of senior staff, including four therapists, the family partner, and the occupational therapist. This left a large hole in the program's ability to adequately triage and intake clients; thus, the program closed the waitlist to non-Medi-Cal clients. Medi-Cal clients also saw increased wait times for intake slots in the program, and the census dropped as a result of not having the therapist coverage to serve the clients with the highest needs. By the end of the FY, the program was able to hire for its bilingual Spanish-speaking therapist, family partner, and occupational therapist positions, and it is fully staffed otherwise.

CRISIS RESPONSE

The San Mateo Assessment and Referral Team (SMART) program provides San Mateo County's residents with a comprehensive assessment in the field and offers an alternative to PES when appropriate or, if needed, writes a hold status and provides secure transportation to the hospital. SMART serves any resident in psychiatric crisis regardless of age as identified by law enforcement. Primary program activities include consultation with law enforcement on scene. SMART can write a 5150 hold if needed and transport the person. If the individual does not meet the 5150 criteria, the SMART medic can provide support and transportation to an alternate destination (e.g., crisis residential facility, doctor's office, detox, shelter, home).

PROGRAM IMPACT

San Mateo Assessment and Referral Team	FY 2023–24
Total calls received	245
Total cost per client	$210

The SMART contract with American Medical Response (AMR) has been providing 5150 evaluation and transport services since 2005. SMART is staffed by AMR paramedics who are also trained in crisis intervention and is activated only by law enforcement officers. The SMART goals and measures for FY 2023–24 are as follows, and both goals have been met successfully:

SMART responded to 245 calls during this FY. The highest volume of calls was Tuesday through Thursday afternoons.

SMART's first goal is to divert 10% of calls from PES admission where a 5150 was not already placed. AMR has succeeded in surpassing this goal. In FY 2023–24, AMR diverted 41.4% in the first quarter, 38.1% in the second quarter, 34.6% in the third quarter, and 10% in the fourth quarter.

SMART's second goal is to respond to 75% of appropriate calls for service. AMR has also succeeded in surpassing this second goal by responding to all appropriate calls for service. In FY 2023–24, AMR responded to 92.9% in the first quarter, 87.9% in the second quarter, 86.7% in the third quarter, and 89.5% in the fourth quarter.

SMART evaluates people in the field or at individual residences upon activation by a law enforcement officer, conducts mental health assessments, places 5150 involuntary holds if meeting the criteria, or connects people to behavioral health services upon stabilizing individuals that would otherwise not have occurred. Because SMART medics receive crisis intervention training, they are able to engage individuals in behavioral health crises with a better understanding of their mental health conditions. Being able to transport people right on the spot to appropriate services has increased timely connectivity and treatment opportunities for many people, especially for those who have disengaged from services.

SMART medics evaluate individuals for both physical and mental health issues. They serve all ages, regardless of housing status, residency status, insurance status, and veteran status. As SMART serves all ages, they respond to many people younger than 18 years who are in emotional crises, including foster youth and at schools. In many circumstances, issues for youth may often be related to peer problems, family issues, and/or substance use issues as means to cope with life stresses. By addressing the youth's concerns timely and empathically, it is more likely for the youth to remain in school and for their family unit to stay intact. When SMART responds to parents in behavioral health crises and gets them directly involved in services, they also indirectly support the needs of their children.

SMART responds to many unhoused adults living with SMI in their encampments, in shelters, or at the San Mateo County Navigation Center. By getting these sheltered/unsheltered individuals evaluated promptly and facilitating access to the right level of services, their mental illnesses are stabilized sooner and resources to address their homelessness can be made available to them.

SMART will also connect individuals who are not already on a 5150 hold but meet criteria for stabilization services to relevant programs for treatment, an example of which is Serenity House.

SMART works closely with San Mateo's law enforcement co-responder mobile crisis team, the Community Wellness and Crisis Response Team, to provide 5150 evaluation, involuntary hold, and connection to higher levels of treatment or outpatient care in a timely manner.

PRIMARY CARE AND BEHAVIORAL HEALTH INTEGRATION

The Primary Care Interface (PCI) program is funded 20% CSS and 80% PEI. The purpose of the PCI program is to integrate mental health services into primary care. The program partners with San Mateo County primary care clinics to provide easier access to mental health services. It started in 1995 at one clinic and is now embedded in five primary care clinics throughout the county. Since the program's inception, its staff has grown from one therapist and nurse to a multidisciplinary team of more than 23 staff members, including marriage and family therapists, licensed clinical social workers, and case managers.

The program serves all age groups, from children as young as 3 years to the geriatric population. The program is offered to those with mild to moderate mental health issues. Approximately 60% to 70% of clients are covered by Medi-Cal, whereas the remaining clients are covered through the county health insurance program, Access, and Care for Everyone.

Primary program screenings, activities, and interventions provided: The primary care clinics use the Patient Health Questionnaire-2 and -9 as well as the Adverse Childhood Experiences Questionnaire to screen adults and children visiting the clinics. After being diagnosed with a mild or moderate mental health condition or risk factor, clients are referred, on the basis of their needs, to psychiatry, therapy, and/or case management. Referrals are also made to provide support for treating alcohol use disorder and other SUDs.

New activities and interventions targeting SUDs: A new intervention undertaken in FY 2023–24 was weekly wellness group sessions that were offered in both English and Spanish. Staff held sessions on four different topics over an 8-week period, alternating weekly between sessions conducted in English and Spanish. At the end of the 8-week period, PCI staff evaluated participant feedback and attendance levels to adapt and improve sessions.

PROGRAM IMPACT

The following table summarizes the number of clients served through the PCI program during FY 2023–24. The program served 2,506 referred individuals, and there were completed intakes for 685 unduplicated clients. The remaining 1,821 referrals were from outreach or triage and did not result in completed intakes. These referrals also included duplicates because one individual could be referred more than once.

Primary Care Interface	FY 2023–24
Clients served (unduplicated)	685
Individuals reached (duplicated)	1,821
Cost per client	$187

Number of Individuals Served Through the Primary Care Interface Program (FY 2023–24)

Individuals served	Definition	FY total
Unduplicated clients served	Number of individuals served in the primary program component(s); unduplicated counts (completed intakes)	685
Duplicated individuals reached	Number of individuals served in all other components, if applicable; may be duplicated counts based on service provided (outreach/triage only)	1,821
Total individuals served	All individuals served across all program components (unduplicated clients served + individuals reached)	2,506

Providing timely access to services: PCI program staff continued to work on site in county primary care clinics in FY 2023–24. This allowed integrated teams at the same site to screen and manage a variety of health issues efficiently and in collaboration with one another. The majority of the program's clients are seen the same day, as they are referred via a warm handoff with a mental health provider during a visit with their primary care provider. In addition, the program hired four new staff members: two therapists, one medical assistant, and one medical office assistant. This accelerated the process of client outreach and appointment scheduling.

Increasing the number of individuals receiving public health services: Clients with Medi-Cal and uninsured clients often have a difficult time finding any providers who have openings. In similar systems, weeks or even months can elapse between a primary care referral to mental health services and the intake appointment. These barriers to entry for behavioral health care tend to cause attrition. In contrast, PCI's warm handoff system eliminates long delays that often lead to attrition, thereby increasing the number of clients receiving mental health services. Program staff also meet regularly with the primary care providers to provide information about symptoms of mental illness, which increases the number of referrals that PCI receives. The addition of a medical assistant and medical office assistant in FY 2023–24 also has greatly improved the program's ability to follow up with clients who had not engaged in treatment for weeks or months. The work of these two employees has both increased client engagement and provided clinical staff with more time to focus on client care. In addition, PCI is working to create a direct linkage between the program and the HPSM. The number of intermediary steps needed to connect new HPSM beneficiaries to PCI services continued to be a prominent challenge for the program in FY 2023–24.

Reducing stigma and discrimination for clients and reducing disparities in access to care: Clients who access mental health services through PCI do not have to go to an external clinic that specifically provides mental health services. When behavioral health and primary care providers are co-located, clients are less likely to field uncomfortable questions from friends or family members about receiving mental health services. Fear of stigma may deter individuals from seeking mental health treatment, and the additional layer of privacy afforded by co-location of behavioral health and primary care clinicians removes this barrier for some clients. Case managers also provide services in clients' homes, which helps those who are unable to physically come into the clinic feel supported. The program continues to offer telehealth appointments before and after standard working hours, which is helpful for clients who cannot leave work to attend an appointment. Moreover, PCI clinicians

coordinate with providers at the county's regional clinics to perform warm handoffs of PCI clients to clinicians who have the capacity and resources to provide long-term mental health services. These strategies enable PCI clients, many of whom come from underserved populations, to have improved access to care. In FY 2023–24, PCI staff have continued to offer behavioral health services to clients of a new clinic that primarily serves immigrant populations, who may struggle to access health and human services resources. Colleagues who work at this clinic provide critical health and human services resources that new immigrants often struggle to access, such as immunizations, physical examinations, mental health services, and referrals to social service providers. In addition, three quarters of program staff are bilingual and can provide services in Spanish for clients whose preferred language is Spanish.

Implementing recovery principles: PCI clinicians are trained in the treatment of clients with SUDs. They strive to provide a welcoming, nonjudgmental care environment. One way that staff do so is through the use of motivational interviewing techniques, which involves meeting the client where they are, assessing where they fall on the stages of change model, and encouraging change talk. Program staff have also been present at community outreach events in the past year, including Juneteenth and SUD recovery events. Furthermore, the program has strong ties with the IMAT team. IMAT coordinates ongoing SUD care services for clients encountered in the medical emergency department or in the field, and PCI supports this work through daily collaboration with the IMAT staff on outreach to clients. With all clients, including SUD clients, the program continues to provide trauma-informed treatment approaches and coordination across providers. Program clinicians are also continuing to target co-occurring mental health and substance use disorder diagnoses through eye movement desensitization and reprocessing (EMDR), which helps individuals process and recover from severe trauma and can lead to SUD remission. In addition, the program began offering two new training courses for staff in FY 2023–24: Race, Equity, and Health and Foundational Equity Training. The program also continues to offer two other training courses: Cultural Humility 101: Building Bridges to Diversity and Inclusion and Embracing Difference Through the Lens of Cultural Humility: Focus on Implicit Bias.

The following table summarizes FY 2023–24 PCI program referral information. Throughout the year, there were 2,528 total referrals. Of the referrals received, 701 resulted in program enrollment, representing 685 unduplicated engaged clients with completed intakes. Note that some clients are triage only, not complete intakes. The average duration of untreated mental illness was 22.1 days. The average length of time between referral date and enrollment date was 21.0 days, ranging from 0.0 to 85.0 days.

Data on Primary Care Interface (PCI) Referrals Received and Clients' Health Care Use (FY 2023–24)

Referral information	
Total number of referrals received to the program	2,528
Total number of referrals that resulted in program enrollment (number engaged)	
For programs with a clinical primary program component only	
Average duration of untreated mental illness (in days)	22.1
Average length of time between referral date and enrollment date (in days)	21.0

Minimum length of time (in days)	0.0
Maximum length of time (in days)	85.0

The following table summarizes the types of behavioral health referrals made as part of the PCI program during FY 2023–24. During the year, there were 431 total behavioral health referrals, with 57 referrals to programs within the agency and 374 to other agencies. There was a total of 28 SMI referrals, three SUD referrals, and 400 other mental health referrals. More SMI referrals were made to programs within the agency than to other agencies, but there were significantly more mental health referrals to other agencies.

Behavioral Health Referrals by Referral Type (FY 2023–24)

Type of referral	FY referrals to programs within agency	FY referrals to other agencies	FY total
Serious mental illness referrals	28	0	28
Substance use disorder referrals	0	3	3
Other mental health referrals	29	371	400
Total	**57**	**374**	**431**

The following table summarizes the types of referrals made to all other service providers as part of the PCI program during FY 2023–24. During the year, there was a total of 537 referrals, with the top referrals including other (254), food (154), and health insurance (40).

Referrals to Other Services by Referral Type (FY 2023–24)

Type of referral	FY total
Other	254
Food	154
Health insurance	40
Medical care	21
Legal	17
Financial employment	15
Housing/shelter	15
Transportation	15
Emergency protective services	2
Form assistance	2
Cultural/nontraditional care	2
Total	**537**

The following table summarizes clients' perceptions of the PCI program's impact on their lives on a Likert-type scale during FY 2023–24. Out of the 701 survey respondents, 82.5% (578) did not respond to the three questions shown in the table. Out of the 123 clients who answered the survey, most

either agreed (40.7%) or strongly agreed (48.7%) that they were better able to manage their symptoms and participate in daily life. Most either agreed (37.1%) or strongly agreed (49.2%) that they thought more positively about challenges and believed the decisions and steps they took impacted their outcome, but 12.1% felt neutral. In addition, 36.6% agreed, 49.2% strongly agreed, and 12.1% felt neutral that they learned skills and strategies to cope with stressors.

Primary Care Interface Clients' Perceptions of the Program's Impact on Their Lives

Response	Number of clients	Percentage of all survey respondents	Percentage of survey respondents who answered question
As a result of participating in this program, I am better able to manage my symptoms and participate in daily life.			
Strongly agree	59	8.4	48.0
Agree	50	7.1	40.7
Neutral	13	1.9	10.6
Disagree	1	0.1	0.8
Strongly disagree	0	0.0	0.0
No response	578	82.5	0.0
Total	**701**	**100.0**	**100.0**
As a result of participating in this program, I think more positively about challenges and I believe the decisions and steps I take impact my outcome.			
Strongly agree	61	8.7	49.2
Agree	46	6.6	37.1
Neutral	15	2.1	12.1
Disagree	2	0.3	1.6
Strongly disagree	0	0.0	0.0
Not applicable	577	82.3	0.0
Total	**701**	**100.0**	**100.0**
As a result of participating in this program, I learned skills and strategies to cope with stressors.			
Strongly agree	63	9.0	51.2
Agree	45	6.4	36.6
Neutral	14	2.0	11.4
Disagree	1	0.1	0.8
Strongly disagree	0	0.0	0.0
Not applicable	578	82.5	0.0
Total	**701**	**100.0**	**100.0**

DEMOGRAPHICS

The following table summarizes the demographic information for the 882 clients who were admitted and actively a part of the PCI program during FY 2023–24. The largest percentage of clients (42.3%) was between the ages of 26 and 59 years, followed by clients between the ages of 0 and 15 years (23.1%); 64.5% identified as a race not listed, and 6.7% identified as White/Caucasian. A majority (64.2%) identified as Hispanic or Latino. A majority also identified as female (50.7%). Most reported

identifying as straight or heterosexual (10.7%). It is important to note, however, that 22.0% did not report information on their race, 20.1% did not report information on their ethnicity, and 87.6% did not report information on their sexual orientation.

Primary Care Interface Program Client Demographics (N=882)

	Number of clients	Total number of clients	Percentage of total
Age			
0–15 years	204	882	23.1
16–25 years	117	882	13.3
26–59 years	373	882	42.3
60 years and older	188	882	21.3
Race			
Another race	569	882	64.5
White or Caucasian	59	882	6.7
Black	17	882	1.9
Other Asian	17	882	1.9
Filipino	12	882	1.4
Multiple	7	882	0.8
Chinese	5	882	0.6
Samoan	1	882	0.1
Hawaiian Native	1	882	0.1
Unknown/not reported	194	882	22.0
Ethnicity			
Hispanic or Latino	566	882	64.2
Not Hispanic or Latino	139	882	15.8
Unknown/not reported	177	882	20
Sex assigned at birth			
Female	447	882	50.7
Male	306	882	34.7
Unknown/not reported	129	882	4.6
Sexual orientation			
Straight or heterosexual	94	882	10.7
Bisexual	4	882	0.6
Lesbian, gay, or homosexual	4	882	0.5
Another sexual orientation	2	882	0.2
Declined to state	6	882	0.7
Unsure	1	882	0.1
Unknown/not reported	773	882	87.6

SUCCESSES

In FY 2023–24, the PCI program added two positions to help with administrative support: a medical assistant and a medical office assistant, both of whom are part-time employees. Previously, clinical staff (such as case managers, therapists, and psychiatrists) made phone calls to manage appointment schedules and verify whether clients were still interested in receiving services. This year, the medical assistant and medical office assistant have been taking on these tasks, allowing PCI clinicians to spend more time on treatment and less time handling administrative tasks.

One successful activity in FY 2023–24 was the weekly wellness group sessions, conducted in both English and Spanish. This activity provided clients with emotional support and helped the program identify individuals who were interested in a particular service. The Spanish language sessions had a higher attendance rate than the English language sessions, and as a result, the PCI program will be holding more sessions in Spanish in the future.

Client Success Story: G.M. is a 71-year-old man referred by his PCP for opioid use disorder treatment. The client had been prescribed two high-dose opioids for pain from his previous PCP, who then retired. The new PCP was uncomfortable prescribing such high doses of opioids and requested the client be switched to buprenorphine, an opioid replacement that is safer. Initially, the client's new PCP referred him to the pain clinic. During this appointment, the client expressed irritation with that clinician's refusal to continue prescribing opioid medications on the basis that this long-standing medication regimen was unsafe. Because the client disagreed with the pain clinic's recommendation for treating his pain, he refused to receive further services through the pain clinic. His PCP then referred him to the PCI program. The client met with PCI's psychiatric NP, who also suggested that he stop taking opioids, prompting the client to become highly defensive about the perceived therapeutic benefits of the medication. He conveyed that he did not believe he had an opioid problem, just a pain problem. In response, the NP used motivational interviewing techniques to meet the client where he was with regard to his outlook on the relative risks and benefits of various pain medications. Slowly, the client began to recognize some of the problems that opioids were causing in his life. She then proposed a treatment plan to switch him to buprenorphine, but the client was not yet ready to accept this advice, proceeding to refuse further services from PCI. After several more visits with his PCP, however, the client returned to the PCI program's NP because he felt that they had a good rapport. He ended up accepting the NP's recommendation to go through medical detoxification and start buprenorphine. The client has finished the transition to buprenorphine—now his only pain medication—and agreed to have his care transferred to the pain clinic for ongoing treatment. The NP's empathic and humanistic approach to treatment as well as the psychoeducation she provided helped the client better understand the problem and accept the recommended solution.

CHALLENGES

In a continuation from FY 2022–23, maintaining PCI program staffing levels again proved difficult this year (FY 2023–24). One of the adult psychiatrists was out on leave for most of the year, and by June 2024, the program had several open therapist and case manager positions. Staffing problems led to delays in initiating therapy, case management, and psychiatric services. The 1,040 rule for extra-help positions also continued to present challenges for the program in FY 2023–24. Because of this rule,

individuals hired to fill extra-help positions can work a total of only 1,040 hours per year, meaning that they are limited to providing 6 months of full-time labor or 12 months of part-time work. Because the program hired the medical office assistant into an extra-help position in the middle of the FY, this staff member has worked full-time for the remainder of FY 2023–24. However, PCI leadership is now faced with deciding whether this staff member should serve 6 months of full-time employment or 12 months of part-time work.

Another challenge faced by the program in FY 2023–24 relates to the long-anticipated switch to a new electronic medical records system. County primary care clinics are switching to a new system soon. Because of the close connection between PCI and primary care clinics, San Mateo County Health leadership agreed to have PCI be part of the initial roll-out of the new electronic medical records. PCI is the only division within BHRS that is going to have functional access to handle referrals and communications with primary care clinics over the remainder of FY 2023–24. The electronic medical records system transition requires many hours of planning as well as staff training, placing additional burdens on an already short-staffed team.

PCI has also experienced difficulties making appropriate dispositions out of their system. The PCI model is intended to provide short-term treatment, up to 6 months, until clients can be transferred into the care of another mental health provider. However, clients sometimes get "stuck" in PCI for longer periods of time because of current gaps in the system of care. Examples include the following:

- Clients who have difficulty making appointments with physicians but are on opioid replacement medications and have been unable to transition to a contract agency.
- Stable clients whose medications for a mental health condition of SUD could safely be prescribed by primary care providers, but whose primary care provider recently resigned.
- Clients who are referred to other levels of care and then are dissatisfied with the care they receive from the referral agency. Some clients become accustomed to the PCI team's high level of service and express disappointment when their new providers offer only telehealth visits instead of in-person services.

Client Challenge Story:

M.H. is a 34-year-old woman living with SMI who is the primary caretaker for her 3-year-old child but currently lacks safe, stable housing. She has been diagnosed with posttraumatic stress disorder, major depressive disorder, generalized anxiety disorder, opioid use disorder, and methamphetamine use disorder. This individual's primary care provider referred her to the PCI program for help addressing these multiple mental health problems. She attended her medication and therapy appointments sporadically, although she was able to start buprenorphine, a medication prescribed to treat opioid use disorder. After she became somewhat stable, PCI's psychiatric NP attempted to transfer her to one of the regional county clinics that treats clients living with SMI and/or SUDs. The new clinic successfully established contact with the client and scheduled her intake assessments. Unfortunately, the client did not show up to her intake appointment, relapsed on substances, and then called the PCI NP to request a new prescription for her medications. PCI has continued to provide support for this very high-risk and high-needs client. Connecting her to a regional clinic with more resources will be helpful, but attempts to finalize this transition have been unsuccessful to date.

RAVENSWOOD FAMILY HEALTH CENTER

Ravenswood	FY 2023–24
Total clients served	80
Total cost per client	$226

Ravenswood Family Health Center is a community-based federally qualified health center that serves East Palo Alto residents. Ravenswood provides outreach and engagement services and identifies individuals presenting for health care services who 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 PEI.

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

PEI PROGRAMS – OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

YOUTH AND ADULT MHFA

Adult MHFA (the program or the course) is an 8-hour public education training program provided by the BHRS ODE. The course introduces participants to the unique risk factors and warning signs of mental health problems in adults, builds understanding of the importance of early intervention, and teaches individuals how to help an individual in crisis or experiencing a mental health challenge. Adult MHFA aims to teach community members and partners in San Mateo County by

- Incorporating culturally humble questions, examples, and resources to help participants to intervene with and refer behavioral health services to marginalized populations in a more culturally responsive way.
- Sharing mental health facts and stories of hope and recovery, which both help reduce stigma of mental health issues and conditions.
- Sharing local resources that participants can refer to for professional behavioral health support, including public health services.
- Partnering with agencies that connect marginalized communities to care, including those serving older adults and immigrant communities to reduce disparities in access to care.

The BHRS ODE works in partnership with other community organizations to facilitate Adult MHFA courses. Between July 2023 and June 2024 (FY 2023–24), the BHRS ODE contracted with trained instructors from Kingdom Love and Voices of Recovery San Mateo County to facilitate courses. Course

instructors provided 14 Adult MHFA courses in in-person, virtual, and blended formats (blended virtual and blended in-person).

In addition to the Adult MHFA course offerings, participants complete five surveys throughout the program to assess course outcomes. The five forms include (a) an application, (b) a preprogram assessment, (c) a post program assessment, (d) a course evaluation form, and (e) a follow-up survey sent 3 to 6 months after completion of the course. These surveys collect demographic and contact information and evaluate outcomes by assessing participants' confidence and changes in knowledge about mental health concepts.

PROGRAM IMPACT

Adult Mental Health First Aid	FY 2023–24
Total clients served	183
Total cost per client	$447*

*Cost includes both Adult and Youth MHFA

Outcome Indicators

Domain	Indicator/question	n	%
Cultural identity/humility	*As a result of this training, I have a better understanding of how mental health and substance use challenges affect different cultures.*	45 of 48	94
	I feel like my identity, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion, etc.) were affirmed by this program/training/event.	112 of 120	93
Access to services	*Through my participation in this event/program/training, I have learned knowledge and skills that I can use to access behavioral health services.*	73 of 73	100

PROGRAM NARRATIVE

Adult MHFA aims to teach community members and partners in San Mateo County about mental health risk factors, warning signs of mental health problems, and the importance of early intervention. The course also builds participants' skills in how to help an individual in crisis or experiencing a mental health challenge, shares information about mental health concepts, and disrupts common misconceptions about mental health. Surveys collected from Adult MHFA participants demonstrated that course outcomes aligned to each of these aims.

Specifically, Adult MHFA incorporates culturally responsive questions, examples, and resources to help participants to intervene with and refer behavioral health services to underserved populations in a more culturally responsive way. As a result, Adult MHFA seeks to improve timely access and linkages for underserved populations.

In addition, Adult MHFA shares mental health facts and stories of hope and recovery, which helps reduce stigma of mental health issues and conditions. Through the course content, instructors share local resources with participants so that they can refer their peers and fellow community members to professional behavioral health support, including public health services, which increases the number of individuals receiving public health services. Adult MHFA also partners with agencies that connect marginalized communities to care, including those serving older adults and incarcerated youth. Moreover, Adult MHFA participants come from a diverse range of experiences, including a diversity of spoken languages, races, ethnicities, and group affiliations. Through this diverse program reach, Adult MHFA effectively reduces disparities in access to care. Finally, Adult MHFA implements the recovery principles of support because participants are equipped with knowledge that empowers them to provide hope and support to those facing mental health issues in their everyday lives.

SUCCESSES

In FY 2023–24, the program manager is particularly proud that marginalized communities in San Mateo County were prioritized, including cities such as Pescadero, Redwood City, East Palo Alto, and South San Francisco. As a result of classes in these locations, partnerships were built with local municipalities, IHSS, behavioral health peer organizations, and job training programs.

CHALLENGES

In FY 2023–24, there were some challenges related to data collection that impacted this year's reporting. First, San Mateo County BHRS ODE collaborated with RDA Consulting to update the surveys administered to program participants, including the (a) application, (b) preprogram assessment, (c) post program assessment, and (d) follow-up survey (administered 3–6 months after the course). The new surveys were finalized during fall 2023, so the new surveys were not implemented until February 2024. While the new surveys were finalized, Adult MHFA participants completed the old versions of the surveys, which had some differing questions or question types. This resulted in some questions being asked on some surveys and not others, which impacted the total number of respondents for certain questions.

In FY 2023–24, San Mateo County BHRS ODE piloted working with one contractor (vs. up to five contractors). There was some time and effort needed for the adjustment and transition for San Mateo County BHRS ODE staff, contractor staff, instructors, and community members. Some challenges came up when some classes were cancelled, and host/partner sites had expectations that were not met. Some solutions used to mitigate the challenges in FY 2023–24 and beyond were to draft an agreement with host/partner sites and also to update the email correspondence with registrants/participants to clarify expectations of a complex process and requirements for Adult MHFA training.

DEMOGRAPHICS

About one fifth of respondents (36 out of 189) reported living in South San Francisco. About one fifth of respondents (37 out of 189) identified as either a client/consumer of behavioral health services or a family member, and almost one fifth of respondents identified as both (30 out of 189, 16%).

Adult MHFA Training Participant Demographics (N = 189) [50]

	Number of clients	Percentage of total
Age		
0–15 years	0	0
16–25 years	22	12
26–59 years	143	75
60–73 years	20	11
74 years and older	0	0
Prefer not to answer/unknown	4	2
Primary language		
English	139	74
Spanish	30	16
Another language	16	8
Prefer not to answer/unknown	4	2
Race/ethnicity		
Asian or Asian American	52	28
Black or African American	13	7
Native American, American Indian, or Indigenous	0	0
Native Hawaiian or Pacific Islander	4	2
White or Caucasian	44	23
Latino/a/x or Hispanic	63	33
Another race, ethnicity, or tribe	7	4
Prefer not to answer/unknown	6	3
Gender identity		
Female/woman/cisgender woman	148	78
Male/man/cisgender man	34	18
Transgender woman/trans woman/trans-feminine/woman	0	0
Transgender man/trans man/trans-masculine/man	0	0
Questioning or unsure of gender identity	0	0
Genderqueer/gender non-conforming/gender non-binary/neither exclusively female nor male	1	0.5
Indigenous gender identity	1	0.5
Another gender identity	1	0.5
Prefer not to answer/unknown	4	2

[50] Of the 189 initial registrants, 183 individuals participated in the training. The following demographic data were collected during the registration process.

	Number of clients	Percentage of total
Sexual orientation		
Gay or lesbian	4	2
Straight or heterosexual	151	80
Bisexual	11	6
Queer	3	1.5
Pansexual	1	0.5
Asexual	2	1
Questioning or unsure of sexual orientation	2	1
Indigenous sexual orientation	1	0.5
Another sexual orientation	3	1.5
Prefer not to answer/unknown	11	6
Behavioral health consumer or family member		
Client/consumer	13	7
Family member	23	12
Both	30	16
Neither	36	19
Prefer not to answer/unknown	87	46

Youth MHFA (the program or the course) is a 6–8-hour public education training program funded by the MHSA and provided by San Mateo County's BHRS ODE. Specifically, the course introduces participants to the unique risk factors and warning signs of mental health problems in adolescents, builds understanding of the importance of early intervention, and teaches individuals how to help a youth in crisis or experiencing a mental health challenge.

The BHRS ODE works in partnership with other community organizations to facilitate Youth MHFA courses. Between July 2023 and June 2024 (FY 2023–24), the BHRS ODE contracted with trained instructors from Kingdom Love to facilitate courses. Course instructors provided 11 Youths MHFA courses in in-person, virtual, and blended formats (blended virtual and blended in-person).

In addition to completing the Youth MHFA course offerings, participants completed five surveys throughout the program to assess course outcomes. The five forms include (a) an application, (b) a preprogram assessment, (c) a post program assessment, (d) a course evaluation form, and (e) a follow-up survey sent 3 to 6 months after completion of the course. These surveys collect demographic and contact information and evaluate outcomes by assessing participants' confidence and changes in knowledge about mental health concepts.

PROGRAM IMPACT

Youth Mental Health First Aid	FY 2023–24
Total clients served	152
Total cost per client	$447

*Cost includes both Adult and Youth MHFA

Outcome Indicators

Domain	Indicator/question	*n*	%
Cultural identity/humility	*As a result of this training, I have a better understanding of how mental health and substance use challenges affect different cultures.*	69 of 81	85
	I feel like my identity, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion, etc.) were affirmed by this program/training/event.	115 of 134	86
Access to services	*Through my participation in this event/program/training, I have learned knowledge and skills that I can use to access behavioral health services.*	52 of 53	98

PROGRAM NARRATIVE

Youth MHFA aims to teach community members and partners in San Mateo County about mental health risk factors, warning signs of mental health problems, and the importance of early intervention among youth. The course also builds participants' skills in how to help a youth in crisis or experiencing a mental health challenge, shares information about mental health concepts, and disrupts common misconceptions about mental health.

Specifically, Youth MHFA incorporates culturally relevant questions, examples, and resources to help participants to intervene with and refer behavioral health services to underserved populations in a more culturally responsive way. As a result, Youth MHFA seeks to improve timely access and linkages for underserved populations.

In addition, Youth MHFA shares mental health facts and stories of hope and recovery, which helps reduce stigma of mental health issues and conditions. Through the course content, instructors share local resources with participants so that they can refer their peers and fellow community members to professional behavioral health support, including public health services, which increases the number of individuals receiving public health services. Youth MHFA also partners with agencies that connect marginalized communities to care, including those serving incarcerated youth. Moreover, Youth MHFA participants come from a diverse range of experiences, including a diversity of spoken languages, races, ethnicities, and group affiliations. Through this diverse program reach, Youth MHFA effectively reduces disparities in access to care. Finally, Youth MHFA implements the recovery principles of support because participants are equipped with knowledge that empowers them to provide hope and support to those facing mental health issues in their everyday lives.

SUCCESSES

In FY 2023–24, the program manager is particularly proud that marginalized communities in San Mateo County were prioritized, including cities such as Half Moon Bay, Redwood City, East Palo Alto, and South San Francisco. As a result of classes in these locations, partnerships were built with local municipalities, libraries, and schools.

CHALLENGES

In FY 2023–24, there were some challenges related to data collection that impacted this year's reporting. First, San Mateo County BHRS ODE collaborated with RDA Consulting to update the surveys administered to program participants, including the (a) application, (b) preprogram assessment, (c) post program assessment, and (d) follow-up survey (administered 3–6 months after the course). The new surveys were finalized during fall 2023, so the new surveys were not implemented until February 2024. While the new surveys were finalized, Youth MHFA participants completed the old versions of the surveys, which had some differing questions or question types. This resulted in some questions being asked on some surveys and not others, which impacted the total number of respondents for certain questions.

In FY 2023–24, San Mateo County BHRS ODE piloted working with one contractor and a new contractor (vs. up to five contractors). There was some time and effort needed for the adjustment and transition for San Mateo County BHRS ODE staff, contractor staff, instructors, and community members. Some challenges came up when some classes were cancelled, and host/partner sites had expectations that were not met. Some solutions used to mitigate the challenges in FY 2023–24 and beyond were to draft an agreement with host/partner sites and also to update the email correspondence with registrants/participants to clarify expectations of a complex process and requirements for Youth MHFA training.

DEMOGRAPHICS

About 15% of respondents (24 out of 156) reported living in San Mateo, followed by 11% each in East Palo Alto (17 out of 156) and Redwood City (17 out of 156). In addition, one fifth of respondents (31 out of 156) identified as either behavioral health services clients/consumers, family members of clients, or both.

Youth MHFA Training Participant Demographics (N = 156)[51]

	Number of clients	Percentage of total
Age		
0–15 years	2	1
16–25 years	23	15
26–59 years	115	74

[51] Of the 156 initial registrants, 152 individuals participated in the training. The following demographic data were collected during the registration process.

	Number of clients	Percentage of total
60–73 years	5	3
74 years and older	0	0
Prefer not to answer/unknown	11	7
Primary language		
English	84	54
Spanish	44	28
Another language	22	14
Prefer not to answer/unknown	6	4
Race/ethnicity		
Asian or Asian American	32	21
Black or African American	11	7
Native American, American Indian, or Indigenous	0	0
Native Hawaiian or Pacific Islander	8	5
White or Caucasian	22	14
Latino/a/x or Hispanic	59	38
Another race, ethnicity, or tribe	13	8
Prefer not to answer/unknown	11	7
Gender identity		
Female/woman/cisgender woman	111	71
Male/man/cisgender man	29	19
Transgender woman/trans woman/trans-feminine/woman	1	0.01
Transgender man/trans man/trans-masculine/man	0	0
Questioning or unsure of gender identity	0	0
Genderqueer/gender non-conforming/gender non-binary/neither exclusively female nor male	0	0
Indigenous gender identity	0	0
Another gender identity	0	0
Prefer not to answer/unknown	15	10
Sexual orientation		
Gay or lesbian	8	5
Straight or heterosexual	107	69
Bisexual	10	6
Queer	4	3
Pansexual	1	0.5
Asexual	1	0.5
Questioning or unsure of sexual orientation	0	0
Indigenous sexual orientation	0	0
Another sexual orientation	1	0.5
Prefer not to answer/unknown	24	15

	Number of clients	Percentage of total
Behavioral health consumer or family member		
Client/consumer	7	4
Family member	15	10
Both	9	6
Neither	19	12
Prefer not to answer/unknown	106	68

PEI PROGRAMS – ACCESS AND LINKAGE TO TREATMENT

OUTREACH COLLABORATIVES

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

See Appendix 8. Outreach Collaborative Annual Report for FY 2023–24.

NORTH COUNTY OUTREACH COLLABORATIVE

The NCOC comprises five partner agencies located in the north sector of San Mateo County: Daly City Partnership (DCP), Daly City Youth Health Center (DCYHC), Pacifica Collaborative (PAC), StarVista, and Asian American Recovery Services (AARS)/HealthRight360. The NCOC's primary objectives are to connect individuals with mental health services, alcohol and substance use treatment, and other social services. The collaborative aims to reduce stigma and discrimination surrounding mental health, alcohol, and other drug issues within the community by increasing awareness of available resources through education and improving access to care.

The NCOC continues to serve as a bridge for service providers, enhancing their understanding of the diverse populations they serve. In addition to connecting with underserved communities, the NCOC has focused on fostering effective collaborative relationships with culturally and linguistically diverse community members. This approach enhances the BHRS's capacity and overall system performance in addressing the needs of various prominent populations in north San Mateo County, including Filipino, Pacific Islander, Latinx, Chinese, and LGBTQ+ communities.

The collaborative has learned that building trust is crucial in creating linkages to services. Knowing individuals personally improves the connection and facilitates warm handoffs. The NCOC recognizes that they often plant seeds of information in various communities, and their consistent presence allows them to nurture these seeds with reassurance that support is available. The Community Outreach Team (COT) often serves as the bridge and foundation that helps forge connections. When community members recognize a friendly face, a relationship has already begun, making them more likely to seek support. The following is an overview of the five NCOC agencies that reside and serve in the north sector of San Mateo County:

- The DCYHC provides effective, safe, and respectful health services to underserved youth and young adults, ages 12–24 years, in north San Mateo County at no cost. Services include physician-led primary health care, counseling from licensed therapists, sexual health education, and social and emotional development support from health educators. Every appointment represents a reduction in the disparity of access to care and an increase in the number of underserved youth receiving public health services in the community.
- A program of HealthRight360, AARS provides culturally informed services to Asian, Pacific Islander, Filipino, and other ethnically diverse communities. AARS is dedicated to reducing the impact and incidence of substance use and offering tailored programs for youth, adults, and families in San Mateo County. Their culturally oriented, gender-responsive approaches are delivered by multicultural staff who are integral parts of the communities they serve.
- As the NCOC partner for StarVista, the Counseling Center provides affordable clinical services to children, youth, adults, couples, and families in San Mateo County. Other StarVista programs focus on specific populations and specialized goals, such as crisis intervention, building healthy families, child abuse prevention and treatment, substance use recovery, and supporting the LGBTQ+ community. All programs adopt a holistic, culturally respectful, strengths-based, and trauma-informed approach.
- DCP provides mental health therapy to individuals, families, and groups, primarily serving low-income participants in Daly City and northern San Mateo County. Their services cater to all ages, with participant demographics mirroring the overall low-income population in the area. DCP offers individual and group therapy in diverse community settings, virtually, and through referrals from community partners such as public schools and local nonprofits.
- PAC's purpose is to connect people, share resources, and support one another to enrich the community. Operating since 1999, PAC consistently connects the community to resources and each other. The Pacifica Resource Center, a key component of PAC, supports the economic security of Pacifica families and individuals by providing a safety net of food, housing assistance, and other critical services. PAC's target population includes low-income individuals, people at risk of or experiencing homelessness, families and children affected by mental health issues, and diverse communities including Chinese,

Filipino, Latino, African American/Black, Pacific Islander, and LGBTQ+ individuals of all ages.

PROGRAM IMPACT

North County Outreach Collaborative	FY 2023–24
Total clients served	8,322
Total cost per client	$30

The NCOC understands that to increase the number of individuals receiving public health services, the COT must be present at various community events. These include resource and wellness fairs, holiday celebrations, Pride events, and general community gatherings such as Fog Fest, Turkey Trot, Nesian Night Market, National Night Out, Shine Family Day, and Recovery Happens. This presence also extends to sports events, dances, and youth-oriented activities such as music festivals that attract younger crowds.

To reduce stigma and discrimination, the COT recognizes the importance of building trust through relationships with community members. The first step in this process is visibility. By being present at these events and maintaining a friendly, welcoming demeanor, they know that often this is the first of many interactions to come—planting seeds that they will continue to nurture at every future encounter.

The COT often shares event responsibilities, because of limited staffing, to ensure coverage when some members are unavailable. For 2-day events, they break down shifts, allowing staff to cover portions rather than entire days, including setup and breakdown. They also encourage other staff members to participate when possible.

Daly City Youth Health Center

In FY 2023–24, the DCYHC created a behavioral health manager position to work with their intake coordinator, streamlining the referral process. This refined system increased community referrals and established clients. All clients are contacted, and appointments made within a week of referral, with timely access tracked in their Avatar electronic health records system.

The behavioral health manager serves as a liaison between the DCYHC, Jefferson Union High School District (JUHSD), and San Mateo Medical Center, improving community service efficiency through a central point of contact for referrals. The DCYHC nearly doubled their outreach events and increased social media presence by hiring a social media coordinator. This led to a 100.8% increase in account engagement and growth in self-referrals. The center used social media to address stigma and discrimination, sharing posts on heritage months, LGBTQIA+ resources, and health education workshops.

The DCYHC expanded to serve Brisbane School District's Lipman Middle School, significantly increasing families and children seeking services. Clinicians implemented a Family Systems Approach to address complex traumas, using evidence-based principles with successful outcomes. The Brisbane School District contract allowed closer work with youth and families, reducing mental health care stigma and gathering community feedback for future efforts.

To improve care access, clinicians began offering therapy appointments in public spaces. The DCYHC continues engaging the Chinese community, hiring a Mandarin-speaking clinician and attending an Immigration Resource Fair. Through partnership with San Mateo Medical Center, they shared COVID-19 vaccination information via various channels. Their primary health clinic provides vaccinations and testing to patients.

The following are outcomes for the DCYHC for FY 2023–24:

- In FY 2023–24, the DCYHC provided one-on-one counseling for 243 people and conducted 108 outreach efforts. They enrolled an average of eight people per month in benefits via an on-site benefits analyst. DCYHC clinicians facilitated 10 ongoing groups focused on emotional intelligence for youth ages 6–26 years and participated in 25 outreach events in FY 2023–24.
- The DCYHC used an evidence-based outcome measurement system, Patient-Centered Outcomes Measurement System (PCOMS), for collecting metrics. In 2023–24, 71.1% of DCYHC clients overall achieved reliable or clinically significant change. Mental health therapists used various questionnaires to identify and treat depression, anxiety, and substance abuse. Each client received an individually tailored therapy plan designed to treat and often reduce these issues, potentially preventing more severe outcomes.

Asian American Recovery Services

AARS/HealthRight360 provides culturally informed outpatient substance use treatment and co-occurring mental health and substance use disorder services to Asian, Pacific Islander, and other ethnically diverse communities in San Mateo County. Their value-driven, client-centered approach offers a safe, supportive environment with an on-site therapist and connections to additional support through their San Mateo partner program.

AARS focuses on PEI, emphasizing stigma reduction through regular community engagement. They prioritize outreach to Native Hawaiian and Pacific Islander communities, particularly Samoan and Tongan. Their Journey to Empowerment program, initiated by a community request, hosts monthly events addressing taboo topics such as mental health, physical health, relationships, LGBTQQ issues, and community healing.

Partnering with other Pasifika organizations, AARS builds community through safe spaces, cultural activities, and resource sharing. They have collaborated on various events, including anti-racism campaigns, movie nights, wellness workshops, and youth-led initiatives.

AARS offers a 13-week culturally adapted parenting course using the Parent Project® curriculum, discussing sensitive topics relevant to the Pasifika community. They also provide a 10-week program for Pasifika youth (ages 12–25 years) in San Mateo County, covering mental health, wellness, and life skills. A youth leadership group engages in community advocacy, supported by case management to facilitate access to resources and encourage interest in health-related higher education.

The organization hosts a Sister to Sister Youth Leadership Conference for Asian American, Native Hawaiian, and Pacific Islander young women, targeting both at-risk individuals and aspiring leaders.

AARS maintains community engagement through their weekly "Talanoa Tuesday" podcast, sharing resources and promoting wellness while keeping the community informed about local events and support services.

Daly City Partnership

DCP provides mental health services in a timely manner. Clients needing services can obtain appointments within a 1-week period. Working with their partner agencies, DCP offers workshops on how to reduce stigma and discrimination regarding mental health. These workshops are conducted within communities and schools as needed. Workshops are offered both on site and virtually, on the basis of preference. At DCP, services are offered at no cost to clients. The ability to provide this service removes one barrier that clients might otherwise face. All clients are given tools to help them better work with issues they are facing.

Pacifica Collaborative

PAC and Pacifica Resource Center work together to ensure that underserved populations receive referrals and timely linkages to services. Pacifica Resource Center's Houseless on the Coast team implements consistent outreach to individuals living in RVs, vehicles, and encampments in Pacifica. The consistency of this outreach, over time, creates trusting relationships with outreach workers and allows for information to be shared without fear or mistrust. This consistent outreach and relationship building enables direct referrals to systems of care, including medical and behavioral health. It also allows people to have hope and energy to work toward their recovery.

Making connections between regular community outreach and health outcomes of people served is not easily tracked unless the outreach worker has direct access to client information. Outreach conducted through food distribution, libraries, social media, and other on-the-ground efforts is not trackable from outreach to health outcomes. Data are collected through the Pacifica Resource Center intake questionnaire.

Pacifica School District provides fiscal oversight of the PAC contract and regularly provides information to parents and the student body of Pacifica School District. Pacifica School District also refers families to services at Pacifica Resource Center, including linkages to food, rental, and housing assistance. Addressing the mental health needs of children and families helps to identify the many health disparities that can arise from untreated mental illness, including prolonged suffering, homelessness, and school dropout rates.

Outreach efforts to the Chinese community include two volunteers from the Pacifica Resource Center who are available to translate for both Mandarin and Cantonese speakers. There are set times during the week when they are available, and appointments are scheduled accordingly. Phone appointments have allowed families to be connected to services through these translation services. Promotion of the Chinese Referral Line includes postcard-size cards at food distribution sites and in the curbside book pickups at the Pacifica Libraries. Two hundred cards were printed and distributed throughout the past FY.

Printed materials about COVID-19 testing and vaccination resources were included in food distribution boxes, in-person congregant senior lunch programs, and through the library. Links to services were shared during collaborative meetings, on social media, and through youth-led podcasts.

SUCCESSES

Asian American Recovery Services

AARS supported a Pasifika organization in leading the San Mateo County ODE PII. They participated in numerous community events and provided comprehensive support to individuals facing various challenges. AARS connected youth to AOD counseling and life skills programs, while assisting Tongan-speaking parents with resources and family partners.

Through their social media presence, AARS collaborated with other Pasifika organizations and were active leaders in the Soalapule Series, addressing mental health in the Pasifika realm on an international level, working with Apia Samoa, American Samoa, New Zealand, Southern California, and AARS in Northern California. This created discussions about wellness on a global level.

AARS hosted a Village Walk to share data and acknowledge community partners. Through their Essence of MANA program and Talanoa Tuesday live podcast, AARS reached 41,323 individuals, increasing Pacific Islander engagement with services.

Participants in the Essence of MANA Parent Project® shared the following:

- "Growing up in a Polynesian household, you know, you don't really hear 'I'm proud of you,' or 'I love you,' so I just really use a lot of positive words of affirmation. And, I love you a lot. Another thing is I definitely learned, like, a lot more about myself, you know. Instead of being mad at my daughter for not knowing how to do her homework, I learned to take a step back and learn patience with her instead of yelling at her."
- "Having Pacific Islander facilitators meant the world to me. Having facilitators that look like me, that grew up with the same culture as me, that understand me and what I had to go through growing up, and know what it's like being a parent that's Pacific Islander as well."
- "I have to agree that is very impactful to have people of color. And even though it's not my ethnicity and culture, it's profound to see other ethnicities and cultures and know that, hey, we are all going through this. We are all the same."
- "I would recommend a person to the Essence of MANA program because I think it'd be great for anyone. It doesn't matter if you're a parent or not. You could be a grandparent; you could be a god grandparent. It's a great resource for adults to get engaged so they can learn more skills."

Daly City Partnership

DCP continued to provide counseling and core services to clients still affected by COVID-19's long-lasting impact. They partnered with the DCYHC's mental health resource coordinator to support recently migrated families dealing with mental health issues stemming from relocation trauma. DCP

case managers worked with BHRS clients, offering shelter referrals and financial assistance to maintain stable housing. More than 350 households received emergency rental assistance and case management.

Our Second Home adapted by offering on-site, teletherapy, and virtual therapy options, collaborating with school districts and the DCYHC. They continued providing no-cost therapy while working to process future medical payments through insurance companies. Despite obstacles, Our Second Home remained committed to serving their community.

DCP expanded its mental health intern program, supervising six Marriage and Family Therapist trainees, whereas Our Second Home hired three additional summer interns. They offered holistic therapies (yoga, art, music), social-emotional learning programs, and support for children with special needs and those with adverse childhood experience factors. Therapy options included solution focused, cognitive behavior, emotion focused, art, drama, and play therapies.

Community outreach efforts included social media presence and a quarterly newsletter reaching nearly 2,000 subscribers. Our Second Home received more than 500 inquiries about childcare, preschools, and events, while also addressing food and housing assistance needs through their online resources. The monthly Special Needs Support Group and social-emotional reading workshops continued virtually, with more than a dozen families participating.

DCP provided crucial resources during the pandemic, helping a client escape domestic violence and start a new life. They supported the community through tragic events, offering multiple therapeutic services to those affected by the loss of a young athlete to suicide. Client testimonials highlighted the positive impact of DCP's services, expressing gratitude for support during difficult times and acknowledging personal growth.

Daly City Youth Health Center

DCYHC clinicians regularly collaborated with community partners, connecting clients to services and assisting them in engaging in community events. They established two new additional community partnerships and attended various county and community meetings throughout the year. The DCYHC created and expanded an extensive list of local community resources offering culturally sensitive services.

The center provided educational presentations in numerous forums, training clinicians and supervisors in other CBOs. They informed community partners about their services and offered workshops for caregivers at local school districts on trauma-informed care. The DCYHC regularly used translation services for meetings, phone calls, and form translations when working with monolingual clients and families.

The DCYHC's Peer Leadership Alternatives for Youth (PLAY) staff conducted multiple anti-stigma events across JUHSD schools. Outreach workers underwent extensive weekly training to provide trauma-informed and culturally responsive care. The executive director provided additional training to providers across the Bay Area on trauma-informed care. The DCYHC increased their social media outreach and hired a social media coordinator to continue these efforts.

The DCYHC increased their participation in community tabling events and continued to provide community-based services. They offered telehealth and school-based services, tailoring service provision to each client's needs. The center secured a company van to help clients access services and attended various networking events to build stronger relationships with the school district and medical side.

A success story highlighted the positive impact of the PLAY program on a student named River Treckeme, who became a youth staff member. River credited the program with personal growth, improved relationship understanding, and enhanced leadership skills.

Pacifica Collaborative

PAC has achieved significant successes through its partnerships and community initiatives. A notable example is the collaboration between Pacifica Resource Center and Coast House, which helped a 69-year-old woman with complex needs. After 18 months in the shelter system, she secured a housing voucher and moved into the Half Moon Bay Villages senior living facility in March 2024. Her family expressed deep gratitude for the beautiful campus and available services, marking a positive outcome for a challenging situation.

The Safe Parking Permit Program, implemented in July 2022, has also shown promise. The program offers nine permits for people living in motorhomes who are seeking permanent housing. To date, six individuals have successfully transitioned into permanent housing, demonstrating the program's potential. The Pacifica Resource Center continues to provide crucial case management and additional services to those on the waitlist, ensuring ongoing support for vulnerable community members.

Community engagement initiatives have played a vital role in addressing social issues. The Art for a More Peaceful and Just Community Project, a collaboration with Sanchez Art Center and Pacificans Care, used visual art to combat hate speech. United Against Hate Week featured the installation of a mandala and distribution of peace/kindness cards at a city council meeting, raising awareness and promoting unity.

Local schools have also contributed to these efforts. Oceana High School organized a Kindness Week involving 800 students, whereas Westmoor High School created a year-long kindness wall project engaging approximately 1,500 students. The Be The Change Youth Council extended this message of kindness to social media, reaching approximately 500 youths. A highlight of these community efforts was the Leap Into Kindness Community Sing Along, where more than 200 community members gathered for a night of peace and songs, fostering a sense of fellowship and kindness.

Recognizing the needs of the aging population, PAC joined Pacifica's Age Friendly Coalition. They created a workplan certified by American Association of Retired Persons (AARP) and the Center for Age Friendly Excellence, demonstrating a commitment to addressing the unique challenges faced by older adults in the community.

CoastPride

The CoastPride partnership with PAC began in June 2022 with Pacifica's first Pride Parade and the display of Progress Pride Flags at city buildings and schools. Following incidents in which Pride flags

were stolen from Sunset Ridge Elementary School and Oceana High School, with one being burned, PAC reached out to CoastPride to plan a unity response. This partnership has evolved into a collaborative effort to support the LGBTQ+ community in Pacifica. CoastPride's participation in PAC has created strong relationships between school districts, city staff, and libraries.

Key outcomes include SOGI training for all Pacifica School District staff, Gender and Sexuality (GSA) clubs at both Pacifica high schools, and a middle school after-school group for LGBTQ+ issues. The partnership has also established a parents and caregivers support group, an older adult LGBTQ+ group, and various family activities. Pacifica's 3rd Annual Pride Parade down Palmetto Avenue and Family Festival at Ingrid B. Lacy Middle School attracted 2,000 attendees, marking a significant community event.

NCOC Overall

The NCOC fostered strong collaboration among its partners. AARS, DCP, DCYHC, and PAC regularly attended NCOC quarterly general/steering committee meetings. The COT met monthly, with four out of five partners participating consistently.

Partnerships flourished, with the DCYHC collaborating with DCP to enhance mental health services and address food and housing insecurities. They secured a grant for additional mental health services in partnership with DCP and AARS. PAC saw increased involvement from the DCYHC, bolstering mental health support in Pacifica.

The NCOC improved community engagement, not only sharing resource information but also empowering community members to voice their needs. They facilitated connections between the community and service providers, enhancing understanding of diverse populations and their requirements.

The COT proved invaluable, fostering deep connections and providing a supportive environment for team members to address personal and professional challenges. These meetings facilitated resource sharing, outreach coordination, case collaboration, and client care connections.

CHALLENGES

Asian American Recovery Services

AARS faced challenges during this period. They relocated their adult outpatient services, requiring staff to move programs and update the building while continuing work. Despite difficulties, they met Medi-Cal service requirements for adult AOD outpatients and hosted an open house in South San Francisco.

Another challenge involved supporting a former client with declining mental health. Despite efforts to redirect the client to appropriate services, the individual refused support, leading to eviction and involuntary psychiatric hold. Staff acknowledged the challenges of navigating independence and emphasized the importance of consistent referrals, direction, compassion, and positivity in such situations.

Daly City Partnership

Post pandemic realities such as food shortages, utility increases, and gas price hikes affected clients, with many failing to requalify for CalWORKs benefits. There was an insufficient number of therapists to meet the high demand for services, exacerbated by the closure of a local university's counseling center. Low-income individuals had limited access due to outdated devices and low internet data.

Mental health funding decreased dramatically, making it difficult to address the growing needs of the community. The ongoing fentanyl crisis and youth deaths presented additional challenges. Clients expressed increased anxiety and depression due to pandemic-related job losses and rising living costs, significantly impacting DCP's mental health interns' caseloads.

Staff had to process their own emotions while dealing with clients' complex issues, including depression, suicidal ideation, domestic violence, child abuse, anxiety, and substance abuse. Sessions with a licensed marriage and family therapist focused on alleviating anxiety and helping clients navigate difficult circumstances, including ongoing social injustice issues.

Increased funding could address many of these challenges, potentially allowing for affordable internet and device lending programs for clients. Despite these obstacles, both organizations demonstrated resilience and adaptability in providing mental health and support services to their diverse community.

Daly City Youth Health Center

Access to care continued to be a problem for community members. The DCYHC addressed this by increasing community outreach and providing diverse service options, including home visits and food delivery in partnership with DCP.

A significant challenge occurred when a behavioral health intern left the traineeship program after just 2 months, resulting in the reassignment of their caseload to other clinicians. This led to heavier caseloads for some trainees and disrupted care for clients.

To mitigate future challenges, the DCYHC has made their interview process more robust, thoroughly explained program expectations to applicants, emphasized the high needs of their vulnerable community, created a new training curriculum with clear objectives, and streamlined the entire traineeship program under the behavioral health manager's guidance. These measures aim to ensure better retention of trainees and maintain consistent care for clients.

Pacifica Collaborative

PAC faced several significant challenges during FY 2023–24. The transition of individuals into new living situations can be difficult, as exemplified by the woman who moved to Half Moon Bay Villages. She struggled to integrate, expressing feelings of discomfort and disconnection from her new community. This highlights the need for ongoing support and integration strategies for individuals transitioning out of homelessness.

The aging population presents another challenge, with more than 40% of people in San Mateo County being older than 55 years, and 75% of Pacifica's houseless population being older adults. This demographic shift requires tailored approaches to service provision and community support.

The Safe Parking Permit Program, although successful in some aspects, has encountered resistance and operational difficulties. Four parking spots are being appealed to the California Coastal Commission by community members unhappy with their locations. More concerning, program participants have faced increased harassment, including vandalism of their RVs, theft of parts, and waste being left around their vehicles. This hostility has led to some participants feeling unsafe and leaving the program, undermining its effectiveness and highlighting the need for better community education and acceptance.

These challenges underscore a broader issue of community resistance to programs aimed at helping unhoused individuals. Despite efforts to promote kindness and understanding, there remains ongoing hostility toward these initiatives and the people they aim to serve.

PAC continues to address these challenges through persistent community engagement, education, and collaborative efforts with various organizations and local government entities. Their work demonstrates the complex nature of addressing homelessness and community division, requiring both practical solutions and efforts to change public perceptions and attitudes.

NCOC Overall

The NCOC faced several challenges during the year. Half of the steering committee members were frequently pulled into other meetings addressing organizational obstacles, affecting their attendance at steering committee meetings. This highlighted the need for a collective vision and more frequent in-person meetings to maintain accountability between agencies.

StarVista's absence from COT meetings created a gap in the outreach group. StarVista ultimately will step away from the NCOC in the new FY because of staffing limitations.

To address these challenges, the NCOC plans to revisit their meeting schedule to ensure better attendance from all steering committee members and partner organizations' community outreach leads at monthly COT meetings.

EAST PALO ALTO PARTNERSHIP FOR BEHAVIORAL HEALTH OUTREACH

The EPAPBHO collaborative comprises community-based agencies from the East Palo Alto region of San Mateo County to provide culturally appropriate outreach, psychoeducation, screening, referral, and warm handoff services to East Palo Alto region residents. One East Palo Alto serves as the lead agency and works in collaboration with El Concilio of San Mateo County (ECSMC), FAL, and 'Anamatangi Polynesian Voices ('APV). The program goals are as follows:

- Increase access for marginalized ethnic, cultural, and linguistic communities accessing and receiving behavioral health services. The collaborative will facilitate connecting people who need mental health and substance use services to responsive programming (e.g.,

Parent Project®, MHFA, WRAP, support services) and/or treatment—specifically, looking at how to increase access for children living with SED and adults and older adults living with SMI or at high risk for a higher level of care because of mental illness.

- Strengthen collaboration and integration. Establish effective collaborative relationships with culturally and linguistically diverse agencies and community members to enhance behavioral health capacity and overall quality of services provided to diverse populations. The collaboration will improve communication and coordination among community agencies involved and with broader relevant efforts through the ODE, HEIs, and others.
- Establish strong linkages between the community and BHRS. It is expected that there will be considerable collaboration that would include but not be limited to mutual learning. The outreach workers will receive trainings from BHRS and the ODE to support outreach activities as needed—for example, Becoming Visible—Using Cultural Humility in Asking Sexual Orientation Gender Identity (SOGI) Questions, HEI-sponsored trainings, and so on. Partnership with the BHRS regional clinic(s), ACCESS Call Center referral team, and many other points of entry to behavioral health services will be prioritized by BHRS. Likewise, the collaborative agencies and outreach workers will work with BHRS regarding strategies to improve access to behavioral health services. They will build linkages between community members and BHRS to share vital community information through the participation input sessions, planning processes, and/or decision-making meetings (e.g., boards and commissions, steering committees, advisory councils).
- Reduce stigma, including self-stigma and discrimination related to being diagnosed with a mental illness or SUD or seeking behavioral health services. The outreach workers will make services accessible, welcoming, and positive through community approaches that focus on recovery, wellness and resilience, use of culturally appropriate practices including provision of other social services and engaging family members, speaking the language, efforts that address multiple social stigmas such as race and sexual orientation, and employment of peers. Specific anti-stigma activities can include but not be limited to community-wide awareness campaigns, education, and training.

The target populations served by EPAPBHO are marginalized ethnic, linguistic, and cultural communities in the region including Latinx, Pacific Islander, African American/Black, and LGBTQ+ communities of all ages. EPAPBHO services are based on two key models of community engagement: the community outreach worker model and CBO collaboration.

- Outreach workers (also known as *promotores*/health navigators) connect with and facilitate access for marginalized populations through culturally and language appropriate outreach and education and provide linkage and a warm handoff of individuals to services. Outreach workers are usually members of the communities to which they outreach. They speak the same language, come from the same community, and share life experiences with the community members they serve. Outreach workers use a variety of methods to make contact with the community: from group gatherings in individuals' homes to street outreach and large community meetings, as well as making direct contact with target

audiences, conducting warm handoffs, and conveying crucial information to provide community support and access to services.

- Strong collaborations with local community-based agencies and health and social service providers are essential for cultivating a base of engaged community members. Organizations leverage their influence, resources, and expertise, especially in providing services that address cultural, social, and linguistic needs of the community. Collaboratives benefit from having regular meetings to share resources and problem solve, having a clearly defined infrastructure and consistent strategy, and offering ongoing presence and opportunities for community members to engage in services.

PROGRAM IMPACT

East Palo Alto Partnership for Behavioral Health Outreach	FY 2023–24
Total clients served	606
Total cost per client	$148

Improves timely access and linkages for underserved populations: Historically, the population served by EPAPBHO are undercounted and underserved. The partnership's ongoing interventions provide timely access and linkages to treatment. For example, during initial screening, outreach workers engage clients when they either come in for services or are engaged in the community. During the verbal assessment, outreach workers help clients with presenting needs for which they are seeking services. Outreach workers listen nonjudgmentally, assessing for risk of suicide or harm to self or others, and give reassurance that there are local programs and services that will address whatever their specific need or concern may be. If/when appropriate, an immediate referral to the appropriate agencies in San Mateo County BHRS's system of care is made for assessment and follow-up treatment. In most cases, partners make warm handoff referrals by accompanying the consumer member to the agency and, depending on their request, participating in the initial assessment appointment. This has become a standard practice for all EPAPBHO partners, particularly among monolingual speakers who need translation services and rely on an ambassador whom they know and trust.

Reduces stigma and discrimination: EPAPBHO partners are founding members of the East Palo Alto Behavioral Health Advisory Group (EPABHAG), convened by One East Palo Alto. EPABHAG was created as an advocacy group to ensure that quality mental health services are provided to East Palo Alto residents. Over the years, it has partnered with BHRS leadership to ensure that programs provided are created by the community and for the community. Major goals of the work have been to raise awareness of mental health issues and reduce the stigma associated with those issues. To this end, EPABHAG has held 12 annual Family Awareness Night events to achieve these goals with the most recent event held May 30th. Since its inception, EPABHAG has served more than 1,000 residents through these events and has addressed topics including but not limited to mental health versus mental illness, stigma, trauma, substance use, wellness, and faith.

Increases number of individuals receiving public health services: EPAPBHO partners facilitate connections between people who may need mental health and substance use services or other social services and relevant programming and/or treatment by

- Performing the initial screening and engaging potential clients,

- Providing brief interventions to engage clients, and
- Referring members who may need behavioral health services to appropriate agencies in the San Mateo County BHRS system of care for assessment and follow-up treatment as needed.

In addition, for most clients, continued support is needed to encourage participation in follow-up treatment. On many occasions, this means providing transportation when the services are outside of the East Palo Alto community, making a reminder phone call, and accompanying them to sessions, as needed.

Reduces disparities in access to care: See comments above regarding stigma and discrimination.

Implements recovery principles: EPAPBHO partners incorporate the five key recovery concepts into outreach efforts as follows:

- Hope—People who experience mental health difficulties get well, stay well, and go on to meet their life dreams and goals.
- Personal responsibility—It's up to the individual, with the assistance of others, to take action and do what needs to be done to keep themselves well.
- Education—Encouraging learning all that one is experiencing so they can make good decisions about all aspects of their life.
- Self-advocacy—Teaching how to effectively reach out to others so that one can get what it is that one needs, wants, and deserves to support wellness and recovery.
- Support—Allowing others to provide support while working toward one's wellness and giving support to others will help one feel better and enhance the quality of one's life.

SUCCESSES

'APV recognizes that a multilevel approach to addressing issues experienced by youth and young adults (both in and out of school) has been crucial for successfully serving families.

One of 'APV's successful interventions is MamaDee 'Uhila's work within the county juvenile system. MamaDee works with young people referred by county probation, providing cultural and linguistic support for these young men and their families. Her approach has effectively served them and connected them to other community programs.

Client Success Story #1: Mr. H arrived in the United States in 2019 and stayed past his return date to the Kingdom of Tonga. He's been living at Fofo'anga in East Palo Alto since 2021. His leg was amputated because of diabetes. He came to 'APV after other Tongan community members told him that 'APV could help with his medical situation.

'APV assisted Mr. H in participating in activities such as COVID-19 pop-up clinics, where he received the vaccine. They provided translation services for his medical appointments at Ravenswood Clinic

and Stanford Medical, as he doesn't speak English. Despite his disability, Mr. H remains active in cultural activities, especially singing.

Mr. H has become part of 'APV's Cultural Practitioners program. He shared valuable knowledge about the four pillars of Tongan culture created by Queen Salote, enriching 'APV's cultural understanding. When Mr. H lost his teeth, 'APV helped refer him to Stanford for dental work. He has become an integral part of 'APV's cultural initiatives, supporting 'APV at town hall meetings, "take the mic" programs, and various festivals.

Update since last year's report: Mr. H has been attending 'APV's Cultural Practitioner Training every Thursday since spring 2024. He currently resides at the Good Samaritan Shelter in San Mateo and is seeking employment. Mr. H successfully completed the 12-week Parent Project® led by One East Palo Alto, applying the tools and strategies he learned to support his children in Tonga.

While job hunting, Mr. H actively participates in community activities, including One East Palo Alto's Wellness Wednesdays and Climate Resilient Communities adaptation, and volunteers with St. Andrew's weekly food distribution. 'APV remains committed to supporting Mr. H in his ongoing progress.

ECSMC continues to successfully engage community members, assess them for mental health needs, and refer them to services.

Client Success Story #2: In one case, a single mother of two children came to ECSMC offices because her electricity had been shut off for 2 days. She was very distressed and nervous because her food had spoiled. ECSMC's case worker assisted her with submitting a Low Income Home Energy Assistance Program (LIHEAP) application and had her electricity restored within a few hours. She was referred to Nuestra Casa and Ecumenical Hunger Program for meals and food for the coming weeks. The client was extremely grateful and relieved. While working with this client, staff also recognized that she could benefit from mental health counseling and referred her accordingly.

FAL continues to do well with people who are fully recovering. Patients can receive ongoing assistance from FAL if they struggle with co-occurring mental health and substance use disorders. FAL maintains its partnership with the East Palo Alto system of care, which includes the Ravenswood Community Health Center, Ecumenical Hunger Program, and the East Palo Alto Community Counseling Center. FAL staff members continue to assist those who have successfully completed residential treatment by helping them find employment, referring them to sober living housing or to shelters, or reuniting them with their families.

Client Success Story #3: One success story involves a client who was facing incarceration, financial hardship, and substance dependency when she entered FAL's treatment program. For more than a week, she collaborated with FAL staff, focusing intently on transforming her lifestyle. On April 3, 2024, she committed to the FAL Residential Treatment Program, determined to shift her perspective and improve her circumstances. Throughout the program, she demonstrated resilience and dedication to personal growth. Upon graduation, she successfully secured employment and continues to maintain her sobriety, embodying the positive change she set out to achieve.

The Mouton Center has gradually reopened its programming hours and activities to the community since the pandemic. A significant success for The Mouton Center was the launch of Wellness Wednesdays for the community in May 2023. These sessions are open to the community to focus on wellness while enjoying healing activities. Topics have included painting, candlemaking, journaling, sharing one's narrative, musical breathing, and coloring for calm.

Client Success Story #4: One of The Mouton Center's clients reported excitement about returning to the wellness center, citing the welcoming and relaxing atmosphere. Another participant, a mother of a child with special needs, shared that she attends the evening painting sessions as a self-care activity. Since the launch of Wellness Wednesdays, The Mouton Center has seen an increase in attendance from the Latinx community, especially young couples. Some couples have expressed gratitude for having a space to enjoy and heal together away from home responsibilities. Many community members attending these sessions agree that wellness offerings are a great way to care for oneself in order to then care for their families and the community at large.

CHALLENGES

'APV faced several key issues in its operations and service delivery:

Cultural humility: County and local organizations serving the community must be sensitive to clients' cultural backgrounds, which can influence their perceptions of mental health and willingness to engage with services. Possible resolution: 'APV to provide training for staff and technicians serving the community.

Continuity of care: Ensuring clients remain connected to services over time can be difficult, especially if they experience crises or face barriers such as transportation and translation issues.

Training and capacity: 'APV staff may need additional training to effectively support clients in navigating county services, requiring time and resources that may be in short supply.

Client motivation and engagement: Clients may struggle with motivation to engage with services, particularly if they are experiencing severe mental health challenges.

ECSMC has dealt with staff shortage during the past year as well as turnover, leading to new staff needing training on assessment and data entry. Although ECSMC has not encountered challenges with engaging clients and making referrals, the organization has observed a trend in which mental health often takes a backseat to physical health in community priorities. Some individuals seeking assistance report difficulty finding suitable support, with a subset expressing doubt about the effectiveness of psychological and psychiatric interventions for emotional health. Stigma concerning mental health services persists, compounded by misconceptions about therapists' roles. Spanish-speaking and Latinx community members have shared experiences of unsatisfactory interactions with therapists or prohibitively long waitlists, often leading to disengagement from services. Case workers have noted a significant demand for culturally and linguistically appropriate mental health services. ECSMC stresses the importance of improving access to culturally relevant mental health services and developing a diverse pipeline of mental health professionals, particularly from the communities they serve.

FAL continues to face challenges due to the COVID-19 pandemic's impact on outreach services. Drug Medical's limitations prevent outreach staff from directly enrolling individuals into the treatment program. Salary constraints remain an issue, hindering FAL's ability to hire more staff for outreach initiatives. The organization adheres to health department regulations to protect staff and client health, working closely with the county.

If Drug Medical were to expand its service area and grant agencies permission to provide services outside San Mateo County, this would enhance FAL's ability to support the community as a whole. Proposed solutions include hiring more outreach workers at competitive market rates for skilled professionals.

A final challenge is resuming meetings after the COVID-19 pandemic, given the staffing shortage and the need for a staff person for the noonday recovery meeting.

COASTSIDE COMMUNITY ENGAGEMENT

The Coastside Collaborative provides culturally responsive outreach to the Coastside community and targets a broad community network with the goal of strengthening service collaboration, coordination, and integration into the Coastside region of San Mateo County. The collaborative is co-chaired by the YLI and ALAS.

During FY 2023–24, the regular attendees at Coastside Collaborative meetings included representatives from YLI, El Centro, La Costa Adult School, City of Half Moon Bay, Cabrillo Unified School District, ALAS, and The Community Alliance to Revitalize Our Neighborhoods (CARON). YLI implemented a Google Group and Shared Drive to facilitate mutual resource sharing among members, helping to streamline communication and collaboration within the Coastside Collaborative. YLI coordinated various presentations and workshops that emphasized opportunities for multisector and cross-collaboration. These included sessions from La Costa Adult School on the community schools grant, updates on the Cabrillo Unified School District's workforce housing project, mold prevention strategies, Half Moon Bay's Downtown Streetscapes Project and the Opportunity Center of the Coastside, and youth internship opportunities available during the summer.

In the upcoming FY (FY 2024–25), the Coastside Collaborative aims to boost resident and youth involvement by increasing participation in meetings and initiating more projects, while improving visibility through events and outreach efforts. The collaborative plans to strengthen engagement from Coastside organizations by increasing outreach efforts, enhancing member commitment, and advancing HEIs. Key activities include organizing events such as the Wellness Festival and Farmworker Bike Event, increasing outreach through partnerships and a shared calendar, and tracking participation with SMART metrics. The collaborative's goals this year include reaching more residents and youth, preparing to include youth on the steering committee by the beginning of the next FY, and growing collaborative membership.

CARIÑO PROJECT (COASTSIDE MULTICULTURAL WELLNESS)

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

In FY 2023–24, the Cariño Project served 572 unduplicated individuals in San Mateo County through their clinical component (therapy); 2,028 individuals (duplicated) were also engaged through various services including groups, training, arts activities, and other supports.

The Cariño Project was founded on the opportunity to create new models of mental health and wellness Wraparound services that are grounded in cultural frameworks of intervention. The program opens pathways for increased services on the Coastside, limited in services. MHSA funding has allowed growth in programming and staff to increase wellness support services across the coast. ALAS is centered on honoring the client and their cultural wealth. The program believes that each person and family is rooted in a history of tradition and culture that strengthens who they are, which should be honored and valued. Operating from a strengths-based and cultural wealth perspective, ALAS values each person, family, and child, embracing each person's identity, sexual orientation, race, ethnicity, and cultural background(s). The Cariño Project strengthens opportunities to work closely with expanded community groups.

PROGRAM IMPACT

Cariño Project [a]	FY 2023–24
Clients served (unduplicated)	572
Cost per client	$807
Individuals reached (duplicated)	2,028
Total served	2,600

[a] Unduplicated clients served are individuals who received therapy and/or case management services; individuals reached include the community at large, families, and others engaged through support groups, events, arts, and other activities.

Outcome Indicators

Domain	Indicator/question	*n*	%
General behavioral health	Due to this program, I am better able to cope with stressors in my life. (follow-up/discharge survey)	5 of 7	71
	Due to participating in this program, I have experienced an improvement in my overall mental health. (follow-up/discharge survey)	4 of 7	57
	Due to participating in this program, I have an improved ability to participate in daily life. (follow-up/discharge survey)	5 of 7	57
Knowledge, skills,	Due to the Cariño Project, I learned something that is useful to me.	32 of 37	86

and/or abilities			
Cultural identity	Due to the Cariño Project, I feel more connected to my culture.	32 of 37	86
Connection and support	Due to the Cariño Project, I feel more connected to my community.	34 of 73	86
	Due to the Cariño Project, I am better able to support myself and/or my family.	72 of 83	87
Stigma reduction	Due to the Cariño Project, I feel more comfortable talking about mental health. (clinical follow-up/discharge survey)	9 of 10	90

DEMOGRAPHICS

Cariño Project Program Client Demographics (N=103)

	Number of clients	Percentage of total
Age		
0–15 years	3	2
16–25 years	9	9
26–59 years	59	57
60–73 years	15	15
74 years and older	0	0
Prefer not to answer/unknown	17	17
Primary language		
English	2	2
Spanish	88	85
Another language	0	0
Prefer not to answer/unknown	13	13
Race		
Asian or Asian American	0	0
Black or African American	0	0
Native American, American Indian, or Indigenous	0	0
Pacific Islander	0	0
White or Caucasian	1	1
Another race (Latino/a/x or Hispanic)	89	86
Prefer not to answer/unknown	13	13
Ethnicity		
Latino/a/x or Hispanic	103	100
Caribbean	0	0
Central American	9	9
Mexican/Mexican American/Chicano	77	75
South American	3	2
Another identity or tribe	0	0
Prefer not to answer/unknown	14	14
Not Latino/a/x or Hispanic	0	0
African	0	0

	Number of clients	Percentage of total
Asian Indian/South Asian	0	0
Chamorro	0	0
Chinese	0	0
Eastern European	0	0
European	0	0
Fijian	0	0
Filipino/a/x	0	0
Japanese	0	0
Korean	0	0
Middle Eastern or North African	0	0
Samoan	0	0
Tongan	0	0
Another ethnicity or tribe	0	0
Prefer not to answer/unknown	0	0
Sex assigned at birth		
Male	23	22
Female	66	64
Prefer not to answer/unknown	14	14
Intersex		
Yes	0	0
No	49	48
Prefer not to answer/unknown	54	52
Gender identity		
Female/woman/cisgender woman	64	62
Male/man/cisgender man	22	21
Transgender woman/trans woman/trans-feminine/woman	0	0
Transgender man/trans man/trans-masculine/man	0	0
Questioning or unsure of gender identity	0	0
Genderqueer/gender non-conforming/gender non-binary/neither exclusively female nor male	0	0
Indigenous gender identity	0	0
Another gender identity	0	0
Prefer not to answer/unknown	17	17
Sexual orientation		
Gay or lesbian	1	1
Straight or heterosexual	76	74
Bisexual	0	0
Queer	0	0
Pansexual	0	0
Asexual	0	0
Questioning or unsure of sexual orientation	1	1

	Number of clients	Percentage of total
Indigenous sexual orientation	1	1
Another sexual orientation	0	0
Prefer not to answer/unknown	24	23
Disability status		
Yes	12	11
No	74	72
Prefer not to answer/unknown	17	17
Veteran status		
Yes	1	1
No	71	69
Prefer not to answer/unknown	31	30

ALAS continues to face the same barriers to demographics collection as in the previous year: (a) determining the "core" client base of their case manager, and (b) client skepticism about completing surveys. The case manager estimates seeing 400 to 500 clients yearly (averaging 35 clients per week), but only about 100 have long-term relationships requiring multiple visits. She has successfully collected demographics from 83 of these core clients, achieving an 83% response rate, up from 55% (*n* = 55 of 100 core clients) in the past year.

Collecting demographic surveys (short or long form) from one- or two-visit clients remains challenging, despite offering various formats (in-office assistance, waiting room completion, take-home surveys, online surveys). The clinical team faces similar issues, with clients often requesting to take surveys home but returning them blank, if at all. The increase in surveys collected from the case manager is encouraging, suggesting that emphasizing client representation to county and state authorities is slowly proving effective.

Clinicians have also succeeded in collecting demographics conversationally, asking questions face-to-face and inputting data digitally (marked in blue on the data sheet).

ALAS plans to reinforce to participants that completing demographic surveys helps represent them to the county and state of California anonymously and comfortably, even if they feel uneasy about being on record for this report. They continue to offer a short-term demographic form as part of a "universal intake" process for clients reluctant to complete long-term demographics. However, all clients who fill out forms choose the longer version, indicating that those willing to provide information are not deterred by the slightly increased length.

REFERRALS

Mental Health and Substance Use Referrals

Type of referral	FY referrals to programs within your agency	FY referrals to other agencies	FY total
Serious mental illness referrals	Not applicable	5	5

Substance use disorder referrals	Not applicable	12	12
Other mental health referrals	15	6	21
Total	**15**	**23**	**38**

Referrals to Other Services

Type of referral	FY total	Type of referral	FY total
Emergency/protective services	4	Legal	38
Financial/employment	4	Medical care	17
Food	1	Transportation	0
Form assistance	0	Health insurance	35
Housing/shelter	1	Cultural, nontraditional care	17
Other	30	**Total**	**215**

PROGRAM NARRATIVE

The purpose of the Cariño Project is to provide Wraparound wellness, arts, mental health, and community-centered services that strengthen individuals and the collective community. This work employs the "cultura cura" model, in which culture, arts, and the community's cultural strengths drive the healing and work done by ALAS. The program offers targeted interventions as well as community events, cultural arts, case management, mental health services, education, and outreach to support the community in a vibrant and energizing way to heal and grow.

The primary population served includes families, children, individuals, older adults, and youth. ALAS primarily serves the Latinx community, most of whom are immigrant families or individuals and primarily low income. The geographic region of the population served extends from Montara to Pescadero, California.

ALAS's overall model focuses on five service areas that work in partnership with one another:

- Cultural arts program, consisting of ballet folklórico, mariachi, and other arts (e.g., painting)
- Education, including weekly tutoring for youth and an annual summer camp
- Mental health and case management
- Community engagement and advocacy
- Farmworker outreach, which has developed into its own standalone program

Under MHSA PEI, the primary program components are mental health and case management.

ALAS's mental health model is a Wraparound, culturally sensitive practice focused on serving families and/or individuals at all levels. Counseling services include crisis counseling, family counseling, and counseling at schools, local churches, and community spaces. ALAS often uses a home visiting model to serve families as well as their Equity Express Bus mobile research center to reach populations with limited access to their office (e.g., farmworkers). In addition, ALAS offers several mental health support groups for specific populations (e.g., women, men, couples) as well as various topics of concern to the community (e.g., grief and stress). ALAS is committed to continually building trust with a community that has historically been underserved in terms of access to mental health and medical services. The organization continues to learn and grow in terms of how best to meet clients' needs, including through the use of referrals. ALAS continues to experience demand for supporting the mental health and wellness of youth and families who typically do not qualify as seriously mentally ill, as reported in previous years.

The case management program works closely with the mental health program, with its own core mission to support the basic needs of families (housing, rent, food, bills), as well as helps them understand what resources are available regardless of income or immigration status (e.g., medical care and insurance). ALAS advocates for clients' needs and connects them to additional county and local programs for services beyond the in-house support they receive. Immigration support remains a significant concern for Coastside families: To this end, the case manager and broader ALAS staff work with U-Visa victims and victims of crimes as well as recently arrived migrants and migrant workers, also referring back to the ALAS mental health team (and external resources) to provide counseling support for immigration and other crises.

Improves timely access and linkages for underserved populations: Through the Cariño Project, ALAS provides Wraparound services that connect clients to the best services to address the whole person. At ALAS, there is an open-door process for all to come in to be met by its staff, who triage them to the best program and service for them. ALAS trains its team to meet with each client and review and assess all supports that can be given to them, whether directly from ALAS or in the community and through county resources. ALAS screens clients for their direct needs and does a full assessment. In addition, whichever program a client enters, ALAS staff assess and refer for other ALAS services. ALAS has strong community partnerships and is familiar with programs across the county—programs and processes that give its staff the breadth of resources to be able to provide additional referrals within a timely manner.

Reduces stigma and discrimination: The Cariño Project has been very successful at growing and bringing the community into the ALAS program. This has happened because ALAS has brought visibility and advocacy, which reduce isolation and stigma. Through program outreach and engagement with community and education, the program has seen a demand for increased mental health services; there is a growing need for more mental health in the Latinx community. More Latinos are talking about mental health and are asking for counseling. The Cariño Project has grown its reach; as a result, there is education, trust, and a place that community members feel safe to come to. In addition, the program's commitment to culture, to advocacy, and to community organizing on the coast with the Cariño Project has also reduced stigma for the Latinx community.

The program is about not just delivering a service but fostering an environment in which the consumer becomes part of the program and of the process and has input for what they want.

Increases number of individuals receiving public health services: Through the case management component of the Cariño Project, there has been an increase in the number of individuals receiving public health. The number has risen significantly as part of the program's work supporting enrollment in health insurance, understanding county programs for health and wellness, and connecting to ALAS free mental health programs and workshops. The program also connects clients to the county specialist for insurance enrollment and has created a space for her to come into ALAS and meet community members on the ALAS Equity Express bus for the services. At all levels, staff are engaged with making sure that they are increasing positive health.

Reduces disparities in access to care: The Cariño Project, which is free, has been a key part of reducing disparities in access to care. Many community members participate in multiple services across ALAS programs. The Cariño Project is about identifying challenges and barriers for community members to access care, and ALAS is very involved in advocacy and problem solving in this area. Most important, the funding and program of the Cariño Project have given ALAS the ability to grow the services to the community, which has been significant.

Implements recovery principles: The Cariño Project strives to implement best practices that support and heal the client for the long term. Through this program, ALAS provides a breadth of services that meet the client where they are and are able to identify a variety of ways to provide support. The program staff also work to connect the whole family to services when possible—providing for the Wraparound of the individual and family. Through an engaged cultural entry point, ALAS provides case management, mental health, advocacy, accompaniment, education, and community support.

Other activities that benefit clients: ALAS centers cultural arts for healing, immersing the community in arts activities closely tied to their mental health work. Their approach incorporates art, music, food, poetry, guitar, songs, and various cultural practices from the Americas into their mental health services. Each of ALAS's programs embeds arts into its services. Many ALAS staff work in an interdisciplinary fashion, participating in multiple programs to build a network of thoughtful, consistent, and interconnected support for the community. For instance, their case manager, who is also an artist, leads the ALAS Moms group, which features a rotating slate of arts and crafts activities each week to help mothers decompress. Staff from the mental health and farmworker programs collaborate to facilitate activities and support groups, some specifically for farmworkers and others open to the broader community.

SUCCESSES

ALAS's holistic approach to community care is illustrated by two notable cases. One victim of the farmworker mass shooting, deeply impacted by grief and trauma, continues to be part of ALAS today. Although hesitant about "traditional" counseling, this client regularly attends ALAS for case management and various mental health/support groups incorporating music and arts. He also participates in ALAS's food and educational programs, experiencing multiple facets of their community work. After a year and a half of involvement, he now regards ALAS as his "home" and

"safe place," having built a sense of community and healing despite lacking other family on the Coastside.

Another community member, who lost their son to a shooting in San Francisco, found limited support from other area or state programs and still lacks closure regarding the perpetrator. ALAS has embraced this family, providing comprehensive support through case management and services and addressing financial, logistical, and mental health needs during and after the funeral. ALAS is actively advocating with local officials to help the family obtain answers about the tragedy, demonstrating their dedicated and attentive client support at various levels. The family continues to participate in numerous ALAS events and programs, particularly a Dia de Los Muertos-themed grief group offered by ALAS clinicians. They have worked with the ALAS team both individually and collectively, knowing that ongoing support is available to them.

CHALLENGES

The county and other partners have provided significant support to ALAS. However, ALAS faces two primary challenges:

- Growth management: As word spreads about ALAS's quality services, the organization has experienced increased demand from a growing population. This necessitates expanding their operational team to guide growth thoughtfully, a process requiring time and resources.
- Building trust in surveys and reporting: The Coastside community has been under intense scrutiny following the 2023 shooting, attracting state and global interest in the struggles of their underserved population. ALAS's mental health and case management staff have invested considerable effort in building and maintaining community trust, often requiring long-term relationship development before clients open up and request needed services.

ALAS continues to face difficulties in obtaining complete surveys from clients. The clinical team reports significant client hesitance regarding surveys, despite offering anonymous completion options and explaining how surveys help improve services. ALAS's CEO, clinical director, and data analyst collaborate closely with staff and the clinical team to strategize balancing data collection/program outcome analysis with community trust. They remain confident in their ability to increase survey completion rates in the future.

SAN MATEO COUNTY PRIDE CENTER

The Pride Center (35% CSS, 65% PEI) creates a welcoming, safe, inclusive, and affirming space for individuals of all ages, sexual orientations, and gender identities through education, counseling, advocacy, and support. The Pride Center takes a holistic approach to improving the health and well-being of the LGBTQ+ community by providing direct mental health services to individuals living with severe mental health challenges and individuals in the community seeking support groups, resources, community-building activities, and social and educational programming.

The clinical program of the Pride Center provides high-quality, LGBTQ+-affirming behavioral and mental health services to marginalized and at-risk LGBTQ+ community members in San Mateo County. Clinical services include individual therapy, relationship therapy, family therapy, group therapy, and case management. The Pride Center work is strengths based and trauma informed, engaging both natural supports and the whole family whenever possible. The primary purpose is to assist clients, their families, and their communities in reducing stigma and supporting the creation of safe, affirming environments for LGBTQ+ clients. To this end, services are aimed at not only reducing high-risk symptoms such as self-harming behaviors and trauma symptoms but also providing family support and education to nonaffirming family members. Last, in addition to offering direct clinical care, the program's clinical team provides extensive consultation and LGBTQ+ training for other mental health and medical service providers, school administrators and educators, parents of LGBTQ+ youth, students, LGBTQ+ older adults, and the general public.

The mission of the Pride Center is to create a welcoming, safe, inclusive, and affirming community climate that fosters personal growth, health, and opportunities to thrive for individuals of all ages, sexual orientations, and gender identities through education, counseling, advocacy, and support.

Its vision is to create an innovative, respectful, and equitable community of all ages, ethnicities, cultures, sexual orientations, and gender identities that supports complete inclusion, is free of discrimination, strives for knowledge, challenges barriers, and seeks to empower agents of social change.

PROGRAM IMPACT

Pride Center [a]	FY 2023–24
Clients served (unduplicated)	147
Cost per client	$4,285
Individuals reached (duplicated)	12,140
Total served	12,287

[a] Unduplicated clients served are individuals who received therapy and case management; individuals reached include all other individuals who participated in peer groups, youth and older adult services, trainings, outreach, and events.

Outcome Indicators

Domain	Indicator/question	n	%
General behavioral health	CANS and ANSA Depression subscales [a] (population: therapy services)—improved/remained the same	30 of 35	86
	CANS and ANSA Anxiety subscales [a] (population: therapy services)—improved/remained the same	30 of 35	86
	Number of clients who reported an improvement in their mental health as measured by the following: "*How would you rate your mental health in the last 30 days?*" (population: therapy services)—improved/remained the same	29 of 35	83
	Number of clients who reported an improvement in their ability to cope with stress as measured by the following: "*How would you rate your*	26 of 35	74

Domain	Indicator/question	n	%
	ability to cope with stress in the last 30 days?" (population: therapy services)—improved/remained the same		
Improved knowledge, skills, and/or abilities	ANSA Interpersonal/Social Connectedness and CANS Interpersonal subscales (population: therapy services)—improved/remained the same	25 of 34	74
Connection and support	ANSA Natural Supports and CANS Community Connection subscales (population: therapy services)—improved/remained the same	30 of 35	76
Self-empowerment	Number of clients who reported improved self-empowerment as measured by the following: "*I am confident I can affect my life through the decisions I make.*" (population: therapy services)—improved/remained the same	26 of 35	74
Stigma reduction	Number of clients who reported reduced self-stigma as measured by the following: "*I feel comfortable talking about my sexual orientation*" (population: therapy services)—improved/remained the same	28 of 35	80
	Number of clients who reported reduced self-stigma as measured by the following: "*I feel comfortable talking about my gender identity*" (population: therapy services)—improved/remained the same	30 of 35	87

[a] The Depression and Anxiety subscales of the Child and Adolescent Needs and Strengths (CANS) assessment and Adult Needs and Strengths Assessment (ANSA) are considered "needs" and scored between 0 and 3. A score of "0" indicates that no need is present, whereas a "3" demonstrates high need. The Interpersonal and Natural Supports subscales are considered "strengths" and also scored between 0 and 3. For strengths, a score of "0" indicates a positive core strength, and a score of "3" indicates that no strength is identified.

DEMOGRAPHICS

San Mateo Pride Center Program Client Demographics (N=148)

	Number of clients	Percentage of total
Age		
0–15 years	15	10
16–25 years	50	34
26–59 years	79	53
60–73 years	4	3
74 years and older	0	0
Prefer not to answer/unknown	0	0
Primary language		
English	134	91
Spanish	3	2
Another language	2	1
Prefer not to answer/unknown	9	6
Race		
Asian or Asian American	15	10
Black or African American	4	2
Native American, American Indian, or Indigenous	1	1
Pacific Islander	1	1

	Number of clients	Percentage of total
White or Caucasian	57	39
Another race/multiple	44	30
Prefer not to answer/unknown	26	18
Ethnicity		
Latino/a/x or Hispanic	31	21
Caribbean	1	1
Central American	7	5
Mexican/Mexican American/Chicano	21	14
South American	2	1
Another identity or tribe	0	0
Prefer not to answer/unknown	0	0
Not Latino/a/x or Hispanic	117	79
African	4	3
Asian Indian/South Asian	3	2
Chamorro	0	0
Chinese	6	5
Eastern European	13	9
European	36	24
Fijian		0
Filipino/a/x	8	5
Japanese	0	0
Korean	0	0
Middle Eastern or North African	0	0
Samoan	0	0
Tongan	1	1
Another ethnicity or tribe	7	4
Prefer not to answer/unknown	39	26
Sex assigned at birth		
Male	31	21
Female	34	23
Prefer not to answer/unknown	83	56
Intersex		
Yes	1	1
No	71	48
Prefer not to answer/unknown	76	51
Gender identity		
Female/woman/cisgender woman	19	13
Male/man/cisgender man	14	9
Transgender woman/trans woman/trans-feminine/woman	1	0.5
Transgender man/trans man/trans-masculine/man	62	42
Questioning or unsure of gender identity	6	4

	Number of clients	Percentage of total
Genderqueer/gender non-conforming/gender non-binary/neither exclusively female nor male	38	26
Indigenous gender identity	1	0.5
Another gender identity	0	0
Prefer not to answer/unknown	7	5
Sexual orientation		
Gay or lesbian	28	19
Straight or heterosexual	7	5
Bisexual	22	15
Queer	19	13
Pansexual	21	14
Asexual	7	5
Questioning or unsure of sexual orientation	5	3
Indigenous sexual orientation	0	0
Another sexual orientation	3	2
Prefer not to answer/unknown	36	24
Disability status		
Yes	48	32
No	23	16
Prefer not to answer/unknown	77	52
Veteran status		
Yes	0	0
No	58	39
Prefer not to answer/unknown	90	61

REFERRALS

Types of Referrals

Type of referral	FY referrals within agency	FY referrals to other agencies	FY total
Serious mental illness referrals		3	3
Substance use disorder referrals	4	9	13
Other mental health referrals		3	3
Total	**4**	**15**	**19**

Type of referral	FY total
Emergency/protective services	4
Financial/employment	33
Food	27
Form assistance	12

Type of referral	FY total
Housing/shelter	31
Legal	22
Medical care	20
Transportation	5
Health insurance	13
Cultural, nontraditional care	6
Other	32
Total	**205**

PROGRAM NARRATIVE

Improves timely access and linkages for underserved populations: The Pride Center provides underserved and marginalized participants with multiple avenues through which to access services and receive LGBTQ+-affirming treatment and connections to resources:

Functional one-stop shop and resource hub: The Pride Center is unique in that it offers not only direct mental health services but also community-building social events, educational trainings/workshops, pathways to leadership and community empowerment, and direct access to resources and local service providers to improve the overall health and well-being of local LGBTQ+ individuals and the LGBTQ+ community countywide. At every facet of Pride Center programming, there is an opportunity for individuals to learn more about and gain access to clinical services and resources.

- Clinical referrals: Within 2 business days of receiving referrals, Pride Center clinical staff will attempt to contact the referred individual to provide more information about case management and/or mental health services, assess any immediate needs that the individual may have, provide resources and/or information as needed, and schedule a screening appointment. The clinical program coordinator and intake coordinator assume responsibility for managing incoming counseling inquiries. Coordinated with the clinical team, the program is constantly working on its waitlist procedures to improve initial response times and decrease the amount of time it takes to get clients enrolled in services. The clinical program coordinator is also frequently in contact with StarVista's database management team for continued process evaluation.
- Prioritization of underserved and marginalized groups: As a whole, Pride Center staff have decided to prioritize services to underserved and undertreated individuals and members of high-risk, marginalized, and otherwise vulnerable groups (e.g., nonheterosexual, noncisgender members of the LGBTQ+ community; transgender and genderqueer/non-conforming/variant minorities; people of color; low-income individuals; and victims of abuse, bullying, and/or crime). Low-fee and pro bono services have been offered to undocumented clients or those faced with financial hardship.
- Meeting individuals where they are: The Pride Center follows a client-centered approach. Treatment planning is done in collaboration with the client, and goals are what the client

themself wants to work on rather than what the clinician thinks may benefit them. For example, if a client wants to work on reducing substance use but does not want to become abstinent, the clinician uses a harm-reduction-focused approach to treatment rather than an abstinence-focused one. In addition, the clinical team makes efforts to work around potential barriers to care—such as food access, transportation, and housing status—by assisting clients in navigating community resources through either direct case management or collaborating with the client's assigned non-Pride Center case worker.

- Reducing gender dysphoria: The Pride Center clinical team continues to support clients in navigating and accessing medically necessary transgender-affirming care to help alleviate feelings of gender dysphoria. The Pride Center clinical team supports transgender, gender-diverse, and non-binary clients in this way by assisting with legal name and gender marker changes on identity documents, writing letters of support for clients to access both hormone replacement therapy and gender-affirming surgeries, connecting clients to resources and providers for services such as gender-affirming voice training, and more. With the support of the Pride Center, clients report that living their authentic lives and feeling safe to truly be themselves have a significant positive impact on their mental health and well-being.

Reduces stigma and discrimination: The clinical program reduces stigma and discrimination by

- Organizing and participating in community and social events that foster positive representation of the LGBTQ+ community. Pride Center staff and programs directly reflect the diverse community and individuals served.
- Empowering vulnerable community members through mentorship, guidance, and psychoeducation concerning coping skills and strategies to help manage and overcome stressful circumstances.
- Educating LGBTQ+ families, both directly and indirectly through collaboration with PSWs, to increase families' acceptance, understanding, and support of their LGBTQ+ family members, reducing stigma and fostering a protective factor for clients. Furthermore, clinicians are well equipped in providing appropriate resources to LGBTQ+ family members to educate themselves in better understanding and supporting their LGBTQ+ family member.

Increases number of individuals receiving public health services:

- Many clients and community members express that they engage with the Pride Center specifically because they know it is a safe and welcoming environment. Many are concerned about the quality of care and treatment they might receive from other providers because of their LGBTQ+ identity, as there is a pervasive fear due to a history of discrimination and mistreatment.
- The clinical team has continued its outreach efforts to increase community engagement with the agency's psychotherapy and case management services. Outreach has included active participation in LGBTQ-specific Listservs such as Mind the Gap, Gaylesta, and Bay

Area Open Minds as well as building relationships with practitioners at other local agencies such as CORA, the Felton Institute, and the Edison Clinic, among others. The clinical team also continues to strengthen relationships with the Pride Center's partner agencies.

Reduces disparities in access to care: The Pride Center is committed to providing mental health services to the LGBTQ+ community throughout San Mateo County. To reduce disparities in access to care, the center prioritizes clinical services to individuals who

- Are members of marginalized and underserved communities.
- Have untreated or undertreated behavioral needs, including mental health and/or substance-abuse related needs.
- Have experienced emotional/behavioral disturbances over a prolonged period of time causing difficulty and distress in relationships at home, school, work, and/or community.
- Are at high risk for increasing levels of severity of presenting issues without mental health intervention.
- Are experiencing homelessness or at risk of becoming homeless.
- Lack safety because of domestic violence/abuse.
- Are low income.
- Experience isolation and/or social anxiety.
- Demonstrate self-endangering behavior and/or history of suicide attempts or ideation.
- Are victims of or witnesses to violent crimes (bullying, gun violence, domestic violence, etc.).

Whenever possible, Pride Center staff provide resources and information to clients to help improve their access to services by reducing barriers preventing them from receiving needed support. For example, some clients requesting services lack access to a phone and/or suffer from severe agoraphobia (fear of leaving the house). Staff have provided county resources that offer no-fee or low-fee cell phones to these community members. Staff have also offered to meet clients in the field and have encouraged them to use the Non-Emergency Medical Transportation benefit offered to HPSM members, which provides free transportation to eligible clients so they can visit the Pride Center for clinical services. Similarly, encrypted, HIPAA-compliant teletherapy services are used. This technology allows clinical staff to provide essential services to clients who may be homebound or unable to physically visit the center (such as those with chemical sensitivity issues or disabilities).

Implements recovery principles:

- Development of positive coping skills—Clinicians use cognitive behavioral therapy (CBT) and Seeking Safety interventions to help clients develop a broad spectrum of healthy coping skills tailored to individual needs. Coping skills are practiced in session with the

therapist and assigned as homework to help clients build new patterns for addressing stressful, potentially triggering scenarios.

- Harm reduction—When working with substance use, clinicians take a client-centered approach, meeting clients wherever they are in recovery and following their goals. If a client does not want to cease substance use, clinicians use a harm-reduction approach to help decrease the likelihood of injury or overdose while using and refer for higher level services if indicated. If the client's goal is to reduce substance use rather than achieve complete abstinence, clinicians support this goal.
- Client-centered, trauma-informed approach—Treatment goals are client centered, and treatment plans are created in collaboration with the client. The Pride Center has a strict policy against substances on site, which extends to the telehealth platform for therapy services and relies on client self-reporting. Clinicians also use motivational interviewing tailored to clients' stages of change. All clinical treatment is trauma informed, starting with the initial assessment. Substance use is addressed alongside present trauma-related symptoms, rather than treating dual diagnoses separately.

Other activities that benefit clients:

- Clinical: Reducing gender dysphoria—the Pride Center clinical team continues to support clients in navigating and accessing medically necessary transgender-affirming care to help alleviate feelings of gender dysphoria. The Pride Center clinical team supports transgender, gender-diverse, and non-binary clients by assisting with legal name and gender marker changes on identity documents, writing letters of support for clients to access both hormone replacement therapy and gender-affirming surgeries, connecting clients to resources and providers for services such as gender-affirming voice training, and more. With the support of the Pride Center, clients report that living their authentic lives and feeling safe to truly be themselves has a significant positive impact on their mental health and well-being.
- Therapy services at the Pride Center aim to include not only acute care of currently presenting symptoms but also prevention-focused interventions. Such interventions include safety planning, collaborating with other care providers such as psychiatrists and case managers, and psychoeducation of the client (and family, when applicable) concerning diagnosis and care options.
- Clinicians regularly provide clients with community resources and socialization opportunities, as needed and requested by clients. These resources are vital to decreasing social isolation, creating routine, and increasing quality of life for clients with severe and persistent mental health challenges.
- Peer support groups: The peer support group program strives to accomplish the MHSA intended outcomes. The peer support program helps improve participants' mental health by providing a space in which people can socialize with others and form a sense of community. This is a critical step in addressing the isolation that many LGBTQ+ individuals experience. The peer support groups also help prevent ongoing mental health issues from

progressing to mental illness. Community, relationships, and belonging are critical parts of an individual's mental health and wellness.

- Training/education: The training and education program reduces stigma and discrimination by educating local community members and other service providers through trainings and consultation on topics such as sexual orientation, gender identity, and their impacts on the health and well-being of the LGBTQ+ community. Staff work to increase collective understanding about the relevant issues that LGBTQ+ people face, both past and present. Staff also work to incorporate the principles of cultural humility alongside tips on how to be a stronger LGBTQ+ advocate. In grounding education and trainings in these principles, the Pride Center aims to demonstrate that one training is not enough. Rather, there must be continued learning and working with marginalized communities.

SUCCESSES

A. Clinical (Therapy and Case Management)

General Successes

Many clients express engaging with the Pride Center specifically because they know it is a safe and welcoming environment. The center continues to receive positive feedback from therapy and case management clients, who share that they feel their identities are seen, validated, and affirmed.

The Pride Center is recognized as a reputable source of high-quality LGBTQ+ affirming therapy and community support. External providers frequently refer clients to its programs and services. Parents reach out to the clinical team for resources to support their LGBTQ+ children, and school social workers and guidance counselors seek information and support for their students and families.

Given the higher rates of suicidality among LGBTQ+ individuals, Pride Center clinicians are well trained to understand risk factors, assess for suicidal ideation, and effectively intervene using evidence-based best practices. The clinical team receives regular crisis management, suicide prevention, and de-escalation training from the StarVista Crisis Center program.

Successful interventions include acceptance and commitment therapy, cognitive behavioral therapy, dialectical behavior therapy, mindfulness-based interventions, and discussions concerning coping skills and self-care practices. Motivational interviewing techniques have led to rapid improvements in clients' socioemotional functioning and progress on therapeutic goals.

In FY 2023–24, a successful 8-week multisexual therapy group was held, with participants expressing interest in extending the sessions. This in-person group, the first since the COVID-19 pandemic, helped reduce multisexual stigma and increased pride among participants.

Programmatic Success

The Pride Center reopened for in-person visits and successfully operated using a hybrid model, increasing service accessibility. Several new roles were created and filled, including an LGBTQ+ clinical administrative coordinator and mental health clinician, an LGBTQ+ mental health front desk

specialist, and an LGBTQ+ case manager. The center manager role was also established to support on-site needs and guide the clinical team.

Notable Client Success Stories:

- The LGBTQ+ case manager successfully housed and supported a young Latinx transgender client who arrived living in their car, needing immediate shelter before top surgery. Through collaboration with Mateo Lodge/Cassia House, the client was provided temporary accommodation and later enrolled in Spring Street Shelter.
- A 14-year-old transgender client displayed great insight and progress in therapy sessions, recognizing improved mental health compared with the previous year.
- A monolingual Farsi-speaking client seeking LGBTQ+-affirming community support was connected to an organization of their cultural heritage.
- A 29-year-old Filipinx client with frequent suicidal ideation received coordinated care from her psychiatrist and Pride Center clinician, helping her feel less alone and more able to share in a safe, supportive space.
- A non-binary youth successfully moved out of a hostile household into a safe and affirming location.
- A young adult client received housing aid to prevent homelessness for themselves and their disabled relative.
- One client received pro bono therapy services during unemployment, ensuring continuity of much-needed support.

Supporting Transgender, Gender Diverse, and Non-Binary Individuals (TGNB+)

More than two out of three clients supported by the clinical program (71%) identified as transgender, gender diverse, and/or non-binary during FY 2023–24. The Pride Center clinical team supports clients in accessing medically necessary gender-affirming care and connects them with gender-affirming garments. Clients report significant positive impacts on their mental health and well-being.

The Resource Roadmap service-provider trainings and community brochure collection continue to support TGNB+ individuals throughout San Mateo County and beyond. The Pride Center clinical team also assists with legal name and gender marker changes, writes letters of support for hormone replacement therapy and surgeries, and connects clients to resources such as gender-affirming voice training. The Resource Roadmap brochure collection can be accessed at https://sanmateopride.org/resource-roadmap.

During FY 2023–24,

- At least 12 clients began receiving gender-affirming hormone replacement therapy (HRT).
- At least 18 clients received gender-affirming surgery consultations or letters of support.
- At least seven clients successfully received gender-affirming surgery.

The Legal Name and Gender Change Workshop has served 504 individuals to date, with 82 served during FY 2023–24; 100% of attendees report being "very satisfied" with the workshop, and 92% strongly agree that they feel more prepared and confident in navigating the legal process.

Direct feedback from workshop participants remains overwhelmingly positive, with attendees expressing gratitude for the personalized experience, empowerment, and clarity provided in navigating the name and gender change process.

- "As someone who grew up in San Mateo County and relocated before the Pride Center opened, it was so heartwarming to receive this information and guidance from folks in that area and know that others in my hometown are able to receive services there."
- "Thank you again for the workshop—what an amazing resource this was! The whole process seemed very scary and insurmountable with so many different forms to fill out, but this workshop made it super easy!"
- "I enjoyed the personalized experience. My situation could be addressed for my minor who is undergoing the name change/gender marker change process, so I could ask specific questions."
- "I feel more empowered to file the paperwork myself. I am less overwhelmed."
- "[The facilitator] was amazing and I think all pertinent information was included. He went through everything step by step and made a rather daunting process seem almost easy. He basically did everything except fill out our forms for us! All questions were answered promptly and fully."

Trainings/Professional Development Opportunities Attended by Pride Center Clinical Team

The clinical team participated in a wide range of trainings, including the following:

- LGBTQ+ equality and leadership (CenterLink events)
- Cultural humility and anti-oppression work
- Suicide prevention and crisis de-escalation
- Working with LGBTQ+ and neurodivergent youth
- Intersex and gender-diverse health care
- Intergenerational trauma in Asian American and Asian immigrant communities
- Harm reduction and motivational interviewing
- Trauma-informed care for LGBTQ+ children and youth
- Mental health interventions (cognitive behavioral therapy, psychosis support)
- Ethics and law for Board of Behavioral Sciences associates

B. Youth Successes

Events and outreach: In partnership with Outlet, a program of Adolescent Counseling Services, the San Mateo County Pride Center executed various outreach initiatives, making more than 800 points of contact with the community. Highlights include the following:

- Supporting East Palo Alto's first Pride Event and hosting Youth Summer Drop-Ins
- Quadrupling community reach through school outreach events and GSA support
- Hosting an expanded youth and family section at the San Mateo County Pride Celebration

Youth social and support groups: Outlet and San Mateo County Pride Center continued providing targeted social groups for LGBTQIA+ youth, focusing on safety and support. The following are notable developments:

- Trans Talks recordings became a valuable resource for the Thursday Trans Group
- Increased attendance at Sequoia High School's Trans Student Group, with students developing an activism-based Trans Student Union

Education and consultations: Outlet and San Mateo County Pride Center provided education to equip San Mateo County residents with tools to support LGBTQIA+ youth. Key activities included the following:

- SOGIE 101 Workshops for StarVista's HAP-Y program youth cohorts
- Consulting with BHRS Health Ambassadors Program, including Spanish-language support
- Regular outreach to school counseling staff for trainings, consultations, and therapy referrals

Outlet clinical program: Outlet, a program of Adolescent Counseling Services, provides clinical services for youth and their families. Developments include the following:

- Planning a meet and greet between Outlet and San Mateo County Pride Center clinical trainees
- Providing psychoeducation for families concerning gender care and transgender experiences
- Hiring the first bilingual clinical trainee for Spanish-speaking services
- Expanding to the largest clinical cohort for 2024–25, with five clinicians
- Appointing Mimir Castro (he/him) as the new full-time program director for 2024–25

These initiatives demonstrate the Pride Center's commitment to comprehensive support for LGBTQIA+ youth and their families through education, clinical services, and community engagement.

C. Training and Education

BHRS SOGIE 101 (virtual):

- Completed four contracted trainings for 105 people
- High satisfaction ratings: 18/19 rated 4/4, 16/23 rated 10/10
- Positive feedback on thoroughness, clarity, and engaging format

Free community trainings:

- Offered three free trainings during Pride Month:

Becoming Aware of Assumptions/Implicit Bias (31 attendees)

SOGIE 101 (10 attendees)

Trans 101 (10 attendees)

Outside organization trainings:

- 14 new organizations and 17 repeat organizations requested trainings
- Provided 43 total trainings (12 in-person)
- Notable partners: StarVista, Court Appointed Special Advocates (CASA) of San Mateo County, Felton Institute, San Mateo County Office of Education, HPSM

Feedback and ratings:

- Maintained more than 90% positivity rating based on 172 evaluations
- Positive comments on engagement methods, breadth of information, and safe space creation

Additional educational materials (FY 2023–24):

"Exploring Our Roots—Unpacking Bias in Order to Grow":

- Continued offering through Kaiser Foundation grant
- Rebranded title and promotional material, leading to increased registrations
- Provided four virtual trainings to 198 attendees, including two community-wide sessions with more than 30 participants each

SOGIE 201:

- Soft-launched as a follow-up to SOGIE 101
- Focuses on deeper LGBTQ+ issues, increasing understanding, empathy, and support knowledge
- Gathered initial community feedback for future regular offerings

This comprehensive training program demonstrates the Pride Center's commitment to educating both professionals and community members on LGBTQ+ issues, with consistently positive feedback and expanding offerings to meet diverse needs.

D. Community Events

San Mateo County Pride Celebration and Parade 2024 (June 8, 2024):

- More than 6,000 attendees, with hundreds visiting the Pride Center booth
- Pride Center named as one of the parade's grand marshals
- Improved accessibility with ground tiles for easier mobility
- Positive feedback on family-friendly environment and overall setup

Transgender Week of Visibility (March 26–28, 2024):

- This year, the Pride Center hosted Transgender Week of Visibility. Transgender Day of Visibility | GLAAD is internationally recognized on March 31; however, as this coincided with Easter Sunday, it was decided to host a range of activities during the preceding week

(March 26–28) so that more of the Pride community members could participate. Throughout Transgender Week of Visibility, the program specially highlighted our Gender Affirming Closet, Legal Name and Gender Change Workshop, and interactive gender-affirming events:

Special drop-in hours (March 26–28): offered gender-affirming products and resources

Legal Name and Gender Change Workshop (March 27): assisted with documentation alignment

Gender Affirming Workshop "Becoming More Visibly You" (March 28): explored identity affirmation with guest experts

Additional events:

- Regular FriGay Flicks screenings, including Q&A sessions
- Queeraoke events, some hosted by LGBTQ+ commission member Krystle Cansino
- Crafternoon events for community bonding
- National Day of Reading event celebrating transgender and non-binary stories

Other notable events that the Pride Center organized and/or supported:

- Trans* Day of Remembrance
- Vision board craft event with CORA
- College of San Mateo LGBTQ+ Youth Pride Prom support
- Friendsgiving volunteer appreciation

- Sunset hike at San Pedro Valley Park
- June Pride Celebration in collaboration with the San Mateo County PI

Event planning survey:

- Conducted to understand community preferences
- 111 responses received, with gift certificate incentives

Community partnerships:

- Increased collaborations with partner organizations (e.g., Adolescent Counseling Services, Peninsula Family Service)

E. Peer Support Groups

The Pride Center's peer groups continued to meet virtually this year, except for the LGBTQ+ Book Club, which became a hybrid group with staff hosting members who chose to attend in-person at the Pride Center. Some discussions about moving more groups to a hybrid model have occurred within groups; however, there is a desire for a permanently virtual element as it allows increased accessibility for out-of-state and local group members.

- In November 2023, the Pride Center's new lead trainer and peer group coordinator, Ishani Dugar (they/xe), was successfully onboarded and received support from Elana Ron (she/they), the previous peer group coordinator, to take over peer group support duties.
- The Pride Center continues to partner with San Mateo County Libraries and use the list put together by the co-facilitator of the LGBTQ+ Book Club: LGBTQ+ Book Club—in Partnership with the San Mateo Pride Center (cloud.microsoft). The LGBTQ+ Book Club covered a range of books throughout the year, including, among others, "The Guncle" by Steven Rowley, "Pageboy" by Elliot Page, "Last Night at the Telegraph Club" by Malinda Lo, and "Less" by Andrew Sean Greer.
- The Polyamory Power Group covered a diverse range of topics throughout the year, including, among others, asexuality and polyamory, coming out, religion and spirituality, boundaries in relationships, and nondiscrimination protections. The group also featured author talks and Q&A sessions with experts in the field of consensual nonmonogamy and polyamory.

F. Volunteers

The volunteer program has built traction in San Mateo County as people have reached out to the Pride Center seeking ways to get involved and to volunteer. The Pride Center had an influx of volunteers who work well with their unique skill sets. It is important to note that as the center continues to receive these requests, this also impacts StarVista's human resources. Because their human resources department is also relatively small, the Pride Center has experienced delays with onboarding volunteers.

G. Administrative

- The Pride Center created a new system for on-site staff to use when they plan to be working on site to avoid rooms double booking for meetings. With various meeting rooms and workstations/desks available, the center created a document titled “How to Book a Room at the Pride Center.” The purpose of this document is to provide a step-by-step process using Outlook as a tool for scheduling/booking rooms at the Pride Center so everyone on the staff is able to see the calendar.
- Since joining the Pride Center team in November 2023, the new LGBTQ+ mental health front desk specialist, April Qian (she/her), has created and implemented multiple organizational structures that helped to streamline the administrative and overall Pride Center’s operations. Projects include but are not limited to a new purchasing system, restructuring of the weekly team meeting agenda for better visual clarity, and the creation of various how-to guides.
- With Measure K money funded through a rare surplus from San Mateo County, the Pride Center continues to invest in numerous professional development opportunities for the team. Individual members have capitalized on opportunities to increase job skills. The center has also continued to improve safety and security training as a collective team. From these trainings, the Pride Center continues to update and improve virtual and on-site crisis protocols to maintain the safety of the team and community to the best of their ability.
- Pride Center management also developed internal human resources policies applicable to Pride Center staff, including the following:

The Pride Month Expectations Policy explains how the increased workload during Pride season can be more distributed across team roles.

The Advocacy Hours Policy acknowledges that many unstated responsibilities involve advocacy. This policy allows team members to use a set number of work hours to meet community demands while preventing these expectations from dominating the main priorities of their jobs.

The Selfcare Day Policy adds an additional day off per quarter for each Pride Center staff member to incentivize staff retention because of the demanding nature of their jobs.

H. Outreach/Communications

- General outreach success:

This year (FY 2023–24), the Pride Center tabled at 39 in-person events and interacted with 3,217 community members.

At the end of Quarter 4 2022–23, the marketing team had the privilege of welcoming Elana Ron as the new volunteer and peer group coordinator. Beginning in Quarter 1, there was an immediate, noticeable increase in the Pride Center’s presence tabling at a variety of community events throughout San Mateo County.

In Quarter 1, the Pride Center and Outlet collaborated to create a bilingual SOGIE brochure. These brochures provide a general outline/summary of SOGIE in English and Spanish. For more information and to access digital/downloadable copies of these brochures, please follow this link: https://sanmateopride.org/sogie-abcs.

In Quarter 3, the marketing team expanded to include Ishani Dugar, the Pride Center's lead trainer and peer group coordinator.

Throughout the course of the year, there was an overall increase in the amount of consistent, ongoing updates to the Pride Center's website.

- The Pride Center also created new outreach materials in June 2024.

I. Development

The Pride Center received positive feedback from donors, who expressed support for the center's work, mission, and community impact.

Financially, the center had a successful year, securing donations from various sources. All grant proposals submitted by the Pride Center were awarded, including funding from the Kaiser Foundation and BHRS for FYs 2024–26.

In addition, the Pride Center benefited from San Mateo County's rare budget surplus (Measure K). This funding will be used for capital improvements, professional development, technology upgrades, and project support. Some of the funds were allocated to hire additional staff, with a priority on increasing clinical support. This funding extension allows the Pride Center to enhance its services and capacity through June 30, 2025.

Overall, the financial support received enables the Pride Center to continue to expand its vital work in the community.

CHALLENGES

A. Clinical (Therapy and Case Management)

General/programmatic challenges:

- There was a long waitlist for therapy services for clients with HPSM insurance because of high demand. There were not enough clinicians with open availability who could take HPSM clients. When HPSM clients were onboarded, it was found that several of these clients had high needs because of significant trauma and moderate/more severe mental health challenges. Multiple Medi-Cal authorizations also took several weeks to process. This led to clients with Medi-Cal having to wait to receive therapy services.
- For some time, there had been an increasing pattern of requests for lower fees than what is typical for income levels based on the Pride Center sliding scale guidelines. In response to this need, a Letter of Hardship form was reintroduced to the team to make it easier for clients to share why they needed a lower fee for services. Also, protocols were reiterated so clinicians knew how to proceed with discussing fees with clients and referrals.
- The Pride Center clinical staff have found it difficult to get clients to come to the center for in-person services, even though this may benefit some clients. It appears that many clients are accustomed to remote (i.e., telehealth) services and are not in a hurry to attend in-person services. When clients have been in person, it could be an awkward transition for clinicians who were onboarded remotely and have not ever seen their clients in person before.
- There were long waits from the Board of Behavioral Sciences for clinicians to get associate registration and not enough clinicians with open availability to take on HPSM clients for a duration of time.

- One of the Pride Center therapy rooms needed cleaning and touch-ups to improve its appearance to get ready to host an upcoming therapy group. The center manager and one of the Pride Center clinicians put in extra effort to successfully "beautify" the room.
- There was an observed increase in severity levels of mental health issues and clients/community members presenting in crisis when dropping in to the Pride Center. De-escalating these situations and intervening can take significant time, energy, and capacity from the clinical team members and on-site crisis leads.
- Anti-LGBTQ+ issues, both locally and nationally, have affected the mental health of many Pride Center clients in a negative way. Several transgender clients have shared that they are concerned about transitioning because of fear of discrimination and potential danger to themselves. Furthermore, the proposal and passage of anti-LGBTQ+ legislative bills across the country have led to rampant misinformation, especially among some parents of transgender clients.

Staffing/hiring:

- Unfortunately, the clinical supervision coordinator needed to take a period of bereavement leave for several weeks because of a sudden and unexpected loss. During this period, several of their clients were transferred to additional clinicians on the team. Upon their return, their capacity to see clients was reduced and had to be adjusted to accommodate their needs.
- Near the end of Quarter 3, in late March 2024, the Pride Center's LGBTQ+ case manager notified management of their intent to resign from the role, indicating that case management was not a good fit for them at the time. Their last day was scheduled for the first week of April.
- Following the case manager's resignation, the Pride Center was left without a dedicated full-time case manager for the entirety of Quarter 4 (April–June 2024). To address this gap, the Pride Center's LGBTQ+ clinical administrative coordinator, Pearl Chen (she/her), took on the additional role of supporting current and new case management referrals during this period. The level of case management support needed this quarter became higher than anticipated, stretching the center's capacity thin.

B. Youth

- Events and outreach: The Pride Center met with the community frequently in FY 2023–24. However, attendance declined during summer months (Quarters 1 and 4) because of youth and youth-connected adults reducing their participation for travel and time with local communities. This is an annual trend, and outreach continues for those available during summer break.
- Groups: Outlet experienced lower enrollment and attendance for social groups this FY compared with previous years. Feedback was requested from past participants to meet community needs in 2024–25, with plans for alternate formatting and increased marketing. The group intake process will be streamlined to ensure retention after initial

outreach. Social groups have had sporadic attendance since resuming weekly sessions in September 2023. Staff outreach to current and past members yielded mixed results. Peer organizations reported similar attendance issues. Attendance in June 2024 was minimal or nonexistent. Staff engaged group members to assess whether earlier school year ends impacted attendance. Annual Youth Drop-In hours will be used for community reengagement before groups resume in fall. In Quarter 3, homophobic and transphobic incidents in the service area, including vandalism of a partner organization's offices, led to community concerns about safety and visibility, affecting service utilization.

- Education and consultations: Staff turnover resulted in fewer opportunities. Many organizational connections need rebuilding in the upcoming FY by the new Outlet team.
- Outlet clinical program: In Quarter 1, Outlet was in a transitional period because of staff turnover as well as a rebuilding period to refresh the program. Brett Trace served as the clinical coordinator in Quarters 2 through 4 and onboarded the new program director in Quarter 4 to ensure that Outlet maintained services and will continue to expand in the future. The program is receiving more calls from parents anxious about their child coming out and wanting to enroll them in therapy right away. At times, the parents may need therapeutic support more than the child. Outlet is currently not equipped to offer one-on-one parent therapy. There has been a growing number of Outlet clients expressing desires to "pass" as cisgender and/or heterosexual, likely because of the anti-trans climate of national politics. Because of the direct LGBTQIA+ population that Outlet and San Mateo County Pride Center work with, folks expect a certain level of "outness" for services to be used. Referrals for individual therapy were low during Quarters 2 and 3 compared with previous years. Self-referrals are especially low, with most referrals coming from parents or school counselors. As clinical interns transition out, there is an anticipated gap in services. Two clinicians stayed through summer to fill this gap, but one could not continue. This slows client services until new interns are fully onboarded in September.

C. Training and Education

- General:

The lead trainer, Azisa Todd (they/she), departed in September. Previously scheduled trainings needed to be rescheduled until a replacement started. A new lead trainer joined at the end of November, but the 2-month vacancy reduced the number of trainings delivered in the first two quarters. In the fourth quarter, the lead trainer prioritized training requests partly because of Pride Month in June. The main challenge was multiple requests for trainings on the same day, exacerbated by organizations wanting education for their staff during Pride Month. Early solicitation of training requests helped manage conflicts. Encouraging organizations to schedule trainings in advance, especially around LGBTQ+ recognition periods, will be key to meeting community needs without overwhelming staff.

- Virtual trainings: The primary challenge is making education as interactive as possible. The Pride Center continues to adapt discussions and activities to increase audience attention. More requests for in-person trainings were received throughout the year.

- Feedback: Despite evaluation forms being sent to all participants, feedback remains limited. A slide with the evaluation link and QR code was incorporated to capture early evaluations as trainings end. Consistent and timely feedback collection, especially from organizations with their own forms, is crucial for strengthening the training program and addressing partner needs. Despite limited feedback, responses received express immense gratitude for the training efforts.
- Additional educational materials/miscellaneous: The Pride Center occasionally receives inquiries for Spanish trainings on SOGIE topics. These requests cannot be met directly because of the lead trainer's monolingual status. However, an alternate bilingual resource brochure was developed in collaboration with Adolescent Counseling Services Outlet's program coordinator.

ALLCOVE® YOUTH DROP-IN CENTER

The allcove® model, inspired by successful international models in Australia, Canada, and Ireland, creates stand-alone, "one-stop-shop" health centers for young people ages 12– 25 years to access support for mild to moderate needs with mental health, physical health, substance use, peer support, supported education and employment, and family support as well as linkages to community referrals in the continuum of care for more intensive needs. allcove® approaches youth wellness in a comprehensive and youth-friendly way, led by members of an active local Youth Advisory Group, who help design the service and environment they most want to see in their community, and a Community Consortium. Through innovative, evidence-based approaches, allcove® centers have the flexibility to reflect the unique youth culture of each community being served and fill a critical gap in the spectrum of youth mental health and wellness services.

The allcove® San Mateo provides young people ages 12–25 years with access to, but not limited to, the following specific services:

1. Drop-in behavioral health services, resources, and Wraparound services and supports
2. Education and awareness about mental health issues via existing relationships with school-based partners
3. Outreach via school-based relationships
4. Behavioral health education and service pathways for local school districts and community colleges
5. Therapy and peer-support groups for youth

allcove® San Mateo opened its doors to the community on January 22, 2024. The center launched with two clinicians (one bilingual) providing mental health services from 1:00 p.m. to 7:00 p.m. Monday, Tuesday, Thursday, and Friday and from 10:00 a.m. to 2:00 p.m. on Saturdays. Initial staffing included one AOD specialist from the DCYHC and a supported education and employment specialist from NovaWorks. Service volume began gradually as the center focused on outreach, community awareness, and connections with local government agencies, schools, and organizations.

Youth primarily accessed mental health services, with substance use and supported education and employment services receiving equal utilization. In response to increased demand from monolingual Spanish-speaking youth, the center added a second bilingual clinician to expand capacity. As schools closed for summer, the center intensified community-based outreach, planning school assembly presentations for the fall semester and scheduling workshops and events to engage more youth and adults.

The center hosts regular social activities, including movie nights and game nights, which attract consistent and enthusiastic participation. Youth frequently access the space for tours or recreation, and the center continues to offer its conference rooms and other facilities at no cost to local organizations and clubs.

Because the program began mid-FY, complete data collection and analysis will be available in FY 2024–25.

ALLCOVE YOUTH DROP-IN CENTER

OLDER ADULT PEER COUNSELING AND OUTREACH – PEARLS PROGRAM

DCP's Healthy Aging Response Team began implementing the Program to Encourage Active, Rewarding Lives (PEARLS) in spring 2024, partially funded by MHSA PEI funds. As this marks the initial phase of the program, a full year of data is not yet available; that comprehensive data set will be compiled in the upcoming year. However, these first months have been dedicated to crucial start-up outreach efforts.

The Healthy Aging Response Team conducted several outreach initiatives at various venues throughout San Mateo County. These preliminary efforts have already shown promising results, with 199 individuals expressing interest in PEARLS. Outreach events were held at diverse locations, including the following:

- Northeast Medical Services
- Stanford Hospital
- Veterans Administration Hospital
- Burlingame Community Center
- South San Francisco Community Center
- Doelger Senior Center

These initial outreach activities laid a strong foundation for full PEARLS implementation and comprehensive data collection in FY 2024–25.

OLDER ADULT PEER COUNSELING AND OUTREACH - PEER COUNSELING PROGRAM

The Peer Counseling Program from the Peninsula Family Service (50% CSS, 50% PEI) deploys more than 100 trained volunteer counselors to support older adults in San Mateo County through weekly visits. These counselors help manage transitions and life changes, including health concerns, mobility issues, caregiver needs, and grief.

Targeting residents ages 55 years and older who may be depressed, lonely, or isolated, the program offers one-on-one meetings and group support. Volunteers are matched with participants on the basis of shared cultures, languages, and backgrounds, focusing on underserved communities such as Chinese-speaking, Filipino, Spanish-speaking, and LGBTQ+ older adults.

Volunteers undergo a more than 30+ hour initial training and background checks and receive ongoing monthly clinical supervision. They meet weekly with participants by phone, via Zoom, or in person. Some volunteers receive additional training to lead support groups.

In FY 2023–24, the program offered training in English, Spanish, and Chinese. Peer counselors provide emotional support and resource connections and facilitate weekly "Let's Talk" drop-in group sessions both in person and via Zoom.

PROGRAM IMPACT

Peer counseling	FY 2023–24
Total individual clients served	89
Total group clients served	514
Total cost per client	$807
Total clients served	603

Outcome Indicators

Domain	Indicator/question	*n*	%
Stigma reduction	Due to this program, I feel more comfortable talking about my problems. (internal/self) Due to this program, I feel more comfortable reaching out for emotional support. (seeking help/treatment)	Individual: 20 of 26 Group: 12 of 17 Individual: 20 of 26 Group: 7 of 17	77 71 75 40
Improved knowledge, skills, and/or abilities	The program improved my knowledge and abilities to seek support. As a result of participating in this program, I am connected to community resources.	Individual: 20 of 26 Group: 7 of 17 Individual: 15 of 26Group: 14 of 17	75 40 58 81
Connection and support	As a result of this program, I feel supported.	Individual: 15 of 26 Group: 14 of 17	58 81
Self-empowerment	Due to this program, I think more positively about challenges in my life.	Individual: 15 of 26 Group: 13 of 17 Individual: 18 of 26	58 77 71

	Due to participating in this program, I believe that I can affect my life through decisions that I make.	Group: 6 of 17	36
General behavioral health	As a result of participating in this program, I feel less stressed.	Individual: 19 of 26 Group: 7 of 17	72 42

DEMOGRAPHICS

Older Adult Counseling Program Client Demographics (N=603; Group and Individual)

	Number of clients	Percentage of total
Age		
0–15 years	0	0
16–25 years	0	**0**
26–59 years	24	4
60–73 years	103	17
74 years and older	332	55
Prefer not to answer/unknown	144	24
Primary language		
English	241	40
Spanish	109	18
Another language	109	18
Prefer not to answer/unknown	144	24
Race		
Asian or Asian American	46	8
Black or African American	7	1
Native American, American Indian, or Indigenous	5	1
Pacific Islander	0	0
White or Caucasian	158	26
Another race	376	62
Prefer not to answer/unknown	11	2
Ethnicity		
Latino/a/x or Hispanic	114	19
Caribbean	2	0.01
Central American	9	1
Mexican/Mexican American/Chicano	21	3
South American	6	0.1
Another identity or tribe	76	13
Prefer not to answer/unknown	0	0
Not Latino/a/x or Hispanic		
African	2	0.3
Asian Indian/South Asian	27	4
Chamorro	0	0
Chinese	103	17

	Number of clients	Percentage of total
Eastern European	2	0.3
European	16	3
Fijian	1	0.1
Filipino/a/x	164	27
Japanese	2	0.3
Korean	3	0.4
Middle Eastern or North African	0	0
Samoan	0	0
Tongan	1	0.1
Another ethnicity or tribe	168	28
Prefer not to answer/unknown	0	0
Sex assigned at birth		
Male	NA	NA
Female	NA	NA
Prefer not to answer/unknown	NA	NA
Intersex		
Yes	NA	NA
No	NA	NA
Prefer not to answer/unknown	NA	NA
Gender identity		
Female/woman/cisgender woman	395	66
Male/man/cisgender man	174	29
Transgender woman/trans woman/trans-feminine/woman	0	0
Transgender man/trans man/trans-masculine/man	0	0
Questioning or unsure of gender identity	0	0
Genderqueer/gender non-conforming/gender non-binary/neither exclusively female nor male	10	1
Indigenous gender identity	0	0
Another gender identity	0	0
Prefer not to answer/unknown	24	4
Sexual orientation		
Gay or lesbian	NA	NA
Straight or heterosexual	NA	NA
Bisexual	NA	NA
Queer	NA	NA
Pansexual	NA	NA
Asexual	NA	NA
Questioning or unsure of sexual orientation	NA	NA
Indigenous sexual orientation	NA	NA
Another sexual orientation	NA	NA
Prefer not to answer/unknown	NA	NA

	Number of clients	Percentage of total
Disability status		
Yes	NA	NA
No	NA	NA
Prefer not to answer/unknown	NA	NA
Veteran status		
Yes	NA	NA
No	NA	NA
Prefer not to answer/unknown	NA	NA

REFERRALS

Mental Health and Substance Use Referrals

Type of referral	FY referrals to programs within your agency	FY referrals to other agencies	FY total
Serious mental illness referrals	0	2	2
Substance use disorder referrals	0	0	0
Other mental health referrals	2	2	4
Total	**2**	**4**	**6**

Referrals to Other Services

Type of referral	FY total	Type of referral	FY total
Emergency/protective services	4	Legal	4
Financial/employment	4	Medical care	27
Food	11	Transportation	30
Form assistance	20	Health insurance	7
Housing/shelter	9	Cultural, nontraditional care	41
Other	73	**Total**	**230**

PROGRAM NARRATIVE

Improves timely access and linkages for underserved populations: The peer program provides resources and linkages to services. It uses Help@Hand resources, Peninsula Family Service internal resources, and external resources such as San Mateo County linkage and access services to improve access. The program ensures a practice of 24–48-hour turnaround to move clients through the referral process into active services.

Reduces stigma and discrimination: The peer program reduces stigma by increasing awareness of services for older adults, educating about stigmatizing language's impact on health, and promoting inclusive environments. It supports older adults through individual and group sessions, treating all with dignity and respect.

Increases number of individuals receiving public health services: The program consistently provides referrals to participants, primarily linking them to San Mateo County and surrounding county offices and resources. It connects participants to the county health department for access to public health programs and clinical services.

Reduces disparities in access to care: By making resources widely available, the program supports marginalized groups. It empowers participants through education and skill building to engage with health care systems and understand health plans such as the HPSM.

Implements recovery principles: The program integrates prevention, self-care, family support, housing, education, employment, clinical care, community services, recovery supports, primary health and dental care, transportation, spirituality, alternative services, social networks, and community participation.

Other activities that benefit clients: The program partners with the Fair Oaks Adult Activity Center in Redwood City, which offers many programs and services that empower older adults to improve their health, social lives, and personal fulfillment. Participants have access to a variety of group social activities, fitness classes, health screenings, an organic garden club, and information and assistance resources. Nutritious breakfasts and lunches are offered on weekdays, along with bi-weekly brown bag lunches and weekly grocery giveaways.

SUCCESSES

Client Success Story #1: The program recently worked with a client, "Norma," who had been confined to her home and unable to operate a standard wheelchair, connecting her with resources to enhance her mobility and independence. The peer counselor engaged Norma and sought out resources to meet her needs. The counselor found a donor as a resource and provided this to this client. Norma was elated and stated, "I am so happy the program was able to help me get around." Norma reported, "It's not about the chair, but what I can do with the chair that matters." She added, "I can really feel independent again," and "I think Vise [peer counselor] really listened to me and cared enough to make this happen." This ability of the program peers to use resources and link others to resources is a key intervention in the work we do.

Client Success Story #2: The following case illustrates the program's impact on family dynamics and cultural understanding:

"Amanda" and her daughter were having issues and not getting along. Both were adjusting to Amanda now living with her daughter and the daughter's spouse. The peer counselor, Rocio, who is also Hispanic, worked not only with the participant but with the family to facilitate understanding of therapy, particularly family therapy. Rocio was able to communicate and remove stigma and fear concerning therapy for the family culturally. She educated the family and walked them through the process of a referral to Family Care Alliance. Rocio ensured that the services were in Spanish and provided consistent care while adding to the participant's services. The success of this story is that Rocio was able to add additional services for the participant and her family that were vital to her

continued health. Amanda mentioned, “I like having people to talk to about my problems.” Amanda’s daughter told staff, “I think I will start doing services myself because it really helps.”

CHALLENGES

A key challenge for the program has been developing and delivering educational in-services for peer counselors and their participants, particularly addressing transportation issues and technology logistics for those unable to attend in person. To mitigate this, the peer program is actively exploring additional partnerships and funding sources to expand its transportation and technology support services. The program has made significant progress by leveraging internal resources within Peninsula Family Services, such as the “Got Wheels” program for dedicated senior transportation and the “Get Appy” service for in-home technology support and classes. The strategy moving forward is to optimize the use of these readily available resources for both peers and participants.

In addition, the program has faced difficulties in collecting comprehensive SOGIE demographics. To address this, the program plans to implement a more comprehensive approach. This includes distributing SOGIE forms not only to individual participants but also to group participants and integrating these data into the electronic health record system alongside self-reporting surveys. Furthermore, the program aims to improve tracking of timely access to services by using the electronic health record system to timestamp and monitor service referrals at 24/48 hours, and then at 30-, 60-, and 90-day intervals. This systematic approach will allow for more accurate and detailed analysis of service delivery and participant engagement over time.

PEI PROGRAMS – STIGMA AND DISCRIMINATION REDUCTION

STORYTELLING PROGRAM – PHOTOVOICE

In FY 2023–24, PhotoVoice devoted many efforts to its program relaunch taking place in October 2024. In December 2023, the PhotoVoice program coordinator and ODE intern revised the PhotoVoice surveys to be more trauma informed and culturally informed, while assessing ODE indicators that can help in better understanding and working toward destigmatizing mental health and/or substance use conditions. On May 3, 2024, the BHRS ODE’s PhotoVoice program collaborated with health ambassador youth for their “Lift Your Voice Open Mic Event.” The ODE supported this event by providing $20 Target gift cards to all attendees who completed the new and improved PhotoVoice surveys. Seventeen attendees completed the PhotoVoice Viewer Evaluations surveys. On September 4, 2024, the PhotoVoice program coordinator collaborated with ODE’s multicultural organizational development program coordinator to host a PhotoVoice meet and greet. This meet and greet reintroduced the PhotoVoice program to existing PhotoVoice facilitators and other BHRS staff and educated BHRS staff on how to use PhotoVoice among their teams, clients, and community members. Through this meet and greet, the opportunity to join the PhotoVoice facilitator recruitment funded by the MHSA was offered. This ultimately led to one existing BHRS staff member getting recertified in PhotoVoice facilitation, along with one lived experience community member, who is an existing health ambassador and Suicide Prevention and May Mental Health Month

Committee member, receiving their PhotoVoice facilitator certification. Now that there are two official co-facilitators, the BHRS ODE will be piloting its first PhotoVoice session since 2019 for the 17th Annual Housing Heroes Awards. Looking ahead to FY 2024–25, the PhotoVoice program is expected to be fully operational, with events such as the upcoming October Housing Heroes Sessions planned throughout the year. These sessions will be devoted to amplifying community voices on various social issues, starting with addressing inequitable housing in San Mateo County through visual storytelling.

STORYTELLING PROGRAM – YOUTH HELP@HAND

The Youth Leadership Institute (YLI)'s Help@Hand program, a new PEI initiative implemented in FY 2023–24 as part of the broader Help@Hand project, is to support youth ages 15–25 years in San Mateo County by reducing the stigma associated with mental health through innovative, youth-led initiatives. This YLI program within Help@Hand promotes access to behavioral health services, promotes social connectivity through peers, and supports self-directed mental wellness and recovery goals. In FY 2023–24, YLI's Help@Hand program recruited 10 youths and served an average daily attendance of six youth between September 2023 and May 2024. Seventy percent of youth served were ages 16–25 years, with 60% identifying as English speakers and 40% as Spanish speakers. Of the participants, 50% identified as Latinx. Help@Hand youth ambassadors reached more than 109 youths through community outreach presentations, tabling events, and the mental health youth needs survey.

This year, YLI connected youth to campaigns promoting access to mental health services and conversations through animated mental health public service awareness messages and peer-to-peer education. Help@Hand youth have expanded their mental health education by creating five podcast episodes based on youth' mental health presentations. Youth also developed a mental health youth needs survey in collaboration with other youth programs in San Mateo County to identify and understand the mental health challenges, resource accessibility, and support needs among young people. The survey revealed that youth would prefer schools to increase the number of mental health counselors and awareness campaigns. In addition, monolingual speakers, particularly those who speak only Spanish, may require more targeted mental health programs because of language barriers that limit their access to existing resources and support services. Providing resources in their primary language can improve their engagement and ensure that they receive the necessary support.

Help@Hand is dedicated to improving timely access and creating vital linkages for underserved populations, particularly youth living in Half Moon Bay, by connecting them with guest speakers, service providers, and opportunities that offer mental health support, education, and resources. This year, YLI's emphasis on reducing stigma and discrimination through targeted education and outreach led to youth promoting open conversations about mental health in their peer groups, family, school, and communities. YLI observed that by addressing youth-identified mental health topics such as school climate, social media and mental health, technology and mental health, and cultural stigma, youth fostered meaningful discussions that resonated with both youth and adults.

Youth ambassadors continue to break down barriers and access resources through their creation of a podcast series that dives deeper into their mental health presentation topics. By sharing their information in a podcast, youth ambassadors reach their peers and San Mateo County youth outside of the school setting, further promoting and destigmatizing folks seeking mental health support and breaking down barriers of stigma. YLI and youth ambassadors also collaborated with Coastside service providers to develop a mental health youth needs assessment, with results informing the direction of the upcoming allcove® Half Moon Bay youth advisory group. Youth ambassadors also collaborated with California Friday Night Live programs to create an animated public service announcement and developed outreach plans to help spread messages of mental health awareness.

PROGRAM IMPACT

Youth Leadership Institute Help@Hand	FY 2023–24
Clients served (unduplicated)	10
Cost per client	$15,000
Individuals reached (duplicated)	109
Total served	119

DEMOGRAPHICS

Demographic information was not provided because of the small sample size (N = 10) to protect participant privacy.

PROGRAM NARRATIVE

Improves timely access and linkages for underserved populations: Help@Hand youth ambassadors led a narrative campaign to promote awareness and discussion on mental health issues and topics such as social media and mental health, technology and mental health, school climate, culture, and mental health. These peer-to-peer presentations on various topics allowed youth to share resources and feedback on how to improve access to services throughout San Mateo County. For example, students expressed the need for dedicated multilingual youth services in their community and school counselors. Students also shared ideas on promoting the school climate, including more awareness campaigns and educational programs.

Reduces stigma and discrimination: Help@Hand youth ambassadors reduce mental health stigma and discrimination by working on targeted presentations to underserved populations such as their culture and mental health presentations at the Half Moon Bay Library and high school. Guest speakers on their podcast connect youth to personal stories and educational content and provide increased awareness on where to go for support. The purpose of the podcasts and presentations is to promote the number of individuals receiving public health services, encourage open discussions about youth mental health, and create a supportive community for youth to share their mental health needs.

Implements recovery principles: Help@Hand implements San Mateo County BHRS's recovery principles by prioritizing public health tactics in community health advocacy and education. Help@Hand emphasizes equity by uplifting youth voices and advocating for reducing disparities in mental health care access, focusing on serving underserved, underresourced, and marginalized

communities such as Half Moon Bay. YLI continues to foster community-wide collaboration by partnering with government agencies, school districts, service providers, and industry partners, creating a coordinated effort to support mental health recovery and well-being across San Mateo County.

SUCCESSES

Community partnerships contributed significantly to the success of Help@Hand's work this year. Youth collaborated with Royer Studios and the California Friday Night Live Partnership to produce multiple public service announcements focused on social-emotional wellness and a positive school climate. Empowering youth to address challenging topics through art and digital media not only allows them to reflect on their own attitudes and perceptions but also provides a platform to share their stories and promote positive messaging.

Connecting youth to service providers such as San Mateo County NAMI led them to think deeply about what mental health means in different communities and cultures. This year's efforts resulted in self-discovery, forming community partnerships, and developing the courage to discuss challenging topics such as stigma with peers and family members. When youth weren't using technology to educate peers, they used tri-fold boards to educate students on campus and spread awareness. This year prepared a strong foundation for Help@Hand youth ambassadors and youth who generally care about mental health and wellness to advocate for more targeted resources and dive deeper into impactful storytelling initiatives that address the specific needs of their communities.

CHALLENGES

One of the primary challenges YLI encountered was coordinating podcast recordings because of the countywide scope of the Help@Hand initiative and the diverse backgrounds of youth participating in Help@Hand. Because there are 23 school districts in San Mateo County, finding a mutually available time for all youth proved to be a significant hurdle. Compounding this challenge were the various commitments and activities that youth were involved in both within and outside of school. For example, the time that youth were available across districts was limited because of the diverse school calendars. As a result of this challenge, activities such as coordinating guest speaker presentations and completing the podcast recordings took much longer than expected.

MENTAL HEALTH AWARENESS

San Mateo County's anti-stigma initiative aims to eliminate stigma against mental health and/or substance use issues in the San Mateo County community. Primary program activities and/or interventions provided include the following:

- **Annual May Mental Health Month observance:** This is one of the biggest mental health observances of the year for San Mateo County. San Mateo County aligns with the statewide efforts and 2024 theme "Heal Through Connection." The 2024 May Mental Health Month consisted of the following:

Planning committee provided guidance and oversight for the Mental Health Month activities in San Mateo County. Planning committee members included clients/consumers, family members, county staff, and CBO staff. Planning committee meetings convened from February 2024 to June 2024.

Advocacy days are various days in April and May on which community members can make public comments and advocate for mental health at local city and county meetings that proclaim May Mental Health Month; some local governments also light their buildings in green for May Mental Health Month.

Mini-grants and event support are opportunities for county and community partners to apply for a modest amount of monetary funding ($200–$300) and event support for their May Mental Health Month event. The process includes application, selection, event support, deliverable review, and fund disbursement. Event support includes

- Input/ideas on event theme, programming, communication/outreach, and logistics (up to 2 hours consultation)
- Speakers with lived mental health and/or substance use experience
- Digital stories for screening
- PhotoVoices for exhibits
- Event templates (flyer, presentation slides, and chat script)
- Event promotion on website and social media (Facebook, Twitter, blog, and email networks)
- Interpretation/translation with San Mateo County health contractors

Communication campaign promoted May Mental Health Month through the following communication channels.

- **Website** included schedule of events, ways to get involved, and resources for behavioral health.
- **Social media** campaign included social media posted across San Mateo County Health Facebook, Instagram, Twitter, and BHRS Blog. Among Facebook, Instagram, and Twitter, the hashtags #SMCAgainstLoneliness and #MayMentalHealthMonth were featured and shared by organizations and individuals.
- **Email blasts**—Weekly email blasts were distributed to behavioral health staff, community partners, and community members.

- **Outreach materials**—Outreach/promotional materials included t-shirts, tote bags, lanyards, pop keychains, ribbons, and printed materials created by the county and state.

BHC meeting at College of San Mateo on May 1, 2024

Mental Health Month planning committee outreach day at Harbor Blvd., Belmont on May 2, 2024

PROGRAM IMPACT

Mental health awareness	FY 2023–24
Total unduplicated individuals served through trainings and events	1,321
Total duplicated individuals reached through other outreach efforts (website, social media, etc.; details below)	18,573
Total cost per client	$137
Total individuals served	19,894

The #BeTheOneSMC (stigma discrimination reduction) initiative

- *Improves timely access and linkage to treatment* for underserved populations and *increases the number of individuals receiving public health services* by raising awareness in the community about behavioral health resources through online communication and outreach.
- *Reduces stigma and discrimination* by providing education and sharing stories of those with lived experience through community advocacy days, events, and communication campaigns.
- *Reduces disparities and inequities to access to care* by hosting activities that target specific marginalized communities in different regions of the county. For 2023–24, specific marginalized communities targeted included youth, older adults, veterans, and Pacific Islanders.
- *Implements recovery principles* by integrating key recovery principles (particularly individualized and person centered, respect, and hope) in the communication messages and framing of events.

Events: In FY 2023–24, there was a total of 36 Mental Health Month events with an estimated reach of 1,321 duplicated individuals, and 179 survey responses were collected from 21 out of 36 events. Results are as follows:

- **Stigma reduction (external):** 81.56% (146/179) agreed or strongly agreed that they are more likely to believe, as a direct result of this program, that people with mental health and/or substance use conditions contribute much to society.
- **Stigma reduction (help seeking):** 82.68% (148/179) agreed or strongly agreed that they are more willing, as a direct result of this program, to seek professional support for a mental health and/or substance use condition if they need it.
- **Cultural humility/identity:** 89.94% (161/179) agreed or strongly agreed that this program was relevant to them and other people of similar cultural backgrounds and experiences (race, ethnicity, gender, religion, etc.).

Communications:

- Website—total page views = 1,160
- Social media—approximately 12,247 people reached on posts and approximately 302 engagements

- Email blasts sent to following distribution lists and number of subscribers:

BHRS all staff: number of subscribers = 500

BHRS ODE: number of subscribers = 2,338

May Mental Health Month planning committee: number of subscribers = 2,026

SUCCESSES

One of the highlights of 2024 May Mental Health Month was featuring two clients/consumers/ community members in the San Mateo County Board of Supervisors Proclamation for 2024 May Mental Health Month, which served as one of their advocacy days. The speakers, who had graduated from the County Behavioral Health and Recovery Services LEA, were making their public speaking debut. They shared their personal lived experiences with behavioral health conditions and services, advocating for changes they wished to see in their community. Their speeches informed the Board of Supervisors, built empathy, and helped reduce stigma in the county. Moreover, the experience seemed to contribute to the speakers' own healing process. One of the speakers, Joanna (Jo) Padilla, expressed her appreciation, stating, "Again I appreciate the opportunity. It has been such a confidence boost!"

San Mateo County Board of Supervisor Proclamation for 2024 May Mental Health Month, Redwood City, May 21, 2024

Speakers Joanna Padilla and Gina Olinger-Giani, San Mateo County Board of Supervisor Proclamation for 2024 May Mental Health Month, Redwood City, May 21, 2024

CHALLENGES

One challenge of May Mental Health Month was planning the observance theme, marketing, and communications earlier. The California Mental Health Services Authority (or contractor) shipped the physical promotional materials on April 24, 2024, and emailed to unveil the digital toolkit on May 1, 2024. This necessitated rescheduling an in-person Mental Health Month planning committee meeting because of the delay in shipping physical materials. The county also needed to choose its local theme partly because of the delay in releasing the toolkit.

To mitigate these challenges in the future, San Mateo County and other counties have reiterated their feedback given more than a year ago about receiving physical and digital materials ahead of time. This would allow at least a month to market and promote May Mental Health Month.

DEMOGRAPHICS

Mental Health Awareness Participant Demographics (N=179)

	Number of clients	Percentage of total
Age		
0–15 years	16	9
16–25 years	35	20
26–59 years	97	54
60–73 years	15	8
74 years and older	14	8
Prefer not to answer/unknown	2	1
Primary language		
English	136	76
Spanish	28	16
Another language	15	8
Prefer not to answer/unknown	0	0
Race/ethnicity		
Asian or Asian American	35	20
Black or African American	12	7
Native American, American Indian, or Indigenous	2	1
Native Hawaiian or Pacific Islander	25	14
White or Caucasian	50	28
Latino/a/x or Hispanic	51	28
Another race, ethnicity, or tribe	4	2
Prefer not to answer/unknown	0	0
Gender identity		
Female/woman/cisgender woman	122	68
Male/man/cisgender man	44	25
Transgender woman/trans woman/trans-feminine/woman	2	1
Transgender man/trans man/trans-masculine/man	1	0.5

	Number of clients	Percentage of total
Questioning or unsure of gender identity	2	1
Genderqueer/gender non-conforming/gender non-binary/neither exclusively female nor male	6	3
Indigenous gender identity	0	0
Another gender identity	1	0.5
Prefer not to answer/unknown	1	0.5
Sexual orientation		
Gay or lesbian	5	3
Straight or heterosexual	143	79.5
Bisexual	8	4
Queer	3	2
Pansexual	5	3
Asexual	3	2
Questioning or unsure of sexual orientation	2	1
Indigenous sexual orientation	0	0
Another sexual orientation	1	0.5
Prefer not to answer/unknown	9	5
Behavioral health consumer or family member		
Client/consumer	48	27
Family member	34	19
Both	30	17
Neither	43	24
Prefer not to answer/unknown	24	13

PEI PROGRAMS – SUICIDE PREVENTION

SUICIDE PREVENTION ROADMAP IMPLEMENTATION

To address the increased need for suicide prevention in the community, the Suicide Prevention Committee, further described below, developed the Suicide Prevention Roadmap 2021-2026 as part of a larger vision to reduce suicide deaths, suicide attempts and pain associated with suicidal thoughts so that everyone in our community can realize healthy and meaningful lives. The Roadmap builds off of the first Suicide Prevention Roadmap 2017-2020 and the California Striving for Zero Suicide Prevention Strategic Plan 2020-2025. The roadmap includes:

1. Data to understand our local needs, best practices and inform local prevention efforts.
2. Education on how to approach, support and refer those who are at risk for suicide.
3. Resource directory of local suicide prevention programs and activities.
4. Opportunities to lead and/or collaborate that are guided by a comprehensive plan.

SUICIDE PREVENTION PROGRAM

The suicide prevention program aims to coordinate efforts to prevent suicide in the San Mateo County community. The primary program interventions include the following:

1. **Suicide Prevention Committee:** The mission of the San Mateo County Suicide Prevention Committee is to provide oversight and direction to suicide prevention efforts in San Mateo County. Created in 2009, this coalition consists of passionate suicide prevention advocates, including suicide attempt survivors and suicide loss survivors; representatives from behavioral health, primary care, emergency health services, social services, law enforcement, transportation, education, communication and media, art and culture, and spirituality and faith; and community members. The Suicide Prevention Committee uses its strategic plan to prioritize and connect efforts to reduce suicide overall and among specific high-risk communities. For 2024, the Suicide Prevention Committee prioritized "Goal 2: Increase Development and Coordination of Suicide Prevention Resources."
2. **September Suicide Prevention Month:** The purpose of Suicide Prevention Month is to encourage all in the community to learn how we all have a role in preventing suicide. The 2024 Suicide Prevention Month statewide and countywide theme was "Share Hope Together" and local hashtags were #ShareHopeTogether and #TakeAction4MH. Suicide Prevention Month activities included the following:
    a. **Advocacy days** are various days in August and September on which community members can make public comments and advocate for suicide prevention at local city and county meetings that proclaim September Suicide Prevention Month.
    b. **Mini-grants and event support** are opportunities for county and community partners to apply for a modest amount of monetary funding ($200–$300) and event support for their September Suicide Prevention Month event. The process includes application, selection, event support, deliverable review, and fund disbursement.
    c. **Event support includes the following:**
    - Input/ideas on event theme, programming, communication/outreach, and logistics (up to 2 hours consultation)
    - Speakers with lived mental health and/or substance use experience
    - Digital stories for screening
    - PhotoVoices for exhibits
    - Event templates (flyer, presentation slides, and chat script)
    - Event promotion on website and social media (Facebook, Twitter, blog, and email networks)
    - Interpretation/translation with San Mateo County health contractors

    d. **Communication campaign** promoted September Suicide Prevention Month through the following communication channels. New graphics and content align with the statewide theme:
    - Website included schedule of events, ways to get involved, and resources for behavioral health.

- Social media campaign included social media posted across San Mateo County Health Facebook, Instagram, Twitter, and BHRS Blog. Among Facebook, Instagram, and Twitter, the hashtags #ShareHopeTogether and #TakeAction4MH were used.
- Email blasts were distributed to behavioral health staff, community partners, and community members.
- Outreach materials were created and mailed by the state and distributed by Suicide Prevention Committee and county staff.

3. **Suicide prevention trainings:** The following programs were also part of the suicide prevention program, and there are separate annual reports for each of the following programs:
   a. Adult and Youth MHFA (see MHFA sections)
   b. BSBB training (see following data)

PROGRAM IMPACT

Suicide prevention	FY 2023–24
Number of individuals served in the primary program component(s), unduplicated counts (Suicide Prevention Committee members)	200
Number of individuals served in all other components (Suicide Prevention Month attendees and suicide prevention training participants)	400
Be Sensitive, Be Brave training participants	266
Total cost per client	$237
All individuals served across all program components (unduplicated clients served + individuals reached)	866

Outcome Indicators

Domain	Indicator/question	*n*	%
Access to services	Number of suicide prevention event participants who reported "*Through my participation in this training/event, I have learned knowledge and skills that I can use to access behavioral health services*"	21 of 24	88
Connection and support	Number of suicide prevention event participants who reported "*Due to my participation in this training/event, I am more willing to reach out and help someone if I think they may be at risk of suicide*"	24 of 24	100

Data and Outcomes for BSBB for Suicide Prevention

In FY 2023–24, Community Connections Psychological Associations, Inc. (CCPA) delivered 13 BSBB for Suicide Prevention trainings to a total of 196 participants. Data were able to be analyzed from 100 to 125 participants because of incomplete survey results (e.g., participants not completing the pre- or post training questionnaires). For those with available data, age of participants included 61% 26 to 59 years old, 13% 60 years old and older, 14% 16 to 25 years old, and 4% 0 to 15 years old. Gender identity included 71% women, 23% men, 3% genderqueer or non-binary, and 2% who declined to state. Sexual orientation data showed that 74% of participants identified as heterosexual, 16% as LGBQ+, and 10% who declined to state. Participants reported the following breakdown of racial or

ethnic identity: 36% White or Caucasian; 26% Asian or Asian American; 18% Black, African, or African American; 25% Latino/a/x or Hispanic; 5% Native American; 4% Native Hawaiian; and 4% other (note that race/ethnicity numbers have a total greater than 100% because of mixed-race individuals who endorsed more than one category).

BSBB for Suicide Prevention: Overall Ratings of Effectiveness

On average, participants rated the effectiveness of the BSBB for Suicide Prevention training to be very good to excellent (*M* = 4.24, *SD* = 0.89 on a Likert-type scale ranging from 1 = *poor* to 4 = *very good* and 5 = *excellent*). Participants also reported favorable experiences with CCPA's trainers; participants rated the effectiveness of the trainers as very good to excellent (*M* = 4.42, *SD* = 0.84 on the same 5-point Likert-type scale).

BSBB for Suicide Prevention: Improvements in Individual Training Competencies

The effectiveness of BSBB for Suicide Prevention was also measured by conducting independent-samples *t* tests to examine pre-post training increases on an eight-item self-report measure of suicide prevention-related competencies. The survey asked participants to rate their agreement with six statements before and after the training:

1. "I know the warning signs for suicide."
2. "I am able to identify someone who is at risk for making a suicide attempt."
3. "I feel prepared to discuss with someone my concern about the signs of suicidal distress they are exhibiting."
4. "I am aware of the resources necessary to refer someone in a suicide crisis."
5. "I am confident in my ability to make a referral for someone in a suicide crisis."
6. "I have the skills necessary to support or intervene with someone thinking about suicide."

Key findings:

- Before the training, the average response to these statements was neutral (*neither agree nor disagree*).
- After the training, the average response shifted to *agree*.
- This indicates a significant increase in participants' confidence and perceived abilities.
- The improvements were not just by chance—they were statistically significant, meaning the training had a real, measurable impact on participants' skills and confidence.

Before the training, participants generally expressed uncertainty about their ability to handle suicide prevention situations. However, after completing the training, there was a marked shift in their confidence levels. Most participants reported feeling capable of recognizing warning signs, engaging in conversations with at-risk individuals, identifying appropriate resources, and taking necessary actions to provide help. These results indicate that the training program was highly effective in equipping participants with the skills and knowledge needed to address potential suicide situations.

Consistent with the BSBB for Suicide Prevention's specific attention to culture and diversity, participants reported large increases in their comprehension of ways in which culture affects how suicide is expressed and experienced and, in their preparedness, to help people from diverse cultural backgrounds in suicidal distress.

Data and Outcomes for BSBB for Mental Health

In FY 2023–24, CCPA delivered four BSBB for Mental Health trainings in English, to a total of 70 individuals. Data were able to be analyzed from 22 to 33 participants because of incomplete survey results (e.g., participants not completing the pre- or post-training questionnaires or skipping items). For those with available data, age of participants included 27% 16 to 25 years old, 36% 0 to 15 years old, 5% 26 to 39 years old, 9% 60 to 73 years old, and 5% 74 years old and older. Gender identity included 41% women and 59% men. Sexual orientation data showed that 95% of participants identified as heterosexual and 5% as LGBQ+. Participants reported the following breakdown of racial or ethnic identity: 32% White or Caucasian; 5% Asian or Asian American only; 9% Black, African, or African American; 23% Native Hawaiian or Pacific Islander; 23% Latino/a/x or Hispanic; 9% Native American; and 9% declined to state (note that race/ethnicity numbers have a total greater than 100% because of mixed-race individuals who endorsed more than one category).

BSBB for Mental Health: Overall Ratings of Effectiveness

On average, participants rated the effectiveness of the BSBB for Mental Health training to be very good to excellent (M = 4.30, SD = 0.95 on a Likert-type scale ranging from 1 = *poor* to 4 = *very good* and 5 = *excellent*). Participants also reported favorable experiences with CCPA's trainers; participants rated the effectiveness of the trainers as very good to excellent (M = 4.33, SD = 0.96 on the same 5-point Likert-type scale).

BSBB for Mental Health: Improvements in Individual Training Competencies

The effectiveness of BSBB for Mental Health was also measured by conducting paired-samples t tests to examine pre-post training increases on an 11-item self-report measure of mental health-related competencies. As the overall sample of analysis was small (N = 22–33), some differences in pre/post outcome measures could not be detected.

Despite the sample size, results showed that BSBB for Mental Health participants reported a significant increase of large effect size in the overall mean score of mental health-related competencies from pre- to post-training time points; the average pretraining answer was *neither agree nor disagree* (M = 3.13, SD = 0.98), and the average post-training answer was moving toward *agree* (M = 3.88, SD = 0.79). t tests on individual item scores showed that BSBB for Mental Health participants reported large improvements (i.e., as demonstrated by large effect sizes) in knowledge of mental illness warning signs, comprehension of the difference between mental health and mental illness, understanding of two to three mental health diagnoses, preparedness to support someone struggling with mental health, confidence in connecting someone with mental health resources/help, ability to identify coping strategies, and knowledge of local resources/services. Two items did not find an increase: (a) feelings of inadequacy associated with seeking psychological help from a therapist and (b) perceptions of stigma and discrimination toward individuals with mental health conditions ("Most people in my community would treat someone who has been treated for a mental illness just

as they would treat anyone else"). This may be related to stigma (associated with therapy and mental health conditions) being a slower changing construct, as well as the overall low sample size.

SUCCESSES

Intervention 1—Recovery Month and Suicide Prevention Month Collaboration

The San Mateo County Suicide Prevention Committee piloted a collaboration between September Recovery Month (led by BHRS AOD unit and Voices of Recovery San Mateo County - VORSMC) and Suicide Prevention Month (led by BHRS ODE Suicide Prevention Committee). This marks the first and perhaps most extensive collaboration between these two behavioral health observances in San Mateo County. The collaboration included a combined promotional graphic, coordinated city proclamations, and city building lightings across all 20 cities in San Mateo County. In 2023, the County of San Mateo and 19 out of 20 San Mateo County cities proclaimed September as both Suicide Prevention Month and Recovery Month. The county building and two cities (San Carlos and San Bruno) were illuminated in purple to commemorate both observances.

Suicide Prevention and Recovery Month planning committee and partners, Belmont, September 2023

San Mateo County Hall of Justice, September 2023

San Bruno City Hall, September 2023

San Bruno City Hall, September 2023

Intervention 2—What I Wish My Parents Knew

The San Mateo County Suicide Prevention Committee collaborated with the CHI to pilot a program originally developed by San Diego County and disseminated by the California Mental Health Services Authority—"What I Wish My Parents Knew." This youth-led program aims to educate parents on promoting mental health and preventing suicide among their youth.

> *One of the youth leaders, Anastasia Yang, who helped plan and speak at the event said, "The 'What I Wish My Parents Knew' forum provided the space to have a deeper reflection on my own relationships with loved ones and with my mental health. It was wonderful to engage in dialogue with my local community to raise awareness about suicide prevention and mental health, and I was really inspired to see the amount of motivation and willingness to learn from the parents. It's empowering to know that our voices are being heard and that we are making positive changes in our communities!"*

"What I Wish My Parents Knew" forum, Redwood Shores Library, September 2023

More details on this event in HEI CHI reports and a blog post written by CHI co-chair and HEI coordinator are available at https://smcbhrsblog.org/2023/10/12/youth-leaders-share-mental-health-advice-to-parents-at-what-i-wish-my-parents-knew-forum/.

More information on the original formatting is available at https://emmresourcecenter.org/resources/what-i-wish-my-parents-knew-step-step-guide-implement-suicide-prevention-and-mental.

Intervention 3

The Suicide Prevention Month mini-grants program has been an ongoing success. In 2023, four mini-grant recipients each received $300, with a total of $1,200 distributed.

> One of the mini-grant recipients, Kassandra Chavez from StarVista, shared her experience: *"Last year for Suicide Prevention Month, we had the privilege of working with BHRS and MHSA through the planning of our event for youth. Not only were we recipients of the mini-grant, but BHRS was with us every step of the way from providing us with outreach material/goodies for our audience to helping publicize our event on social media and the web!"*

StarVista health ambassador for youth (@hapy_smc) Instagram post recapping event partly funded by 2023 Suicide Prevention Month mini-grants, San Mateo Public Library, September 2023

CHALLENGES

One of the key successes was also one of the main challenges: coordination between September Recovery Month and Suicide Prevention Month. Additional resources and time were needed to figure out how to coordinate and manage double the city proclamations (separate agenda items at each city council meeting). Discussions could begin in October (about a year ahead) to plan potential collaboration to mitigate these challenges in the future. Coordination efforts should involve the behavioral health director, AOD unit, and VORSMC. Future collaboration may or may not include the same elements as the 2023 pilot. The program will need to revisit collective and individual goals to determine the most effective approach moving forward.

DEMOGRAPHICS

Suicide Prevention Program Participant Demographics (N=24)

	Number of clients	Percentage of total
Age		
0–15 years	0	0
16–25 years	14	60
26–59 years	3	13
60–73 years	1	2
74 years and older	6	25
Prefer not to answer/unknown	0	0
Primary language		
English	NA	NA
Spanish	NA	NA
Another language	NA	NA
Prefer not to answer/unknown	NA	NA
Race/ethnicity		
Asian or Asian American	10	42
Black or African American	1	4
Native American, American Indian, or Indigenous	0	0
Native Hawaiian or Pacific Islander	1	4
White or Caucasian	7	29
Latino/a/x or Hispanic	4	17
Another race, ethnicity, or tribe	0	0
Prefer not to answer/unknown	1	4
Gender identity		
Female/woman/cisgender woman	15	63

	Number of clients	Percentage of total
Male/man/cisgender man	4	17
Transgender woman/trans woman/trans-feminine/woman	0	0
Transgender man/trans man/trans-masculine/man	1	4
Questioning or unsure of gender identity	0	0
Genderqueer/gender non-conforming/gender non-binary/neither exclusively female nor male	2	8
Indigenous gender identity	0	0
Another gender identity	1	4
Prefer not to answer/unknown	1	4
Sexual orientation		
Gay or lesbian	0	0
Straight or heterosexual	14	58
Bisexual	5	21
Queer	0	0
Pansexual	0	0
Asexual	3	13
Questioning or unsure of sexual orientation	1	4
Indigenous sexual orientation	0	0
Another sexual orientation	0	0
Prefer not to answer/unknown	1	4
Behavioral health consumer or family member		
Client/consumer	NA	NA
Family member	NA	NA
Both	NA	NA
Neither	NA	NA
Prefer not to answer/unknown	NA	NA

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY

CalMHSA is a Joint Powers Authority, formed in July 2009 as a solution to providing fiscal and administrative support in the delivery of campaigns designed to raise awareness about mental health needs, reduce stigma, prevent suicides and promote mental wellness. CalMHSA provides BHRS with technical assistance and implements PEI statewide projects across the topics of suicide prevention, stigma and discrimination reduction, and the Student Mental Health Initiative.

CalMHSA created the Take Action for Mental Health, a public awareness initiative that encourages individuals to take proactive steps for their own mental health and the mental health of others through three key pillars: **Check In**, which promotes staying connected and engaged in conversations about well-being; **Learn More**, which emphasizes the importance of mental health education to reduce stigma and increase understanding; and **Get Support**, which encourages individuals to seek professional help or access community resources to address mental health challenges. Key initiatives included Mental Health Month (May), Juneteenth (June), Pride Month (July), Suicide Prevention Week/Month (September) and Winter Wellness (December – January).

- Take Action for Mental Health campaign (paid media and social media) total reach: 1,710,353
- Take Action website: 105,558 sessions (engagement with site) and 9,133 resource downloads
- Suicide Prevention week website activity: 5,246 sessions, 1,124 resource downloads
- May Mental Health Month website activity: 67,218 sessions, 1,930 resource downloads
- Toolkits provided: Suicide Prevention Activation Kit, Winter Wellness Digital Toolkit, May is Mental Health Matters Month Toolkit, Pride Digital Toolkit, and Juneteenth Digital Toolkit.

Photo: San Mateo County Psychiatry Residency Training Program

WORKFORCE EDUCATION AND TRAINING

WORKFORCE EDUCATION AND TRAINING

WET exists to develop a diverse workforce. Clients and families/caregivers are given training to help others by providing skills to promote wellness and other positive mental health outcomes, facilitating collaboration to deliver client- and family-driven services, providing outreach to unserved and underserved populations, tailoring services that are linguistically and culturally informed and relevant, and including the viewpoints and expertise of our clients and their families/caregivers. WET was designated a one-time allocation totaling $3,437,600 with a 10-year reversion period. WET activities will continue to be funded by MHSA ongoing.

WORKFORCE DEVELOPMENT

The WET Team strives to equip the workforce, consumers, and family members for system transformation by planning, coordinating, and implementing a range of initiatives, trainings, and program activities for the BHRS workforce, consumers/family members, and community partners.

There are several distinct populations served directly by the WET Team. The BHRS workforce, 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.

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, which 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 are 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 HEIs through the CSIP, which is supported by the Behavioral Health Career Pathways program area.

PROGRAM IMPACT

Training, Education, and Development

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

In FY 2023–24, WET trainings were offered to only BHRS staff and contracted providers.

- Total number of WET implemented/supported trainings: 60
  - Total number of attendees: 1,164
  - Total number of Applied Suicide Intervention Skills Training/suicide prevention trainings: 5
  - Total number of Cultural Humility/Working With Interpreters/SOGI (including training of trainers): 25
- New trainings offered to BHRS:
  - Eye Movement Desensitization and Reprocessing (EMDR): 1
  - Dialectical Behavior Therapy (DBT): 1
  - Portals Into Their World: Social Media and Screens' Impacts on Kids and Teens: 2
- Trainings made available again this year:
  - Introduction to Mindfulness: 3
  - Motivational Interviewing: 1
  - NMT Six Core Strengths training: 3
  - Providers' Vicarious Trauma and Toxic Stress: Cumulative Impact of Supporting Oppressed and Marginalized Communities: 3
- Collaborative trainings:
  - WRAP trainings: 2
  - Family Structural Therapy: 1
  - Behavior Expectations for Clients, Patients, and Visitors (San Mateo County Health Policy No. A-44) Training: 1

Other trainings include Embracing Difference Through the Lens of Cultural Humility: Focus on Implicit Bias, clinical supervisor trainings, Internship Orientation, Prevention and Management of Assaultive Behavior (Beginner + Advanced), Navigating Behavioral Health, Randomized Control Trial Psychological First Aid, law and ethics training, School Based Law and Ethics.

Recruitment and Retention Opportunities

The WET Team in collaboration with CalMHSA provided opportunities for retention efforts through the Educational Loan Repayment Program and retention stipends. The purpose of the retention program is to provide a financial incentive to retain qualified, eligible employees in San Mateo County's Integrated Behavioral Health Care system. The retention program is a financial incentive strategy that is included in the statewide MHSA WET plan. It is designed to retain staff who reflect the populations served and share the same ethnic, cultural, and linguistic backgrounds of the communities served. Through this program, the County Behavioral Health Departments seek to support qualified employees who meet eligibility requirements and commit to a 12-month service obligation.

Through the Educational Loan Repayment Program, BHRS provided staff student loan repayments. These awards are provided to individuals identified by their positions that are hard to fill or retain within the clinical practice setting, in exchange for a 1-year service commitment.

With more than 190 applications submitted overall for both programs, the team was able to award its highest number of awards to BHRS employees: 100.

- Retention stipends awarded: 73
- Educational Loan Repayment Program awards: 27

The WET Team has also made efforts to set a foundation for a pipeline mentorship program to bridge the gap between college students within the San Mateo County community and BHRS professionals. The focus of the program is to build on peer-to-peer mentoring mechanisms by enhancing the connection between staff members of BHRS and college students on track to enter the behavioral health workforce. Mentoring serves to help individuals build professional competencies, develop leadership skills, support career advancement, and prevent job burnout. The mentoring process provides

a wealth of accumulated knowledge and wisdom as well as professional stimulation and growth. It is also an opportunity to contribute to the development of the workforce. The mentoring program is designed to address many levels of needs, including sharing of experience, information, and skills development. This program aims to garner interest among our younger San Mateo County community members to provide them a better understanding of the workforce that is BHRS, so that they have the knowledge to make the choice to enter the field of behavioral health. The ultimate goal of the mentorship program is to one day have these young community members join BHRS as service providers.

Cultural Stipend Internship Program

The WET Team oversees the management and implementation of the CSIP program. This program provides an opportunity for BHRS clinical interns to pair with a specific HEI and develop projects focused on the demographics of their respective HEI. CSIP recipients are selected on the basis of (a) expressed interest in and commitment to cultural awareness and social justice in the community and in clinical settings, (b) personal identification with marginalized communities, and (c) lived experience with behavioral health conditions. Priority is also considered for those interns with non-English language capacity and cultural identity with that language. During FY 2023–24, four students submitted applications for CSIP consideration. Of the four candidates, all were selected on the basis of their qualifications and dedication to advancing BHRS equity priorities.

SUCCESSES

- **Number of CSIP recipients**—Despite having a reduced departmental workforce, the WET Team was able to award four students with a cultural stipend. This stipend awarded students for their efforts in developing a project with their assigned HEI. These projects helped with advancing BHRS's efforts at creating a more inclusive community.
- **BHRS retention efforts**—The WET Team in collaboration with CalMHSA provided opportunities for retention efforts through the Education Student Loan Program and retention stipends. This past year, the team was able to award 73 retention stipends and 27 educational student loan repayments.
- **Building and expanding training promotional effort**—To continue addressing the needs of the workforce, the WET Team has continuously expanded the dynamic external training calendar with additional training opportunities offered throughout the year. This enhancement allows staff to stay informed about upcoming trainings and plan ahead to participate more effectively.
- **Increased access to continuing education units**—This year, 89% of the trainings offered to BHRS staff provide continuing education credits. The WET Team has further enhanced continuing education unit opportunities by incorporating trainings shared by collaborating departments and agencies. This addition not only broadens the range of available courses but also provides staff with more options to meet their professional development requirements. By leveraging these external resources, the WET Team continues to support staff in maintaining their certifications and advancing their careers, ultimately contributing

to improved job satisfaction and retention. Of our 19 trainings, 17 (89%) offer continuing education.

- **Increased training sessions with new training offerings**—The increased training offerings have provided staff with more courses with opportunities to obtain continuing education units. Moreover, new training offerings were available this year, such as Introduction to EMDR and DBT, both of which highlight evidence-based methodologies.

CHALLENGES

- **Agencywide staff shortages**—We experienced staff shortages across all departments within BHRS. We simply did not have the capacity to fulfill the needed positions to support our internship program. These shortages also caused current staff to take on additional work, which hindered their ability to participate in trainings.
- **Clinical internship supervision**—A lack of available supervisors was experienced because of agencywide staff shortages and limited capacity of licensed clinical staff members, leading to a small cohort of clinical interns within BHRS.
- **Training barriers**—Although 60% of attendees who completed the post training evaluation indicated that they had completed the training virtually and preferred it that way, some of our trainings are required to be implemented in person (e.g., Applied Suicide Intervention Skills Training). Limited availability of training spaces has made it difficult to meet both logistical needs and capacity requirements. Navigating these challenges requires careful planning and flexibility to ensure that training sessions are held successfully and are accessible to all participants.

PEER AND FAMILY MEMBER LEADERSHIP DEVELOPMENT

San Mateo County BHRS demonstrates unwavering commitment to peer and family leadership development, driving meaningful engagement in BHRS programs, services, and policies. The OCFA spearheads multiple strategic initiatives, including the LEA, Advocacy Academy, Advocacy Council, Lived Experience Education Workgroup (LEEW), and OCFA Speakers Bureau. The OCFA team consists of six professionals who bring personal or family experiences with mental health or SUD challenges.

The LEA delivers a transformative 12-hour training program for individuals and family members who have navigated significant behavioral health challenges. The program empowers participants to transform their life experiences into sources of strength, fostering the development of courage, resilience, and creativity essential for recovery. Through this process, participants reclaim control of their narratives and forge stronger identities. In FY 2023–24, the OCFA successfully graduated 29 individuals across two sessions—14 in fall 2023 and 15 in spring 2024.

The Advocacy Academy provides an intensive 12-hour curriculum that equips participants with advanced advocacy skills, enabling them to leverage their personal experiences to drive positive systemic change within BHRS and beyond. During FY 2023–24, the OCFA partnered with the Copeland

Center to deliver a specialized Spanish-language session, specifically designed for monolingual Spanish-speaking clients and family members.

Upon completing either the LEA or Advocacy Academy, graduates receive invitations to join LEEW. This influential group harnesses the collective wisdom of individuals with behavioral health experiences to catalyze positive change throughout the BHRS community. LEEW members provide vital perspectives across numerous BHRS workgroups and committees, including HEIs, Quality Improvement Committee, MHSA Steering Committee, Suicide Prevention Committee, BHC, Recovery Happens, and HEIs. Monthly meetings consistently draw 18 to 25 engaged members.

The Advocacy Council serves as a dynamic monthly forum for Advocacy Academy graduates to strengthen their ongoing advocacy initiatives. The council maintains active participation of eight to 12 members and operates under rotating co-facilitation by group members.

The OCFA Speakers Bureau comprises LEA graduates who actively share their powerful narratives at community events and contribute to specialized workgroups and event planning committees. OCFA staff strategically match event organizers with volunteer speakers who offer insights shaped by their lived experience. The FY 2023–24 featured 14 impactful community presentations across various venues, including crisis intervention training, SUD contractors meeting, BHRS interns orientation, suicide prevention events, and the Belmont Symposium.

LEEW and Advocacy Council members receive comprehensive training across critical areas, including MHSA, PSS certification, Care Court, CalAIM, Community Wellness Team, BHRS multicultural organizational development, Heart & Soul, Project Guardian, and the Navigation Center.

PROGRAM IMPACT

Peer training	FY 2023–24
Total individuals served	49
Total cost per client	$686
Total clients served	49

PROGRAM NARRATIVE

Improves timely access and linkages for underserved populations: The BHRS Consumer and Family Leadership Development program enhances access for underserved populations through strategic initiatives including the Advocacy Academy, which delivers specialized advocacy training in Spanish for monolingual Spanish-speaking clients and families. This academy effectively bridges linguistic and cultural barriers, empowering participants to advocate within BHRS and their communities. LEEW members actively drive change through participation in various BHRS committees and initiatives, strengthening connections between underserved populations and behavioral health resources.

Reduces stigma and discrimination: The program confronts stigma and discrimination by empowering individuals with lived behavioral health experiences to transform and share their narratives through structured platforms such as the LEA and OCFA Speakers Bureau. These initiatives foster self-

advocacy, resilience, and authentic sharing of recovery journeys across public and organizational settings. This visibility reduces stigma by cultivating understanding and embracing lived experience as a catalyst for community education. Graduates demonstrate in their communities that recovery is achievable, proving that individuals with behavioral health diagnoses can lead fulfilling lives, thereby eroding stigma and advancing acceptance.

Increases the number of individuals receiving public health services: Through comprehensive training in the LEA and Advocacy Academy, the program builds robust community connections, linking individuals to BHRS resources and developing strong advocates. Graduates serve as trusted messengers in their communities, educating others and encouraging service engagement. Their continued involvement with LEEW and the OCFA Speakers Bureau amplifies mental health awareness through presentations and outreach, creating a multiplier effect that guides more individuals toward mental health and SUD support services.

Reduces disparities in access to care: The program directly addresses barriers faced by underserved populations through culturally informed and language-specific advocacy training, exemplified by the Spanish-language Advocacy Academy. Through sustained engagement in LEEW and the Advocacy Council, graduates shape BHRS policies and services, incorporating diverse perspectives that enhance service accessibility. These efforts systematically reduce disparities by ensuring that BHRS offerings respond effectively to varied community needs while promoting awareness of available services.

Implementing recovery principles: The program embodies recovery principles through the LEA, which empowers individuals to reframe their experiences into sources of resilience and personal agency. Participants develop ownership of their narratives and positive self-identity, aligning with core recovery values of hope, self-determination, and community engagement. The Advocacy Council and LEEW provide ongoing platforms for active involvement in the behavioral health community, embodying recovery and growth.

SUCCESSES

The LEEW has strengthened its community leadership while expanding members' BHRS knowledge. Members have established new partnerships with churches and libraries and now independently organize public events. Increased stipend distribution reflects growing system engagement. LEEW leaders now serve on key bodies including the BHRS BHC, HEIs, Quality Improvement Committee, and MHSA Steering Committee.

CHALLENGES

LEA graduates need additional mentorship that exceeds the OCFA's current capacity. The LEEW seeks greater diversity, particularly youth, LGBTQIA+ community members, and individuals with SUD lived experience.

Photo: Kapwa Kultural Center (KKC) and Café, Grand Opening

INNOVATION

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 nonbehavioral health; and/or apply a practice that 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 of MHSA Innovation Projects is part of the comprehensive Community Program Planning (CPP) process. The following six projects were in place in FY 2023–24 (see Appendices 9–14 for the INN Evaluation):

1. Kapwa Kultural Center (KKC) and Café, see Appendix 9, is a social enterprise café and cultural hub for Filipino/a/x youth in northern San Mateo County. In its third year, KKC has made substantial progress in its initial implementation stage, despite challenges along the way. The program also continued the workshops piloted in the second year, offering valuable opportunities for more than **100** participants to develop skills in leadership, mental health, and wellness. One of the key accomplishments has been the successful youth retreat and leadership development sessions for Kapwa Youth Advisory (KAYA) members. These sessions provided an opportunity for youth to reconnect with their roles, reflect on their wellness journeys, and engage in leadership development and self-advocacy training. In this year, KKC leadership also launched its internship program, which saw six interns engaged in on-the-job training.
2. Adult Residential In-home Support Element (ARISE) program creates a model for residential in-home services to support clients living with SMI and/or SUD who are at risk of losing their housing, see Appendix 10. Residential in-home support workers—approved IHSS providers—are provided with specialized training in collaboration with peer support staff and an occupational therapist. In FY 2023–24, the program served **22** clients who were admitted and actively participating in ARISE. The program met two out of three housing stability targets. Clients reported significant improvements in their living environments and mental health after enrolling, and in-home support workers successfully provided tailored support services to clients, helping them maintain cleaner living spaces and reduce social isolation.
3. The Farmworker Equity Express is a mobile behavioral health service for farmworkers that launched in August 2023 to support the mental health needs of farmworkers and their families in San Mateo County, the see Appendix 11. In FY 2023–24, the Farmworker Equity Express served **710** unique individuals through outreach, food distributions, groups, and community engagement events and 2,250 duplicated individuals reached. This initiative aims to enhance access to behavioral health care for a community that often encounters barriers including isolation, language differences, and limited access to health services. By incorporating cultural arts practices, the program creates pathways to engage farmworkers and their families with behavioral health services that encompass prevention, early intervention, treatment, and recovery. Using a mobile unit that travels to farms throughout the region, the program brings culturally responsive mental health support farmworkers and their families in familiar, comfortable settings.

4. Music therapy for Asians and Asian Americans, see Appendix 12, project provides music therapy for Asians and Asian Americans as a culturally responsive approach to reducing stigma, increasing behavioral health literacy, promoting linkages to behavioral health services, and building protective factors to prevent behavioral health challenges and crises. In FY 2023–24, **50** individuals participated in the program. North East Medical Services, a nonprofit community health center, partnered with Creative Vibes Music Therapy, a private practice that uses a resource-oriented approach to providing music therapy. Together, they launched the first cohort of music therapy in 10 weekly sessions of group music therapy classes and a behavioral health peer support group for elementary, middle, and high school students as well as adults and older adults.
5. Pacific Islanders Organizing, Nurturing and Empowering Everyone to Rise and Serve (PIONEERS) program, see Appendix 13, addresses wellness and behavioral health needs of Native Hawaiian and Pacific Islander youth and young adults through providing linkages to services, empowerment, leadership development, and community advocacy. In FY 2023–24, **40** youth were served by the PIONEERS program, which established youth cohorts at local schools and launched the Leadership in Training Council, which grew to provide meaningful emotional wellness support. The program also successfully engaged with the broader Pacific Islander community through events and partnerships, while maintaining high participant satisfaction with services.
6. Recovery Connection Drop-in Center, see Appendix 14, provides drop-in services for individuals living with substance use challenges and/or mental health challenges at all stages of their recovery, from pre-contemplative to maintenance and enhancement. The Recovery Connection will center around WRAP programming, use a peer support model, provide linkages as needed, and serve as a training center to expand capacity countywide. In FY 2023–24, **134** clients were served by Recovery Connection, which achieved progress through relocating to a larger, more accessible central location that increased program participation and enhanced service delivery capabilities. The program strengthened its community partnerships, creating valuable bi-directional relationships that expanded services and opportunities for clients. Staff reported a highly supportive work environment with professional development opportunities, improved operational infrastructure, and an inclusive culture that enabled many former clients to transition into full-time staff roles.

Photo: Waverly Place Apartments, Redwood City, CA

HOUSING

HOUSING

MHSA housing funds provide permanent supportive housing through a program administered by the California Housing Finance Agency to individuals who are eligible for MHSA services and meet eligibility criteria as experiencing homelessness 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. Additionally, the No Place Like Home (NPLH) program provided funding to acquire, design, construct, rehabilitate, or preserve permanent supportive housing. This led to one housing development in San Mateo County, Light Tree Apartments in East Palo Alto and a total of 9 behavioral health supportive housing units.

The MHSA Housing Taskforce Recommendations from May 2021 included the allocation of $10 million to develop permanent supportive housing units as part of the local Department of Housing Affordable Housing Funds projects. It was estimated that the county could develop about 24 units per $5 million contribution. Two separate Affordable Housing Fund Notices of Funding Availability were released in the summer 2021 and 2022 to select the housing project developers. This led to a total of 59 permanent supportive housing units across 9 affordable housing developments. Additionally, MHSA funding was allocated to support the Cordilleras Suites and Mental Health Rehabilitation Center, which resulted in 28 permanent supportive housing units and 29 transitional housing units.

Part of the MHSA Three-Year Plan strategy recommendations from the community program planning process is the development of permanent supportive housing slots for individuals living with mental health and substance use challenges that do not require homelessness as an eligibility requirement. This is something to be explored as investments in housing developments continue.

MHSA Permanent Supportive Housing Developments

Year	Housing Development and Location	Developer	Units
2009	Cedar Street Apartments 104 Cedar St., Redwood City	Mental Health Association	5 behavioral health units 15 total units
2010	El Camino Apartments 636 El Camino Real, South San Francisco	MidPen Housing	20 behavioral health units 106 total units
2011	Delaware Pacific Apartments 1990 S. Delaware St., San Mateo	MidPen Housing	10 behavioral health units 60 total units
2017	Waverly Place Apartments 105 Fifth Ave., North Fair Oaks	Mental Health Association	15 behavioral health units 16 total units
2019	Arroyo Green Senior Housing (ages 62+) 707–777 Bradford St., Redwood City	MidPen Housing	6 behavioral health units 177 total units
2019	Fair Oaks Common 2821 El Camino Real, Redwood City	Alta Housing	6 behavioral health units 67 total units
2024	Kiku Apartments	MidPen Housing	9 behavioral health units

	Downtown San Mateo		224 total units
2025	493 Eastmoor, Daly City	The Core Companies and Abode Housing	11 behavioral health units 72 total units
2025	Week St. Apartments, East Palo Alto	MidPen Housing and East Palo Alto Community Alliance Neightborhood Development Organization (EPACANDO)	8 behavioral health units 135 total units
2026	1580 Maple Street, Redwood City	MidPen Housing	14 behavioral health units 110 total units
2026	North Fair Oaks Apartments Redwood City	Affirmed Housing	11 behavioral health units 84 total units
2026	Fire House Square Apartments South San Francisco	Eden Housing	6 behavioral health units 82 total units
			121 total behavioral health units

Photo: Navigation Center of San Mateo County, Redwood City, CA

CAPITAL FACILITIES AND TECHNOLOGY NEEDS

CAPITAL FACILITIES AND TECHNOLOGY NEEDS

At the initiation of the MHSA, San Mateo County has had no viable opportunities under the Capital Facilities section of this component because the guidelines limit use of these funds to only county owned and operated facilities. It was decided, through a robust stakeholder process, to focus all initial CFTN resources to fund eClinical Care, an integrated business and clinical information system (electronic health record), as well as ongoing technical support. The system continues to be improved and expanded in order to help BHRS better serve the clients and families of the San Mateo County behavioral health stakeholder community.

During the COVID-19 pandemic, devices (phones, tablets) and data plans were provided to BHRS clients to support their engagement with telehealth and other online supports, as part of a 1-year one-time funding. Starting in FY 2021–22, stakeholders prioritized the continuation of the program. The MHSA now funds the ongoing procurement of devices with data plans for BHRS clients. In addition, basic technology supports for clients are provided via a virtual and/or over-the-phone information technology ticket system and digital literacy training for peer staff through a contract with Painted Brain, a peer-run organization with technology expertise.

CFTN has been allocated $330,000 per year for client devices and data plans. A part-time peer worker under the OCFA was recently hired to support device distribution and the training plan, and this would include improved tracking, data collection, and reporting on the project's impact as it relates to improving client engagement in behavioral health and recovery services.

APPENDIX 1. BHRS CULTURAL COMPETENCE PLAN

2024 Cultural Competence Plan

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Table Of Content

This 3-year Cultural Competence Plan (CCP) focuses on fiscal year (FY) 2023-2024 while referencing the two preceding fiscal years. For more details, please refer to:

- FY 2022-2023 CCP Update: San Mateo County Cultural Competence Plan 2022-2023
- FY 2021-2022 CCP Update: San Mateo County Cultural Competence Plan 2021-2022

Introduction

Located on the San Francisco Peninsula, San Mateo County (SCM) is bordered by the Pacific Ocean to the west and San Francisco Bay to the east. The 2023 population estimated by the U.S. Census Bureau was 726,353. A reduction in population from the data available in 2019. The median age of San Mateo County residents is 39.3 years; 5% of the population was under 5 years old; 19.3% were under 18 and 18.3% were 65 or older.[1] An estimated 35.2% of San Mateo County residents were foreign-born, and this is among one of the highest percentages for foreign-born residents in the Bay Area Region.

SMC Behavioral Health and Recovery Services (BHRS) has a demonstrated commitment to the work of health equity, fostering a culturally responsive and inclusive system, and a recognition that our diversity is one of our greatest assets. The work of equity requires multipronged solutions many of which involve the Office of Diversity and Equity (ODE). Through the compiling of the data and analysis of this report, we recognize the challenges we continually are faced with including social determinants of health an ever-changing political landscape, and fear that many of our residents are holding. In an effort to better serve the most marginalized, we see we have a long way to go but also feel heartened by the work accomplished so far.

Criterion 1: Criterion 1: Commitment to Cultural Competence

Criterion 1: Provide documents on how the county intends to serve the community appropriately.

The County of San Mateo (SMC) continues to work toward Shared Vision 2025 until the next update. The five outcomes that were identified in this plan were a healthy, prosperous, liveable, environmentally conscious, and collaborative community. The Cultural Competence Plan ties into this shared vision through the goal of a healthy community that outlines the vision of safe neighborhoods being areas that provide residents with access to quality healthcare and seamless services. Additionally, in 2023 the Board of Supervisors passed an ordinance[1] to promote racial and social equity, inclusion, and belonging. This ordinance established key responsibilities for county officers, and employees while discharging their public responsibilities. This ordinance declares that the county will intentionally address issues of inequity within the institution, proactively advance equity, and promote a culture of belonging, as permitted by law. BHRS has implemented portions of the ordinance, including creating Equity Impact Statements for board-level contracts, supporting the BHRS components of the Health Racial and Social Equity Action Plan, and supporting data-informed decision-making, engaging stakeholders and clients in community engagement efforts. This comes after a Resolution to advance and improve San Mateo County's Racial Equity efforts was passed in 2021 and a resolution committing the County of San Mateo to the Anchor Institution Framework and calling for the development of a plan for inclusive staffing, procurement and investment in 2022.

Another way the county has shown commitment to equity is by becoming certified as a "Welcoming Place.[2]" San Mateo is the first county in California with this certification, which shows its commitment to immigrant inclusion and belonging. BHRS played a role in this certification process by showcasing the work of the Health Equity Initiatives and Health Ambassador Program.

San Mateo County's Office of Racial and Social Justice[3] under the County Executive's Office, has supported the county in advancing equity. Equity is the goal of just and fair inclusion into a society where all can participate, prosper, and reach their full potential. In order to move equity forward it is necessary to create conditions that allow all to reach their full potential (Policy Link). The Chief Equity Officer has built a cross-departmental team with seven committees that finalized the development of a countywide Social and Racial Equity Plan (SREAP). Additionally, affinity groups have also been created for those who identify with marginalized identities as well as allies. This Office has also pushed forward enhancing staff capacity through equity modules in supervisory skills, advancing the supplier diversity study and the shared prosperity coordinating council. BHRS has been deeply involved in this work by sharing learnings, resources, and partnerships.

Another county-wide effort that will greatly influence priorities has been that San Mateo County is the first county in the US to recognize loneliness as a public health emergency. David Canepa, a Board of Supervisor, introduced the resolution with the hope that there would be further state action as well as awareness of the issue and support to address this behavioral health impact. This priority informed our SMC 2024 Mental Health Month where the theme was "Heal Through Connection" and "#SMCAgainst Loneliness".

BHRS Mission, Vision and Values

The following statements were developed out of a dialogue involving consumers, family members, community members, providers, and staff who share their hopes for the BHRS Division. The members of the BHRS community agree to support the Vision, Mission, and Values and to strive to demonstrate our commitment within both our individual and collective responsibilities.

Vision

We envision safer communities for all where individuals may realize a meaningful life and the challenges of mental health and/or substance use are addressed in a respectful, compassionate, holistic, and effective manner. Inclusion and equity are valued and central to our work. Our diverse communities are honored and strengthened because of our differences. (rev. May 2019)

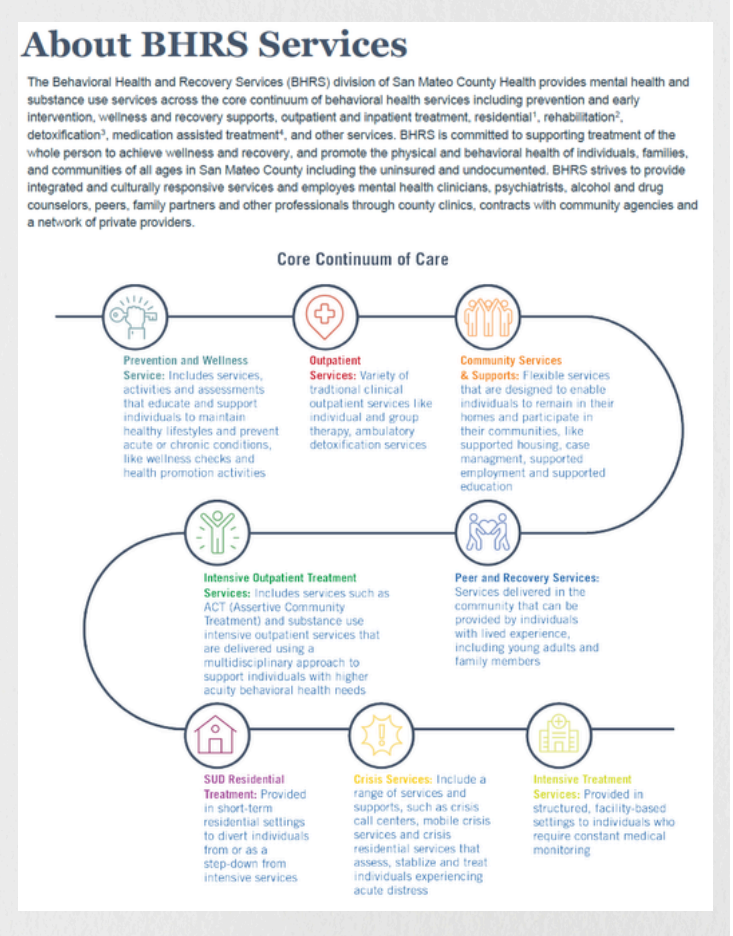
Mission

We provide prevention, treatment, and recovery services to inspire hope, resiliency, and connection with others to enhance the lives of those affected by mental health and/or substance use challenges. We are dedicated to advancing health and social equity for all people in San Mateo County and for all communities. We are committed to being an organization that values inclusion and equity for all. (rev. May 2019)

- *The Vision and Mission statements were revised in 2019 as part of our MCOD work to more explicitly state our commitment to diversity, equity, inclusion and belonging. The Values below will also be revised.

Values

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



BHRS's commitment to Cultural Competence also includes the recommendation for different terminology that is more responsive and reflective of ongoing learning, from "cultural competence" to "cultural humility" and "diversity, equity, inclusion, and belonging". Within BHRS we encourage the use of more inclusive terms, such as Latinx, Filipinx, etc. Throughout this report, identifiers such as Hispanic and other gender binary terms are used to reflect the original data or information source. We did not change these in this report, however continue to advocate for inclusivity in our data collection methods.

Transitions

Behavioral Health and Recovery Services (BHRS) is a San Mateo County (SMC) Health Division in which the Office of Diversity and Equity (ODE) is located. Throughout the last 3 years there has been a number of transitions that have impacted division leadership. Scott Gilman left his position as BHRS Director in August of 2022, and the division transitioned to an Interim Director, Lisa Mancini who was coming from the SCH Health Aging and Adult Services Division. She held her role from August 2022 to March 2023.

In March the Director Role was given to Dr. Jei Africa, who was once the founding Director of the BHRS Office of Diversity and Equity (ODE). Additionally, under new leadership, BHRS has created the Office of Improvement and Innovation which will be key to improved client outcomes and a supported workforce. This is an important step in developing infrastructure and will expand existing BHRS efforts such as employee wellness and engagement, data tracking and reporting, and integrating trauma-informed approaches. During his first year and a half, Dr. Africa has focused on organizational and systems change by prioritizing transparency and accountability in BHRS.

Office of Diversity and Equity (ODE)

The role of the Office of Diversity and Equity (ODE) within the BHRS division is to advance health equity in behavioral health outcomes of marginalized communities throughout San Mateo County. This year ODE celebrated their 15-year anniversary and proudly shared highlights and accomplishments in their retrospective webpage[4]. It was noteworthy to take stock of all the accomplishments, partnerships, and support for families and communities the office has initiated and continued throughout this time.

With this celebration, it is also necessary to reflect on the challenges, one of which has been staffing. The staffing of the office has dramatically changed, in 2019 there were 19 staff members, then in 2021, only 5 positions remained within the office, after losing many extra help and limited term staff in FY 20-21. This shrinking greatly affected the office during the COVID-19 pandemic. The grief of losing staff not only affected remaining staff, but also the trust that was built with our community partners and clients. Today, ODE has 17 staff members, including one limited-term position and one intern. The Director of ODE also serves as the statewide required role of Cultural Competence/Ethnic Services Manager (CC/ESM) for San Mateo County and participates in the County Behavioral Health Directors Association (CBHDA), Cultural Competency Equity and Social Justice Committee this way BHRS can support and learn best and promising practices in the field as well as stay connected to statewide efforts. Additionally, ODE's Director and CLAS Coordinator lead the Bay Area Regional ESM group supporting our neighboring counties and encouraging shared learning. ODE leadership and staff have also taken the lead in many equity efforts including the County's partnership with the Government Alliance on Race and Equity (GARE), dating back to 2017. In 2018 the ODE Director led this group and then created a partnership with SMC Public Health and Policy Division where they began co-leading the Health GARE cohort together.

15 Year Anniversary

Over the past 15 years, ODE has grown from a lunch meeting at a BHRS clinic to a full-fledged office situated within BHRS, that works to implement and drive the commitment of the Cultural Competence Plan. ODE has been an essential piece of driving workforce, community, and stakeholder engagement as well as energizing the work around diversity and equity for San Mateo County. As the commitment to diversity, equity, inclusion, and belonging (DEIB) is felt county-wide and through the division, the importance of ODE becomes even greater. While there is an urgency for all staff to think of how to incorporate equity into their work, there is still a need for expert guidance and ODE embodies both the expert guidance that is shared through workforce and community voice as well as the expertise in driving forward internal DEIB efforts. Equity language, community needs, and research in this field change constantly and this office holds an important role in steering the ship toward equitable outcomes in partnership with the leadership, community, and workforce. This commitment to equity can be felt through the ODE Director Dr. Maria Lorente Foresti being honored and inducted into the SMC Women's Hall of Fame in 2024.

The Office of Diversity and Equity (ODE), primarily funded through the Mental Health Services Act (MHSA), focuses on advancing cultural competence, reducing ethnic and racial disparities, preventing serious mental illness and suicide, increasing access to care, linking individuals to treatment, reducing stigma and discrimination, and promoting awareness of mental health and substance use disorders.

With the upcoming transition to the Behavioral Health Services Act (BHSA) starting in July 2026, ODE looks forward to collaborating with leadership to provide thought partnership on diversity, equity, inclusion, and belonging (DEIB) considerations while supporting the system through this significant change.

Some of the ways BHSA will enhance the County's behavioral health systems are by raising awareness, promoting early identification of behavioral health challenges, simplifying access to treatment, improving service effectiveness, and combating stigma. It builds on strategies to meet communities' needs for culturally responsive services, aiming to improve health outcomes and reduce disparities. Key goals include improving penetration rates for marginalized communities, integrating mental health with alcohol and other drug services, and ensuring the adoption of evidence-based practices. The act also seeks to reduce silos in planning and service delivery, mandate stratified data and targeted strategies to address disparities, and prioritize community-defined practices to enhance diverse representation and equity.

The BHSA emphasizes mental health promotion and early intervention (PEI) by engaging diverse communities, individuals, families, and partners in accessible settings such as schools, cultural/community centers, and other health providers. PEI programs focus on stigma reduction, school-based mental health, population-specific promotion, capacity building, crisis services, and peer-to-peer support. Peer services draw on lived experiences to combat stigma and remove barriers to recovery.

Additionally, vocational services play a vital role in supporting recovery by providing skill development, career counseling, job placement, coaching, and retention support for clients and families. Workforce development efforts focus on recruiting and training individuals from underrepresented communities through career pathways, technical assistance, internships, and financial incentives. Together, these initiatives aim to create an equitable, accessible, and integrated behavioral health system that prioritizes wellness, recovery, and inclusivity for all.

Theory of Change

In the Spring of 2017, BHRS ODE established a Theory of Change (TOC) process to create a shared understanding of how ODE activities contribute and align with the long-term goal of BHRS' efforts to promote equity, cultural humility, and inclusion. This Theory of Change acts as the ODE Strategic Plan and was developed with the input of workforce members, clients, family members, and feedback from community stakeholders. These pathways have become a shared language and are often referred to in any planning process with ODE stakeholders. With the implementation of BHSA, these pathways may be adjusted and shaped by evolving regulations and priorities.

Long-term Goal: In collaboration with, and for communities, advance health equity in behavioral health outcomes of marginalized communities by influencing systems change and prioritizing lived experience.

Pathways in Theory of Change: Based on the beliefs that 1) advancing health equity is a key strategy to the prevention of mental health and substance use issues; 2) overall systems need redesign to address inequities where individual, institutional, and structural biases are addressed; 3) lived-experience matters; and 4) a value-based approach centering cultural humility, inclusion, social justice, community collaboration and focus on wellness, recovery and resilience are necessary; the four (4) ODE pathways were identified: **Workforce Development & Transformation, Community Empowerment, Strategic Partnerships, and Policy & System Change.**
The most recent BHRS CCP is organized based on ODE's Priority Pathways and incorporates the comprehensive stakeholder engagement process, needs assessment and data, and learning from the past 10 years of addressing cultural competence in San Mateo County.

Goal 1: Workforce Development and Transformation – Expand on Workforce Development and Transformation that prioritizes cultural humility, inclusion, and equitable quality care.
Goal 2: Community Empowerment – Create opportunities for individuals with lived experience, families, and community members to engage in decisions that impact their lives.
Goal 3: Strategic Partnerships – Strengthen and create new meaningful partnerships in the community to maximize reach and impact on equitable behavioral health outcomes.
Goal 4: Policy & Systems Change – Influence organizational-level policies and institutional changes across San Mateo County agencies to positively impact behavioral health outcomes.

Engagement in these pathways allows the ODE to think expansively about their roles, and through this method, BHRS is able to invest more in strategies that address social determinants of health outcomes. This enables us as a system to move towards getting to the root causes of inequity and start to address important barriers to accessing behavioral health services for marginalized communities. This expansion allows us to continue culturally sensitive health education and awareness campaigns for decreasing stigma but expands our ability to move towards health equity.

BHRS Policies & Procedures

The policy that was most recently passed and has an equity impact is **A-44: Behavior Expectations for Clients, Patients, and Visitors.** This policy came out of our Multicultural Organizational Development (MCOD) work and later became a collaborative effort with other Health divisions to expand and become a policy and training. This policy strives to ensure a safe, secure, respectful, and healing environment for everyone, including patients, clients, visitors, providers and staff. It prohibits abusive language including threats and slurs, harassment, assault, and weapons, and provides action to ensure a safe environment.

BHRS continues to abide by the County's Bilingual Salary Differential Allowance Policy for non-supervisory employees required to use a second language critical to day-to-day operations and the Americans with Disabilities Act (ADA) Policies and procedures.

The National Standards for Culturally and Linguistically Appropriate Services (CLAS) related policies and practices are listed below under the relevant CLAS standard.

Principle Standard (CLAS Standard 1)

- **BHRS Policy 18-01:** Cultural Humility, Equity, and Inclusion Framework BHRS is committed to providing effective, equitable, and welcoming behavioral health and compassionate recovery services that are responsive to individuals' cultural beliefs and practices.

Governance, Leadership and Workforce (CLAS Standards 2-4)

- **BHRS Policy 92-03:** Affirmative Action - BHRS is an equal opportunity employer committed to fair and equitable selection procedures and practices.
- **BHRS Policy 08-01:** Welcoming Framework - BHRS, including management, staff, and providers, is committed to creating and sustaining a welcoming environment designed to support recovery and resiliency for those seeking services and their families. The intent is to let people seeking services and family members know that they are "in the right place" regardless of when and where they arrive for support and services.

- **BHRS Policy 14-02:** Family Inclusion Policy - BHRS is fully committed to involving family members of clients/consumers to the fullest possible involvement to encourage active, culturally responsive partnership with the family, the consumer/client, and clinical staff within all levels of the division.
- **Transgender Policy -** Reaffirms the County's commitment to providing a welcoming, safe, and inclusive environment for all employees and provides guidance to address the issues that arise pertaining to transgender and transitioning employees, clarifies expectations and processes for managers, supervisors, and employees.

Communication and Language Assistance (CLAS Standards 5-8)

- **BHRS Policy 99-01:** Services to Clients in Primary or Preferred Language - States that efforts will ensure communication in clients' primary or preferred language by maintaining sufficient bilingual staff at key contact points to support target language, assign language proficient staff at sites with localized language need and additional recommendation for culturally responsive care.
- **Health System Policy A-25:** Client's Right to Language Services Notification - Limited-English proficient (LEP) clients will be informed in their primary language that they have the right to language assistance and that services are available free of charge.
- **Health System Policy A-26:** No Use of Minors for Interpretation - Staff will discourage LEP clients from using friends or family members and will not allow minors to interpret.
- **BHRS Policy 05-01:** Translation of Written Materials - Procedures for translation of written materials ensures the information provided to consumers will be faithful to the intent of the document, contextually accurate, free from any errors, and culturally appropriate and understandable to readers.

BHRS Policies & Procedures

Engagement, Continuous Improvement, and Accountability (CLAS Standards 9-15)

Cultural Competency Plan Requirement for Contractors - All San Mateo County BHRS contracts that provide client services must follow cultural competence requirements, to help our system align with National CLAS (Culturally and Linguistically Appropriate Services) Standards. Contractors are required to submit cultural competence information annually to provide an update on their efforts to address the diverse needs of clients, families, and the workforce. Since FY 21-22, this information has been collected via a survey to increase the rate of submissions and track progress more seamlessly. In FY 23-24 twenty-seven (27) Cultural Competence (CC) survey submissions were received, out of 42 possible respondents. Contractors provided feedback on their current progress and challenges in advancing CLAS, below are some of the findings from the information reviewed:

- There was a 29% increase in survey submissions from the year prior.
- 77.8% of contractors reported their attendance/participation in BHRS' Diversity and Equity Council (DEC), Health Equity Initiatives(HEI), and/or other community partnerships.
- 70.4% offer language assistance services via an external language line or interpretation service.
- 70.3 % reported that their (CBO) staff completed the 8-hour annual training requirement.
- 59.3 % of contractors have an existing cultural competence committee within their organizations.

To continue supporting our contractors, the DEC will be working on providing more training opportunities in the coming fiscal year. Additionally, BHRS will be working to launch a pilot that extends BHRS' resources to contractors that currently do not have any language assistance services available.

External Quality Review Organizations (EQRO) BHRS Quality Improvement Work Plan for cultural competence activities includes the following: "Working Effectively with Interpreters in Behavioral Health" refresher course training will be required for all direct service staff every 3 years.

- All staff with direct client contact will accurately report the client's "Preferred Language" including American Sign Language (ASL) or aids like braille or Teletype and/or Telecommunications Device for the Deaf (TTY/TDD) using the drop-down language option in electronic healthcare records (Avatar) progress notes. Trends will be determined and identified as "emerging languages."
- All staff will complete the mandatory training on cultural humility.
- All staff with direct client contact will appropriately ask the client's Sexual Orientation and Gender Identity questions (SOGI).

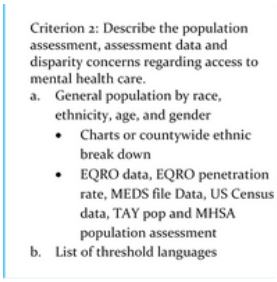
Data Collection of Sexual Orientation and Gender Identity (SOGI) and Race Ethnicity and Language (REAL) - Standardizing how information is collected in the electronic health records for sexual orientation, gender identity, sex, preferred name, and personal pronoun. Training and technical assistance will be provided to staff. Similar efforts will be undertaken to standardize and disaggregate race and ethnicity data. In 2024, 26.63% of clients were documented as "unknown" for the gender category in our EHR. Highlighting the importance of continuous training and support to ensure accurate information is captured.

BHRS Policy 06-02 Consumer/Client and Family Member Stipends for Services to Behavioral Health & Recovery Services – Describes one mechanism to promote and fairly compensate participation of consumers/clients and family members in key behavioral health activities including committees, consultations, focus groups, and services. Policy update expected to be completed early next fiscal year.

BHRS Policy: 14-03: Selection of Evidence-Based and Community-Defined Practices defines a process for selection and evaluation of proposed practices that facilitates broad-based and consistent evaluation of these proposals, is inclusive of a broad range of multi-cultural practices, and places importance on reducing disparities in access to care.

BHRS Policy A 44: Establishes a safe, secure, respectful, and healing environment for everyone through respectful behavior from both our staff and those persons receiving services on our premises, at home, via phone or email, virtually online, and in the community. Prohibits the use of abusive language including threats and slurs, harassment, assault, or weapons.

Criterion 2: Updated Assessment of Service Needs


Criterion 2: Describe the population assessment, assessment data and disparity concerns regarding access to mental health care.

a. General population by race, ethnicity, age, and gender
   - Charts or countywide ethnic break down
   - EQRO data, EQRO penetration rate, MEDS file Data, US Census data, TAY pop and MHSA population assessment

b. List of threshold languages

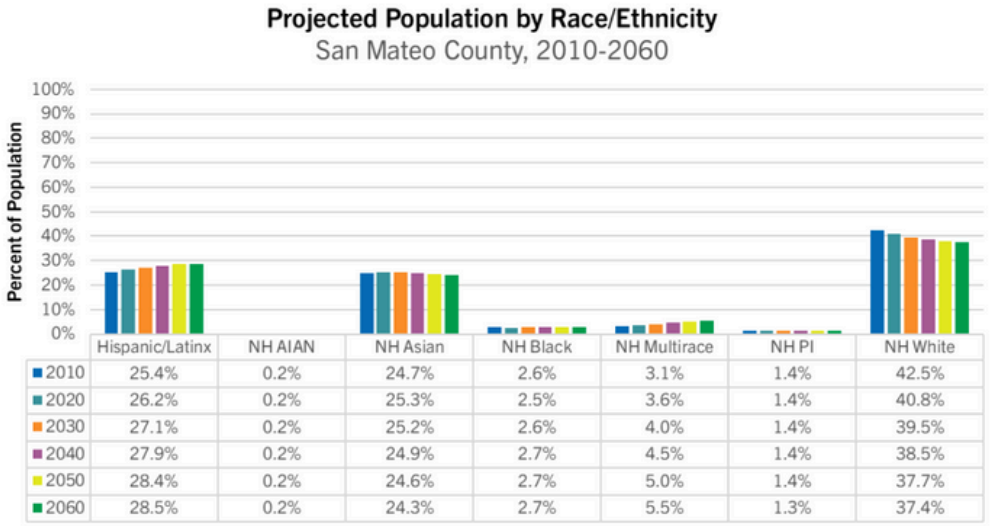
General Population Overview

San Mateo County has an estimated population of 728,762[5] this is a 4.67% decrease in population from 2020 to 2024. This decrease in population was greatly affected by decreased births, increased deaths, and migration out of the county. This decrease is projected to be a part of a larger increase of 11.7% from 2010 to 2060.[6] As our population continues to shift SMC can expect an increase in population over the next several decades among those aged 60 or older. This segment of older adults will make up nearly 36.2% of the population by 2060.[7] 45.3% of persons over the age of 5 speak a language other than English at home, which is higher than the CA percentage of 43.9%. San Mateo County continues to see a demographic shift when it comes to Race/Ethnicity with Non-Hispanic (NH) White (37.23%), Hispanic/Latinx (25.35%), and NH Asian populations (31.6%) making up the largest racial/ethnic groups, followed by Multirace (12.7%), Black (2%) and Native Hawaiian/Pacific Islander (1.17%) and American Indian/Alaska Native (0.90%).

35.2% of the population is foreign born and the Migration Policy Institute estimates that 55,000 people are currently undocumented. With the majority coming from Mexico, the Philippines, and El Salvador. 77% of undocumented individuals had access to insurance.

Demographic Projections

Over the next few decades, the NH White population is expected to decrease 12% between 2010 and 2060, while the Latinx population is expected to increase 12% between 2010 and 2060. Additionally, the number for Multirace is expected to also increase.



	Hispanic/Latinx	NH AIAN	NH Asian	NH Black	NH Multirace	NH PI	NH White
2010	25.4%	0.2%	24.7%	2.6%	3.1%	1.4%	42.5%
2020	26.2%	0.2%	25.3%	2.5%	3.6%	1.4%	40.8%
2030	27.1%	0.2%	25.2%	2.6%	4.0%	1.4%	39.5%
2040	27.9%	0.2%	24.9%	2.7%	4.5%	1.4%	38.5%
2050	28.4%	0.2%	24.6%	2.7%	5.0%	1.4%	37.7%
2060	28.5%	0.2%	24.3%	2.7%	5.5%	1.3%	37.4%

Sources:
• California Department of Finance. Demographic Research Unit. Report P-3: Population Projections, California, 2010-2060 (Baseline 2019 Population Projections; Vintage 2020 Release). Sacramento: California. July 2021.

This cultural and demographic shift paired with the shift for older adults point to a need to make sure that services are culturally congruent, relevant and accessible to growing populations in our county that currently experience disparities.

Sexual Orientation and Gender Identity (SOGI)

SOGI data is difficult to obtain because many data sources do not have it available or have such low numbers reported that the data becomes unstable*. Below are the results from the California Health Interview Survey from the University of California, Los Angeles (UCLA), this data is collected via telephone throughout the state of California. In order to reach stability with the data we have pooled a number of years below for data.

*Data instability means the data is unreliable or inconsistent due to factors like small sample size, high variability, or errors, making it unsuitable for drawing accurate conclusions.

Sexual Orientation and Gender Identity Adult Data 2015-2023

Table 1: Gender Identity (2 Levels)

All Adults

Gender Identity	Region	Percentage	Confidence Interval	Population Estimate
Cisgender (not transgender or gender-expansive)	San Mateo	99.3%	98.9 - 99.7	596,000
	Entire State	99.2%	99.2 - 99.3	29,207,000
Transgender and gender-expansive	San Mateo	0.7%	0.3 - 1.1	4,000
	Entire State	0.8%	0.7 - 0.8	228,000
Total	San Mateo	100.0%		600,000
	Entire State	100.0%		29,435,000

Table 2: Gender Identity (2 Levels)

Teen Population

Gender Identity	Region	Percentage	Confidence Interval	Population Estimate
Cisgender (not transgender or gender-expansive)	San Mateo	99.3% *	98.4 - 100.0	59,000
	Entire State	97.5%	97.2 - 97.9	3,000,000
Transgender and gender-expansive	San Mateo	-	-	-
	Entire State	2.5%	2.1 - 2.8	76,000
Total	San Mateo	100.0%		60,000
	Entire State	100.0%		3,076,000

*Statistically unstable.

Table 3: Sexual Orientation (4 Levels)

All Adults

Sexual Orientation	Region	Percentage	Confidence Interval	Population Estimate
Straight	San Mateo	93.5%	92.1 - 94.9	565,000
	Entire State	91.3%	91.1 - 91.6	26,914,000
Lesbian or Gay	San Mateo	2.5%	1.7 - 3.3	15,000
	Entire State	3.0%	2.9 - 3.2	894,000
Bisexual	San Mateo	2.4%	1.5 - 3.4	15,000
	Entire State	3.8%	3.7 - 4.0	1,135,000
Not sexual / celibate / other	San Mateo	1.6%	0.8 - 2.3	10,000
	Entire State	1.8%	1.7 - 1.9	529,000
Total	San Mateo	100.0%		604,000
	Entire State	100.0%		29,472,000

*Teen Gender Expression data is statistically unstable for evaluation or drawing conclusions

San Mateo County is home to California's first LGBTQ+ Commission that works closely with the San Mateo County Pride Center. Data collection has been a crucial topic for many groups and organizations that serve LGBTQ+ community members. In March 2021 the Pride Center published a LGBTQ+ COVID-19 Impact Survey Data Report. This report was important for seeing the impact on the LGBTQ+ community during the pandemic, especially with very limited data sources. The data collection was done through survey measures and outlined how COVID-19 impacted community members of various identities, and collected data such as employment, housing stability, financial stability, physical health, and access to supportive resources.

In June 2021, CoastPride opened to support LGBTQ+ individuals and families along San Mateo County's coast. Serving the region from Pescadero to Pacifica, the nonprofit fosters belonging, promotes safety, and celebrates diversity through education, social services, and community events. Partnering with schools and local organizations, CoastPride works to build an inclusive community where all can thrive. BHRS ODE is proud to support this growing organization as it expands services through a Measure K funding award in the next fiscal year.

Threshold Languages

54.8% of people in SMC speak only English, while 45.2% speak a language other than English. The highest percentage at 17.5% speak Spanish followed by various Asian and Pacific Islander Languages at 20%. The California legislature requires the Department of Health Care Services (DHCS) to implement requirements for language group concentration standards through its contracts with Medi-Cal managed care for Limited English Proficient (LEP) members through the provision of high-quality interpreter and linguistic services, and that translated written informing materials must be provided to all monolingual or LEP members that speak the languages identified by DHCS for the county service area, including alternative formats for individuals with disabilities.

As of July 2021, DHCS informed the County of San Mateo Mental Health Programs that according to the language group threshold standards, the county would be required to provide translated materials in Spanish, Chinese (Mandarin and Cantonese), and Tagalog. In addition, our partners at the Health Plan of San Mateo recommended Russian be included as a required language. The SMC Health System also identified Tongan and Samoan as priority languages based on the growing number of clients served. Lastly, emerging languages such as Arabic, Burmese, Hindi, and Portuguese have also been identified.

Social Determinants of Health and Racial Equity

As research continues on the topics of the Social Determinants of Health (SDOH) and their effects on behavioral health, the connection becomes stronger. We continue to see that people who are exposed to more unfavorable social circumstances which in the US context today continue to be those most marginalized and affected by racism, we see elevated vulnerability to poor mental health over the life course[8]. Structural racism shapes the social determinants of health through policy, disproportionately affecting ethno-minoritized groups, LGBTQ+ individuals, displaced persons, refugees, disabled people, and those living in poverty, leaving them most vulnerable to social conditions that exacerbate behavioral health challenges while also creating significant barriers to accessing care. For example, lack of safe and affordable housing, quality education, clean water, food, economic opportunity, and social connectedness all impact health and can pose barriers. At BHRS we work to expand our understanding of the social determinants of health and see the intersection with clinical work such as Adverse Childhood Experiences, how services are rendered to be accessible, resources offered to individuals we serve, and staff training. It is clear to see that our clients do not live in a vacuum and that to achieve wellness it will not only be clinical work that aids in recovery but also a deep consideration and advocacy for transformational societal change.

BHRS is working with San Mateo County Public Health, Policy, and Planning (PHPP) and its community partners to create the 2023-2026 San Mateo County Community Health Improvement Plan (CHIP). The CHIP is a community-driven plan focused on improving the health outcomes of those who live, work, learn, and play in San Mateo County. On November 1, 2023, PHPP conducted a virtual CHIP Kick-Off. Representatives from over 90 community-based and non-profit organizations, hospitals, Health Plan of San Mateo, members of San Mateo County Health Programs, and community advocates and leaders participated in the meeting. During the CHIP Kick-Off, participants reviewed key findings from the 2023 Community Health Needs Assessment and feedback from community forums held in September and October 2023. At the end of the meeting, attendees participated in a prioritization process to identify health areas to include in the CHIP. Based on the prioritization process, the following are the three priority areas in the 2024-2026 CHIP for San Mateo County: 1) Access to Health Care Services; 2) Mental Health; and 3) Social Determinants of Health.

Housing

- In 2022, the median price of a single-family home in San Mateo County was $1,910,000 an increase of 0.6% from 2021 a 12.5% increase from 2020, and 22.5% from 2019.[9]
- 77.9% of adults over 18 years and older consider the availability of affordable housing in their community as fair or poor.[10]
- Homeownership rates for White and Asian households are significantly higher than those of Black, American Indigenous Alaska Native, Latinx, and Native Hawaiian Pacific Islanders.[11]
- High housing prices have various consequences including crowded housing conditions which can spread communicable diseases, something we saw during the COVID-19 pandemic and the disproportionate burden on Latinx low-income residents. Unaffordable housing also diverts money away from other household needs such as medical care, healthy food, or childcare.[11]

Education

- Latinx students account for over half of all SMC student suspensions, despite making up only 38% of the student body. Black students are overrepresented among student suspensions.[11]
- Asian and White students had the lowest four-year push-out rates in San Mateo County and California. Latinx, Black, and PI students had the highest four-year push-out rates in SMC with Latinx students having the highest rate at 8.7%.[12]
- 52.5% of the population aged 25 and over have a bachelor's degree or higher.[13]

Economic Stability

- White and Asian Households on average, receive $64,000 more a year than Black households, $58,000 more than AIAN households, and $65,000 more than Latinx households.[11]
- Census tracts in Redwood City, Menlo Park, and East Palo Alto have the highest percentages of households using CalFresh.[14]

Health Care Access

- Access to care affects migrant farm workers, older adults, and undocumented communities making them particularly vulnerable.
- Latinx residents are less likely to have a usual source of care, 7% less than white residents in the county.[15]
- Black residents of San Mateo County have a shorter expected lifespan, averaging 11, 9, and 4 years less than Asian, Latinx, and white residents, respectively.[15]
- Black residents have high rates of preventable hospitalizations, with 549 more preventable deaths per 100,000 people than Latinx residents in San Mateo County.[15]

Substance Use

Substance use and related disorders have been long misunderstood and stigmatized by both the healthcare systems and the community at large. We know that substance use poses many health risks including injury, illness, domestic violence, and loss of family. Additionally, people who struggle with Alcohol and Other Drug (AOD) challenges without adequate harm reduction efforts available to them run a high risk of contracting hepatitis B and C infections through injection drug use. There are also long-term consequences such as increased rates of chronic depression, psychosis, and sexual dysfunction. However, when we speak of substance use we rarely speak of the causes of use especially in communities that experience the largest disparities and have been marginalized. In 2023 AOD, a unit of the BHRS, launched a partnership with various Community-Based Organizations to conduct community needs assessments about substance use in marginalized communities including, African Americans, Pacific Islanders, and Latinx community members. Each of these communities went through a process in partnership with the county that was community driven from the questions asked to the analysis of the data.

The African American Community Assessment[16] conducted by the Bay Area Community Health Advisory Council (BAHAC) revealed that major reasons for substance use included isolation, loneliness, and grief and that 64% of youth surveyed who identified a lack of companionship used substances. Additionally, experiences of stress related to racism, community racism, and lack of connection were also associated with substance use. 69% of adults and 73% of youth reported experiencing racism personally. Protective factors included a sense of belonging, a personal support system, and community connection.

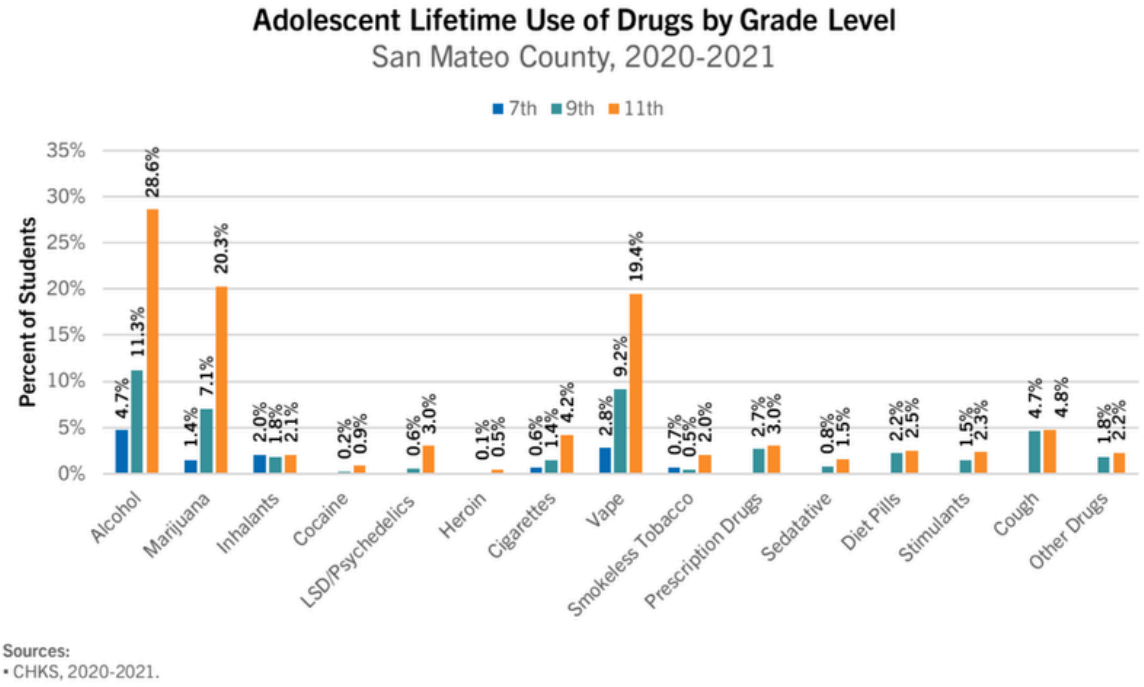
The Latine Community Assessment[17] conducted by Ayudando Latinos A Sonar (ALAS) found that the main challenges for substance use were financial challenges, affordable housing, and lack of services in Spanish. 34% of adults felt sad or alone and 17% did not know where to go for services. 18% of youth use substances to deal with stress at school, 16% to deal with anxiety and 36% of youth that engaged in self-injurious behavior did not receive services.

The San Mateo Tongan community assessment[18] was headed by Taulama for Tongans who administered surveys and conducted focus groups and found that 13% of adults use substances to deal with stress at home,

20% felt isolated from others, and almost 30% of those who answered no to accessing behavioral health services experienced barriers to access. Cost of living was a huge stressor including housing instability as well as access to affordable quality food and utilities. Key themes included youth using substances to escape and numb pain, and a lack of knowledge of community resources.

All of these community organizations included recommendations for assessing substance use and mental health to be implemented collaboratively that included addressing SDOH, such as housing affordability, capacity building for providers to center cultural humility and language access availability as well as mentoring programs, educational initiatives, and youth-led boards.

Additional substance use data reveals that drug use among adolescents increased with age and it was found that 28.6% of 11th graders had tried alcohol and 20.3% tried marijuana and 19.4% have tried vaping/e-cigarettes.[19]

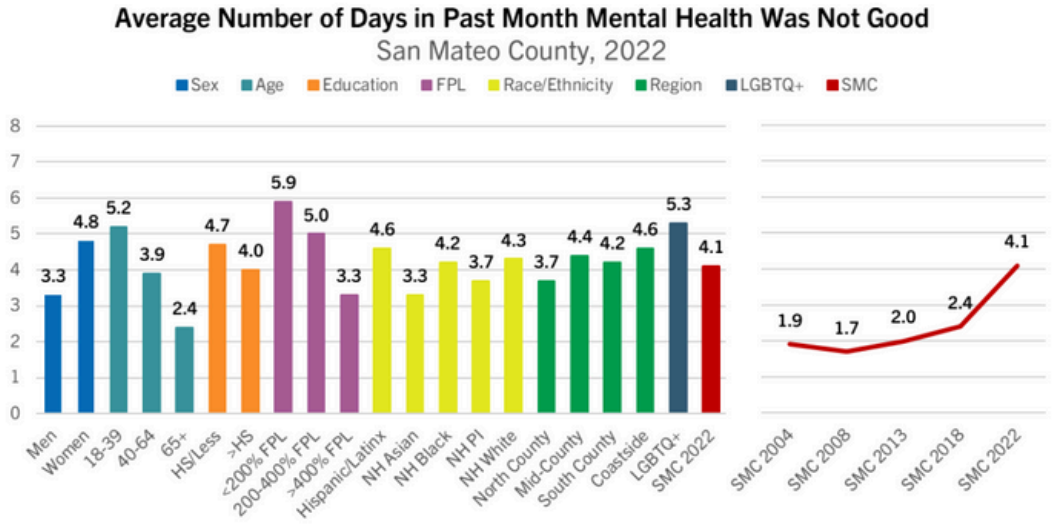


Age-adjusted rates of Emergency Department visits due to opioid overdose in SMC were 12.7/100,000 lower than the state rate of 17.5/100,000, and opioid prescriptions were below the state rate.

Alcohol abuse is the most common substance use problem we face as a majority of the population engages in drinking alcohol. 16.5% of adults reported binge drinking in the past 30 days which is higher than the state rates. Binge drinking is highest among young adults aged 18-39 (24%), Pacific Islanders and Latinx respondents. Nearly 1 in 2 San Mateo County adults reported they would not know where to access treatment for a drug-related problem for themselves or a family member. This is an increase from 4 out of 10 respondents in the 2013 Community Health Assessment and shows that over time fewer people know where to access treatment for drug-related problems. [21]

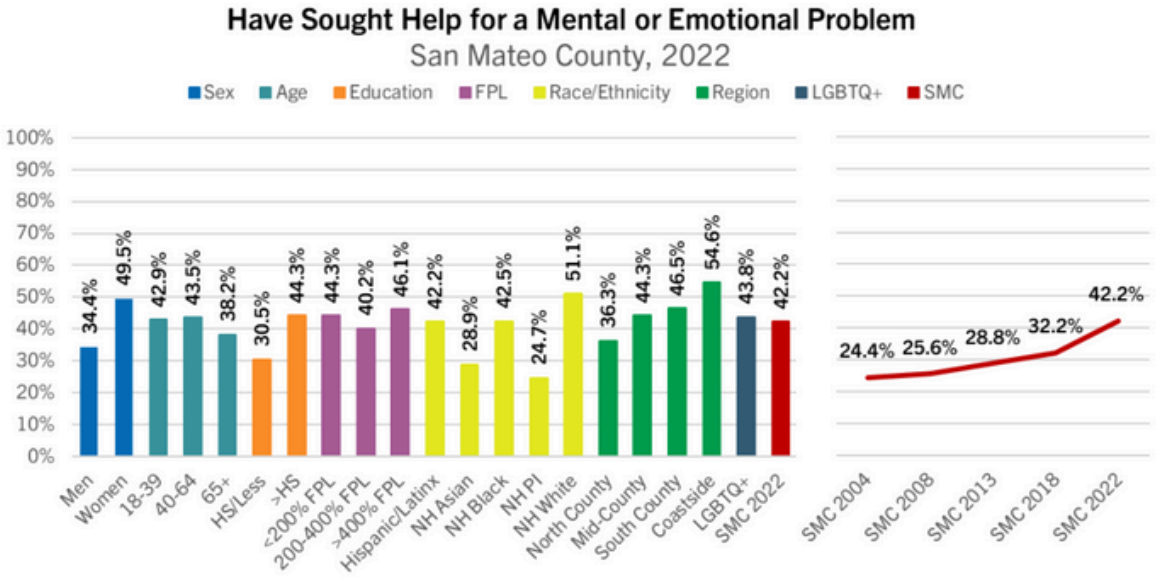
Mental Health Indicators

Adults reported an average of 4.1 days in the preceding month in which their mental health was not good, which is significantly higher than in previous years. Those who survive below the 200% poverty threshold have the highest average number of poor mental health per month. Additionally, averages are also higher for those 18 to 39, those who are Latinx, and LGBTQ+ respondents.[20]



Sources:
• 2004/2008/2013/2018/2022 San Mateo County Health and Quality of Life Survey, Professional Research Consultants, Inc.
Notes:
• Asked of all respondents.

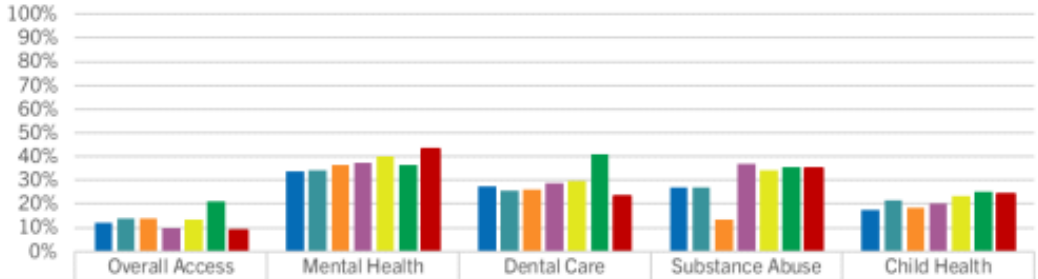
17.6% of adults surveyed in 2022 reported they have a history of mental or emotional illness and more than 4 in 10 have sought some form of professional help for a mental and emotional problem. This is significantly higher than previous findings. Utilization of services is particularly low among men, persons with only a high school education, NH Asian and NH Pacific Islander respondents and North County residents.[20]



Sources:
• 2004/2008/2013/2018/2022 San Mateo County Health and Quality of Life Survey, Professional Research Consultants, Inc.
Notes:
• Asked of all respondents.

Through the Health and Quality of Life Survey county respondents were asked to evaluate the ease of access to each of four types of healthcare services; mental health, dental care, substance abuse, and child care. Of the listed categories respondents were most critical of mental health services (40.1% rate this as fair/poor) and evaluations this year were significantly worse than those in 2004 and 2008.[20]

Perceive "Fair/Poor" Access to Health Care Services
San Mateo County, 2004-2022

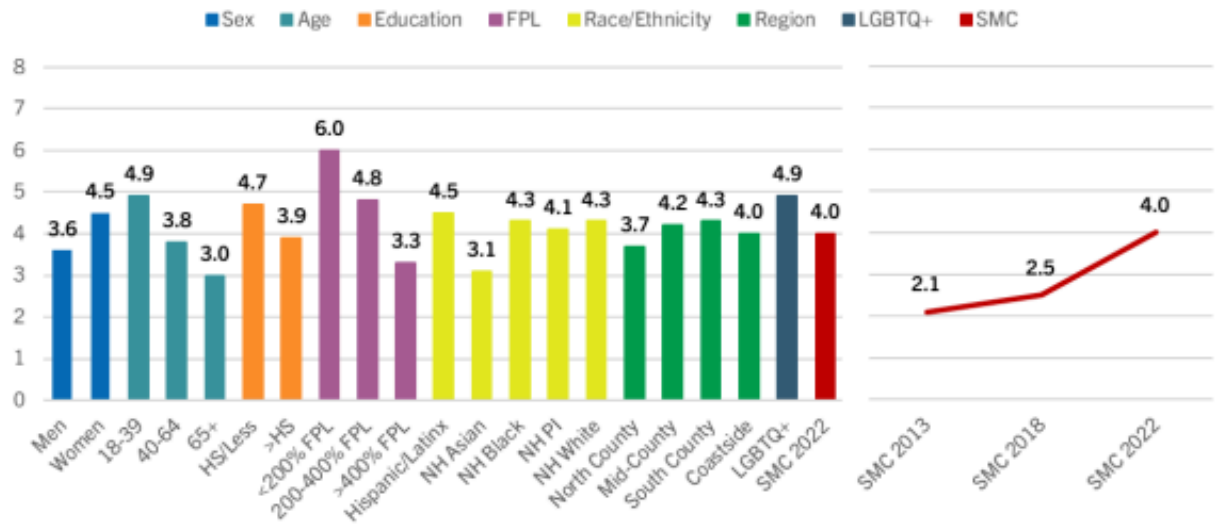


	Overall Access	Mental Health	Dental Care	Substance Abuse	Child Health
SMC 2004	12.3%	33.9%	27.4%	26.8%	17.3%
SMC 2008	13.7%	34.1%	25.6%	27.0%	21.7%
SMC 2013	13.7%	36.3%	26.0%	13.6%	18.3%
SMC 2018	9.8%	37.4%	28.7%	36.9%	20.0%
SMC 2022	13.3%	40.1%	29.8%	34.4%	23.5%
<400% FPL 2022	21.1%	36.5%	40.8%	35.6%	25.3%
>400% FPL 2022	9.1%	43.2%	23.3%	35.1%	24.3%

Sources:
• 2004/2008/2013/2018/2022 San Mateo County Health and Quality of Life Survey, Professional Research Consultants, Inc.
Notes:
• Asked of all respondents.

Additional data from the 2023 Community Health Needs Assessment shows that surveyed adults reported an average of 4 days in the preceding month in which they felt sad, blue, or depressed, higher than previous findings. Those most affected were women, those without post-secondary education, persons living below the 200% poverty threshold, Latinx respondents, and LGBTQ+ respondents among others, and averaged a higher number of days of depression.[20]

Average Number of Days in Past Month Respondent Felt Sad, Blue, or Depressed
San Mateo County, 2022



Sources:
• 2013/2018/2022 San Mateo County Health and Quality of Life Survey, Professional Research Consultants, Inc.
Notes:
• Asked of all respondents.

Another finding of the 2023 Community Health Needs Assessment[20] was that from the SMC adults surveyed about 8% had thought about taking their own life in the past 12 months. This percentage was higher among community members from the Pacific Islander community and those who were LGBTQ+. Additionally, 15.6% of seniors have someone for emotional support a “little” or “none” of the time.

Youth mental health data also shows us a trend of worsening mental health affected by the COVID-19 pandemic, political environment, and social determinants of health.

- Multiracial Students had a higher percentage of chronic sadness followed by Latinx, NHPI, and Black students.[19]
- Black students have the lowest percentage of being satisfied with their life.[19]
- SMC reports lower levels of depression than the state but SMC high schoolers were more likely to seriously consider suicide in the past year than statewide 16.3% of 9th graders and 17.6% of 11th graders.[22]
- Suicidal ideation is more prevalent among LGBTQ+ youth (44%), Native Hawaiian/Pacific Islanders (30.2%), multi-racial students (22.4%), and Black Students (17.4%). [22]

From the various data sources used in this section, we see that there has been an overall worsening of behavioral health in the San Mateo County community. Many of these effects are felt due to the increased isolation during the COVID-19 pandemic, which also caused a rise in anxiety, depression, and suicidal ideation. Community members have identified that there were many people seeking support for isolation, but also that they have observed a reluctance to ask for help especially if police enforcement will be involved. Also, economic hardships are felt both by adults and the youth in their families, and this makes it so that there is less money for treatment, but also adds stress and anxiety to daily life. Economic instability, housing and access to care continue to be significant social determinants of health that need to be addressed. Community members through the various needs assessments conducted by community organizations, non-profit hospitals, and the county have highlighted the need for more culturally responsive services and providers who are culturally and linguistically congruent.

Additionally, greater collaboration and coordination among the hospital providers, county and community organizations is needed as worsening behavioral health is a symptom of greater problems that need to be addressed through multi-pronged actions. SMC Health has increased collaboration through the county's first Community Health Improvement Plan which includes AOD, BHRS, Public Health, other county divisions as well as community partners and hospital partners. Additionally, the implementation of the Behavioral Health Services Act (BHSA) gives us an opportunity to increase partnerships with our Public Health department and continue to work on population health strategies collaboratively.

Penetration Rates

Penetration rates (PR) are calculated by taking the total number of individuals who receive Specialty Mental Health Services in a Fiscal Year (FY) and dividing that by the total number of Medi-Cal eligible adults for that FY. The data measures used for each fiscal year are derived from the annual External Quality Review Organization (EQRO) report. .

Drug Medi-Cal Organized Delivery System

SMC has a broad availability of recovery support services across the agency, and interagency collaboration is coordinated and impressive. The highest penetration rates were among African Americans and Whites, Latinx populations had lower penetration rates than statewide, and Asian/PI folks had the lowest penetration rates. From Calendar Year (CY) 2021 to CY 2022, there was an increase in rates for African Americans, Latinx, Native Americans, and White racial groups. Overall PR in 2022-2023 is significantly lower than same-size counties and statewide averages, notably affecting the Latinx community since they are the highest proportion of beneficiaries which points to a need for an increase in meaningful outreach.

Table 4: San Mateo DMC-ODS Medi-Cal Eligible Population, Members Served, and Penetration Rates by Racial/Ethnic Group, CY 2022

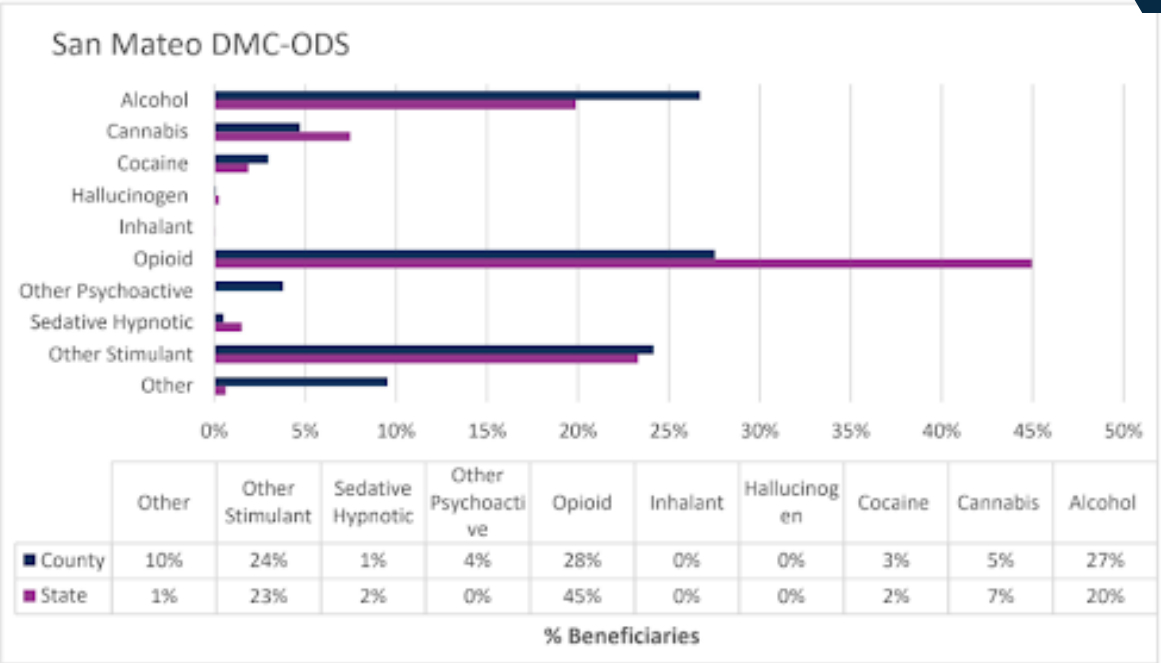
Racial/Ethnic Groups	# Members Eligible	# Members Served	County PR	Same Size Counties PR	Statewide PR
African American	3,182	50	1.57%	1.35%	1.19%
Asian/Pacific Islander	24,608	-	-	0.23%	0.15%
Hispanic/Latino	52,646	191	0.36%	0.69%	0.69%
Native American	177	<11	-	2.07%	2.01%
Other	29,889	304	1.02%	1.51%	1.26%
White	16,081	258	1.60%	1.85%	1.67%

Table 4: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Race/Ethnicity, CY 2021

Race/Ethnicity Groups	# of Eligibles	# of Clients Served	County PR	Similar Size Counties PR	Statewide PR
African-American	3,438	75	2.18%	1.33%	1.13%
Asian/Pacific Islander	26,283	-	-	0.23%	0.15%
Hispanic/Latino	66,230	209	0.32%	0.54%	0.56%
Native American	185	<11	-	1.76%	1.75%
Other	29,498	286	0.97%	1.32%	1.15%
White	17,036	302	1.77%	1.77%	1.64%
TOTAL	**142,668**	**921**	**0.65%**	**0.97%**	**0.85%**

The most common diagnostic categories in the DMC-ODS were Opioid, Alcohol, and other stimulants. Alcohol was more prevalent than statewide and opioid-related diagnoses were less. There is also an overrepresentation of the “other” category in San Mateo.

Figure 5: Percentage of Beneficiaries by Diagnosis Code, CY 2021



	Other	Other Stimulant	Sedative Hypnotic	Other Psychoactive	Opioid	Inhalant	Hallucinogen	Cocaine	Cannabis	Alcohol
County	10%	24%	1%	4%	28%	0%	0%	3%	5%	27%
State	1%	23%	2%	0%	45%	0%	0%	2%	7%	20%

% Beneficiaries

Mental Health Plan (MHP)

Through the External Quality Review, SMC received positive feedback regarding the value of diversity, equity, and inclusion, a culturally competent workforce, collaborations with partners, and community outreach by family and members. For penetration rates, the MHP penetration rates were higher in San Mateo than statewide for all racial/ethnic groups. However, the Asian/Pacific Islander rate remains the lowest. The most proportionally overrepresented racial/ethnic groups among members was White, and the most underrepresented were Latinx and API.

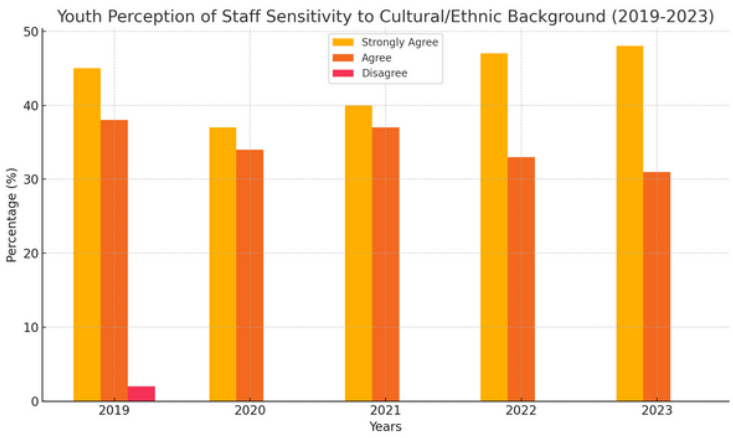
Race/Ethnicity	PR MHP 2021 (%)	PR State 2021 (%)	PR MHP 2022 (%)	PR State 2022 (%)
African-American	11.82	7.64	11.98	7.08
Asian/Pacific Islander	2.44	2.08	2.48	1.91
Hispanic/Latino	3.05	3.74	3.55	3.51
Native American	12.17	6.33	13.33	5.94
Other	5.29	4.25	5.44	3.57
White	9.89	5.96	9.82	5.45

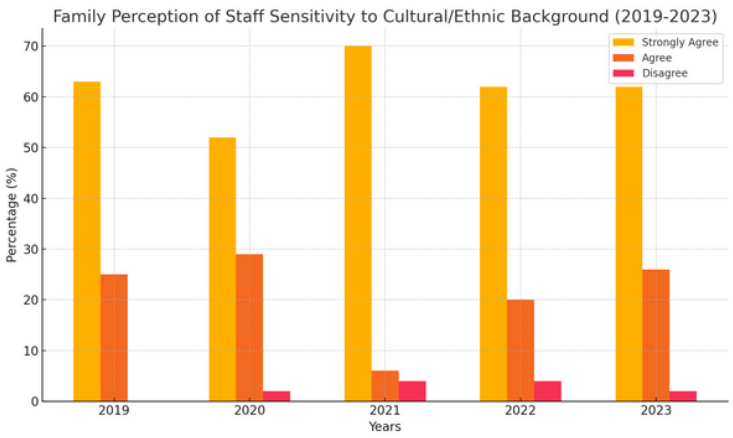
Over the past 3 years, there has been a consistent trend in penetration rates for racial/ethnic groups with API and Hispanic/Latino exhibition the lowest rates. In 2021 SMC reported a lower Latinx penetration rate compared to counties of a similar size and the statewide average. Now, San Mateo figures exceed those of counties of similar size and are aligned with statewide PRs. Penetration rates for API, although lower than its other race/ethnicity PRs, have been consistently higher than the corresponding averages for counties of similar size and statewide.

Client Surveys

Client satisfaction surveys were gathered as required by DHCS once each calendar year. These surveys serve as a way to collect data for reporting on the federally determined National Outcome Measures (NOMs) and additionally, continue to inform BHRS on service provision and quality improvement. One of the questions on the survey states “Staff were sensitive to my cultural background (race, religion, language, etc.)” The survey is delivered to adults, youth, older adults and family.

For youth, there was a dip from 2019 (45%) to 2020 (37%) and then a marked increase in 2021 (40%) to 48% in 2023 that strongly agreed that staff were sensitive to their cultural/ethnic background. For families, there was a decrease from 2019 (63%) to 2020 (52%) and then an increase (70%) in 2021 and another decrease in 2023 (62%) in 2023 that strongly agreed that staff were sensitive to their cultural/ethnic background. The same pattern can be observed with Adults and Older Adults.





Criterion 3: Strategies and Efforts to Reduce Behavioral Health Disparities

Criterion 3: Provide the mechanisms and processes used for the systematic collection of baseline data, on-going info about groups served

a. Planning, tracking and assessment of cultural competence

Systematic Collection of Baseline Data, Tracking and Assessment

ODE continues to strive towards the goal of promoting cultural humility and addressing health disparities, health inequities, access to care, and stigma associated with mental health and alcohol and other drugs. There are a variety of mechanisms and processes for the systematic collection of baseline data, and ongoing information about the groups that are served.

ODE Indicators, Demographic Data and Satisfaction Surveys

ODE has identified 5 impact indicators based on our Theory of Change frameworks, mission, values, and strategies. All ODE programs and activities have standardized satisfaction and evaluation questions to inform the impact on any relevant key indicators. Additionally, ODE collects the demographics of participants for every event that is hosted and funded through MHSA. This process enables the staff to recognize groups that are being served, those underserved, and those that may not be served at all.

The ODE demographic survey was developed in partnership with our Health Equity Initiatives to ensure culturally appropriate identity categories across race, ethnicity, sexual orientation, and gender identity. On the following page, you will find a draft sample event survey that incorporates both indicators and satisfaction-type questions. We make sure that all surveys are available in English, Chinese, Tagalog, Spanish, Russian, Tongan, Samoan, and Portuguese to reach the majority of our diverse communities in San Mateo. Additional language translation services are provided upon request to ensure that the voices of all community members are heard and represented.

SHORT - MHSA PARTICIPANT DEMOGRAPHIC SURVEY

San Mateo County is committed to serving diverse communities. Your answers to these questions will help us understand whom we serve and who we still need to reach. All this information is **VOLUNTARY** and **CONFIDENTIAL.**

What age range are you under? (check ONE)

☐ 0-15 years	☐ 60-73 years
☐ 16-25 years	☐ 74+ years
☐ 26-59 years	☐ Decline to state

What is your primary language spoken at home? (check ONE)

☐ English	☐ Mandarin	☐ Tagalog	☐ Tongan
☐ Spanish	☐ Cantonese	☐ Russian	☐ American Sign Lang.
☐ Another language:		☐ Decline to state	

What race(s)/ethnicities do you identify with? (check ALL that apply)

☐ Asian or Asian-American	☐ Native Hawaiian or Pacific Islander
☐ Black or African American	☐ White or Caucasian
☐ Latino/a/x or Hispanic	☐ Another race, ethnicity, or tribe:
☐ Native American, American Indian, Indigenous	☐ Decline to state

What is your gender identity? (check ONE)

☐ Female/Woman/Cisgender Woman	☐ Male/Man/Cisgender Man	
☐ Transgender Woman/Trans Woman/Trans-Feminine/Woman	☐ Transgender Man/Trans Man/Trans-Masculine/Man	
☐ Genderqueer/Gender Non-Conforming/Gender Non-Binary/Neither exclusively Female or Male	☐ Indigenous gender identity	
☐ Another gender identity (including more than one gender identity): _	☐ Questioning or unsure of gender identity	☐ Decline to state

What is your sexual orientation? (check ONE)

☐ Heterosexual or Straight	☐ Gay	☐ Queer	☐ Pansexual
☐ Lesbian	☐ Bisexual	☐ Asexual	☐ Indigenous sexual orientation
☐ Another sexual orientation (including more than one sexual orientation):		☐ Questioning or unsure of sexual orientation	☐ Decline to state

Do you identify as behavioral health client/consumer or family member? (check ONE)

☐ Client/consumer ☐ Family member	☐ Both ☐ Neither ☐ Decline to state
What zip code do you spend most of your time in? _____	Date of today's event or program:

ODE evaluation form

To allow for BHRS to assess the impact across all of its PEI-funded programs, the data collection and reporting framework uses a set of Outcome Domains under which programs can report their specific data. ODE Programs select the domain(s) that best align with the intent of the intervention (why the program was developed), program goals, and primary anticipated outcomes (vs. secondary/tertiary impacts). The ODE uses the following domains to learn about our events' impacts.

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

The specific evaluation questions (listed below) use a scale ranging from 1, representing "strongly disagree," to 5, indicating "neutral," and 10, signifying "strongly agree."

1. Through my participation in this event/program/training, I have learned knowledge and skills that I can use to access behavioral health services.
2. I feel like my identity, cultural background, and experiences (race, ethnicity, gender, religion, etc.) were affirmed by this program/training/event.
3. Due to my participation in this program/training/event, I feel more confident in my ability to create change in my community.
4. This program/training/event affirmed that people with mental illness are capable and able to make positive contributions to society.
5. Due to this program/training/event, I feel more comfortable talking about my mental health and/or substance use.
6. Due to my participation in this program/training/event, I am more confident in my ability to advocate for the behavioral health needs of myself and/or my child/ren and/or another family member.

Alcohol and Other Drugs

Alcohol and Other Drugs (AOD) Contracts, Compliance, and Monitoring Team program staff develop and monitor contracts and services for quality and compliance with federal, state, and local requirements. Training and technical assistance are provided by BHRS direct service and program staff to build capacity and enhance quality and compliance throughout the system of care.

- Contracted Community Services
  - Prevention, treatment, and recovery service contractors work within communities to improve health, wellness and promote recovery
  - Drug Medi-Cal Organized Delivery System (DMC-ODS) and Substance Use Block Grant (SUBG) treatment services are provided via contracts with community-based organizations.
  - The substance use treatment provider network has 25 facilities offering a full continuum of services; and 10 prevention partners.
- Cultural Competency Site Visit Results and Monitoring:
  - The AOD Contracts, Compliance, and Monitoring Team implements a monitoring procedure to ensure cultural competency standards are maintained across all AOD contracted providers. Our FY23-24 site visit protocols incorporate assessments of Cultural Competency Standards through multiple mechanisms including:

  Annual Site Visit Monitoring includes:
  - Review of personnel files to verify completion of required annual cultural competency trainings.
  - Assessment of policies and procedures for cultural competency compliance.
  - Evaluation of facility environment and materials, including the availability of materials in threshold languages, visible posting of required taglines, accessibility of interpretation services, and cultural representation in facility displays and materials.
  - Client chart audits to verify cultural and linguistic needs assessment, provision of language assistance services when needed, documentation of culturally appropriate interventions, evidence of cultural considerations in treatment planning, and integration of cultural competency standards within service delivery monitoring, particularly for specialized programs such as perinatal services where gender-specific and culturally appropriate care are essential.

Key Findings and Quality Improvement Focus

Through the monitoring process in FY23-24, several areas for enhancement were identified:

- Training Compliance: Site visits revealed that providers need to strengthen their compliance with cultural competency training hour requirements. In response, BHRS has:
  - Increased communication and support around training requirements and deadlines.
  - Provided additional resources and training information to help Contractors complete required training hours.
- Documentation Enhancement Initiatives:
  - Based on monitoring findings, BHRS has implemented specialized progress note training to improve documentation quality.
  - Treatment plan development training to ensure cultural considerations are properly integrated.
  - Regular quality review sessions with providers.
- Strengthened Oversight Process: To ensure continuous quality improvement, BHRS has established:
  - Monthly meetings between providers and program analysts to review:
    - Program utilization.
    - Implementation challenges.
    - Progress on correction plans.
    - Technical assistance needs.
    - Regular data review sessions to track progress and identify emerging trends.
    - Collaborative problem-solving approaches to address identified challenges.

These monitoring efforts have resulted in improved provider performance and enhanced service delivery across our system of care.

HEI Strategic Planning Process

In the Winter of 2023, the 9 Health Equity Initiatives (HEI) began to engage in a Strategic Planning Process. Following the passage of Proposition 1 (BHSA) in 2024, the focus of this process shifted to developing Work Plans that facilitate the transition from MHSA to BHSA. This process sought to center the voices of HEI co-chairs and members that include staff, individuals we serve, community members, and partnering organizations. Meetings were held with co-chairs and data was pulled specific to each HEI that showed any disparities in access as well as documented behavioral health needs. Each HEI then was able to give feedback and ideas for the direction for the next 1.5 years, and participation included folks in the meeting but also a survey to prioritize strategies. Within these strategic work plans, we were able to see opportunities for collaboration between HEIs as well as common challenges. Through this process, there were plans for a new slate of trainings, continuation of outreach and engagement events, and more involvement in data analysis for policy change.

Goals, Strategies, and Activities

The current BHRS Cultural Competence Plan strategies and activities continue to be organized based on ODE's Theory of Change Pathways since we have not received the final updated criteria for county plans.

Goal 1: Workforce Development and Transformation: Expand on Workforce Development and Transformation that prioritizes cultural humility, inclusion, and equitable quality care.

- Strategy 1: Deepen BHRS' commitment to diversity, cultural humility, and inclusion principles through a Multicultural Organizational Development (MCOD)process.
- Strategy 2: Implement a systemic approach to Workforce Education and Training.
  a. Provide training to introduce and initiate dialogue and individual-level culture shifts related to cultural humility, trauma-informed care, co-occurring informed and other integrated care, evidence-based practices, lived experience and client/family members integration, self-care, and other BHRS transformation goals.
  b. Establish policies, leadership engagement, and quality improvement focus to sustain the transformation goals.
- Strategy 3: Create pathways for individuals with lived experience in behavioral health careers and meaningful participation.

a. Provide trainings for and by consumers and family members on various behavioral health, wellness, and recovery topics.
b. Create new career pathways and expand existing efforts for clients and family members in the workforce.

- Strategy 4: Promote behavioral health careers and other strategies to recruit, hire, and retain diverse staff.
  a. Attract prospective candidates to hard-to-fill positions.
  b. Increase diversity of staff to reflect the service population.
  c. Promote the behavioral health field in academic training institutions.
  d. Promote interest among and provide opportunities for youth.

Activities and programs that support the Workforce Development and Transformation:

Multicultural Organizational Development (MCOD) is an organizational change framework focused on building BHRS's capacity to advance equity, diversity, inclusion, and belonging principles in the workplace. BHRS focused on internal capacity development to work effectively and respectfully with diverse cultural, linguistic, and social backgrounds. To accomplish this goal, BHRS is using four levels of organizational change which include personal, interpersonal, cultural, institutional, and structural/systemic. In 2018 an MCOD Action Plan was finalized which includes goals, strategies, shorter-term activities, tasks, and metrics. The MCOD Action Plan is currently being updated and will integrate trauma-informed systems practices (Refer to criterion 6).

- **Highlights**
  - Beginning in 2023 the newly restructured BHRS executive team began working with an expert equity consultant to recalibrate their role in leading equity work in BHRS. The consultant's goal was to provide support and continued learning to maintain gains from the past two years. Previous work included overseeing specific DEIB activities and presentations to increase executive team knowledge, assignment of accountability partners, and group and individual executive team consultation.

Government Alliance on Race and Equity (GARE) is a national network of governments working to achieve racial equity and advance opportunities for all. Racial equity is critically important to getting different outcomes in our communities and our goal extends beyond closing the gaps.

To advance equity we must focus not only on individual programs but also on policy and institutional strategies that are driving the production of inequities.

Highlights

- The Health GARE Cohort, co-led by Behavioral Health and Recovery Services (BHRS) and Public Health Policy and Planning (PHPP), comprises 27 members representing seven divisions within Health: Aging and Adult Services, BHRS, Family Health, Health Administration, Health IT, PHPP, and the San Mateo Medical Center.
- In April 2024, BHRS, in collaboration with Health Administration and Aging and Adult Services, launched the Pronoun Badge Topper Pilot program. This new, optional initiative enables workforce members to display their pronouns on the SMC employee badge, fostering a more inclusive and welcoming environment for all county staff.

  The effort aligns with the Health Racial Equity Action Plan (REAP), MCOD, and Pride Initiative, supporting inclusion, belonging, and the celebration of workforce diversity while helping to prevent unintentional misgendering. The program is ongoing, with continuous improvements based on workforce feedback, such as expanding pronoun options, creating a customizable order form for badge toppers, and enhancing distribution processes.
- In early 2024, BHRS, in collaboration with the Health GARE Training Committee and a consultant, completed the modularization of the Race, Equity, and Health (REH) Training originally developed by the Health GARE team. This modularization transformed the original training into a series of smaller, self-directed online components, making it more accessible to Health staff who work weekend or evening shifts or require accommodations due to the typical length of in-person training sessions. The updated format includes a 90-minute introductory facilitated session, four 15-minute self-paced modules, and a facilitated closing session. Feedback from the pilot implementation has been reviewed, and updates are currently being made to enhance the program further.
- In 2024, the Health GARE SEED (Spotlighting Engagement of Equity Development) Lab launched an innovative communication tool, the interview video series What the HEC (Health Equity Champions). Over the past fiscal year, four episodes were created and released:
  - Celebrating Juneteenth
  - Celebrating Pride Month (Part 1) and Gender-Affirming Care (Part 2)
  - A Discussion with Our New Deputy County Health Chief, covering Power, Equity, and Accountability (Part 1) and Grief and Power (Part 2)
  - Office of Diversity and Equity: 15-Year Anniversary Celebration

This new format has successfully fostered engagement and provided valuable learning opportunities around diversity, equity, inclusion, and belonging. The series has been well-received with over 900 views, generating more recommendations for future topics than the team can currently accommodate. We look forward to continuing this dynamic and engaging communication approach.

- There have been several transitions for the group in terms of staffing. SMC Deputy County Health Chief and our Executive champion retired, and the co-lead of the group was promoted to a different position and provides a different level of support. Various other health equity champions have also moved positions or have reported increased workloads and an inability to support the GARE Health cohort as in previous years.
- In fall 2021, GARE conducted a Racial Equity Employee Survey, with 2,109 SMC employees participating. Of the County's 32 departments, County Health accounted for 544 responses, representing 34.3% of the total. Within County Health, BHRS contributed 115 responses, or 21.4% of County Health's participation. The insights gained from the survey are actively informing ongoing efforts to respond to the needs and experiences of our workforce.
- Our Health GARE team contributed to the yearly report and update of the Health Social and Racial Equity Action Plan (SREAP) and our ODE team continues to work on its alignment with the BHRS MCOD Action Plan.
- The Cross-Divisional GARE team continued hosting our foundational Race, Equity, and Health Training. To date, 951 Health workforce members (695 BHRS Staff) have taken the 4-hour training.
- The GARE Training Committee launched the 21-Day Racial Equity Challenge Program. To date, the Health GARE cohort has hosted 4 group challenges with 36 participants. BHRS has sponsored some of these 21-day challenges, such as June Pride Month and November Native Heritage Month.
- In January of 2023 our Health GARE cohort, led by BHRS and PHPP received the Diversity, Equity, & Inclusion-Stars Award, which recognizes and rewards County programs that foster and promote diversity and inclusion for employees and/or populations served.
- The Health, Equity, and Race Training was again provided in person, as well as virtually. As previously mentioned the training was adapted (modules) for workforce members who did not have the capacity to complete the training due to their work schedule (PM shifts, weekend shifts).
- The Health Executive Council, with support from the Health GARE Cohort, moved forward on several of our SMC Health Social and Racial Equity Action Plan (SREAP) goals. Goals aligned and supported by BHRS MCOD Action Plan work listed under REAP goal. Specifically, the goals on foundational understanding of intersection between race, equity, and health, and having a shared culture of safety to normalize conversations about racial equity.
- In May 2023, the Health GARE Cohort hosted its annual Strategic Planning Retreat. The retreat achieved its goals of sharing updates on the REAP and

County Wide Core Equity Team progress, highlighting equity accomplishments across SMC Health, fostering cross-divisional collaboration, and identifying opportunities to expand these efforts. Discussions and brainstorming during the retreat will guide our ongoing work and inform the support provided to the Health Executive Council.

Behavioral Health Career Pathways Programs aim to recruit, hire, support, and retain diverse staff in behavioral health careers. The components include:

- Highlights:
  - Loan Repayment (refer to Criterion 5).
  - Employee Retention Bonus (refer to Criterion 5).
  - Creation of Job postings with an equity lens (refer to Criterion 5).
  - In 2023, a hiring bonus program was launched for hard-to-fill positions, offering a $15,000 incentive for eligible roles.
  - Diversity, Equity, Inclusion & Belonging Recruitment Checklist List developed and implementation started. Based on the BHRS' Multicultural Organizational Development (MCOD)framework goals, BHRS worked with the Health Administration to create a Health-wide recruitment interview "Question Bank." Additionally, BHRS collaborated to create a hiring/recruitment checklist that includes DEIB questions in a County Health hiring checklist. A pilot of the checklist will be completed next fiscal year within BHRS.

SMC BHRS Employee Equity Award: The BHRS Workforce, Education, and Training team identified the benefits of a yearly acknowledgment that honors three BHRS workforce members who have shown passion, dedication, and action to bolster practices and policies that support equitable outcomes.

Staff Celebrated for Equity Work

- Ziomara Ochoa Receives 2023 Alumni Impact Award. Ziomara Ochoa, Youth Services Deputy Director of BHRS, was awarded the 2023 Alumni Impact Award by the National Hispanic and Latino Executive Leadership and Fellowship Program. Selected for the 2022 cohort, Ochoa later mentored a 2023 fellow, contributing to meaningful change in her community and County Health.
- Dr. Jei Africa was Honored with the ACHE Regent's Award. Dr. Jei Africa, Director of BHRS, received the American College of Healthcare Executives (ACHE) Regent's Award for his significant contributions to healthcare management excellence in Northern and Central California.
- Louise Rogers Receives SMC Equity Award. County Health Chief Louise Rogers was awarded the SMC Equity Award for her leadership in advancing

diversity, equity, inclusion, and belonging initiatives within County Health, including promoting the Social and Racial Equity Action Plan and supporting inclusive hiring practices.

- Women in County Government Honors BHRS Staff at the annual Women in County Government Luncheon, two BHRS staff were recognized: Ziomara Ochoa received the Development Champion Award for her leadership in Child and Youth Services. Sandy Torres, Mental Health Counselor on the Crisis Response Team, was honored with the Public Service: Going the Extra Mile Award for her support of Half Moon Bay shooting survivors and her work on assisted outpatient treatment. These awards highlight the ongoing dedication of County Health leaders in driving equity and excellence.
- Dr. Maria Lorente-Foresti was inducted into the San Mateo County Women's Hall of Fame. BHRS Office of Diversity & Equity (ODE) Director. Dr. Lorente-Foresti was recognized for her leadership in advancing efforts to support the County's behavioral health system in advancing cultural responsiveness and inclusiveness for the individuals we serve, workforce, and community members.

Goal 2: Community Empowerment - Create opportunities for individuals with lived experience, families, and community members to engage in decisions that impact their lives. ODE has established and sought opportunities to continue to empower community members, particularly those groups who have historically been underrepresented and/or identified as vulnerable populations. ODE has a membership at various community committees, meetings, and associations to be engaged in solutions and assure voice and representation to the feedback of BHRS priorities. These empowerment activities and engagements include: The Lived Experience Academy Group, the Health Ambassadors (Adult and Youth programs), the Diversity and Equity Council, and the Mental Health Services Act Steering Committee.

- Strategy 1: Recruit, train, hire, and support behavioral health clients and family members at all levels of the behavioral health workforce.
- Strategy 2: Create, support, and enhance existing programs that build community empowerment and capacity building for behavioral health recovery and skills training.
- Strategy 3: Create opportunities for genuine shared decision-making with community members.

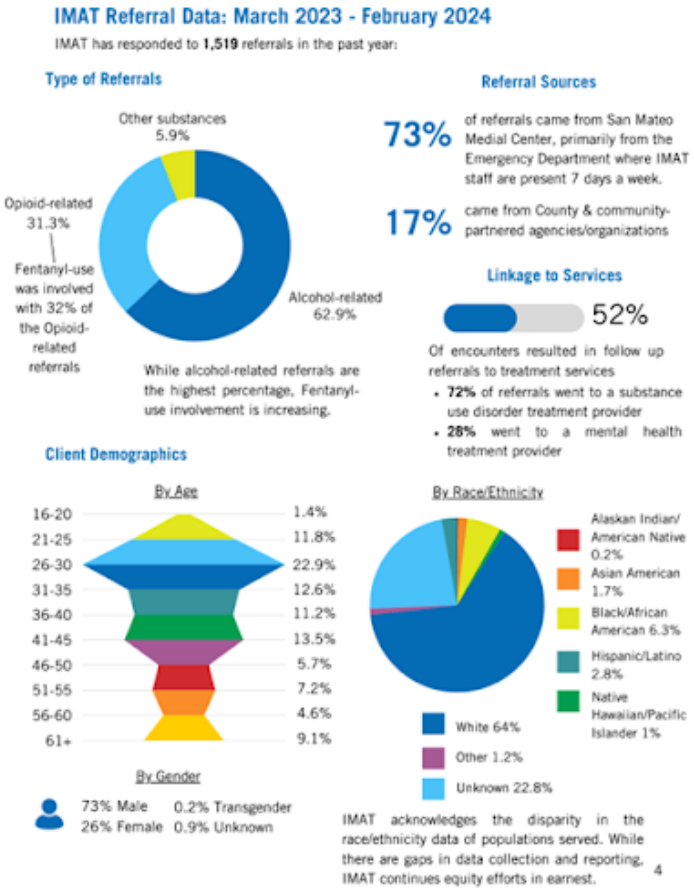
Activities and programs that support Community Empowerment:

- Health Equity Initiatives (HEIs) were created to address access and quality

of care issues among underserved, unserved, and inappropriately served communities. There are nine HEIs representing specific ethnic and cultural communities that have been historically underserved: African American Community Initiative; Chinese Health Initiative; Filipino Mental Health Initiative; Latino/a/x Collaborative; Native & Indigenous Peoples Initiative; Pacific Islander Initiative; PRIDE Initiative; the Spirituality Initiative; and the Diversity and Equity Council.

- **Alcohol and Other Drug Prevention Partnerships** exist throughout San Mateo County. These partnerships are community-based and act locally to identify and address community-level conditions that promote or encourage underage alcohol use and to reduce the harmful consequences of alcohol and other drug use. The partnerships include the North County Prevention Partnership, One East Palo Alto: Substance Abuse Prevention Coalition, Peninsula Conflict Resolution Center: North Central San Mateo Prevention Partnership, Puente De La Costa Sur: South Coast Prevention Partnership, Redwood City 2020: Alcohol and Other Drugs Prevention Partnership, San Mateo County Health System: Alcohol & Other Drug Services, and Youth Leadership Institute: Coastside Prevention Partnership.

- The Integrated Medication Assisted Treatment (IMAT) team **Expands Outreach to the Navigation Center.** The IMAT team was formed in 2015 to provide an evidence-based treatment approach for substance use disorders. The goal is to help people with addiction to alcohol and opioids find their chosen recovery path using harm reduction techniques, behavioral therapies, and medication. In April of 2023, the 240-bed Navigation Center opened in Redwood City. The goal of this state-of the-art facility is to offer shelter, food, counseling, and linkage to a variety of support services. As part of this effort to provide wraparound services, the IMAT team has been offering regular support to the Navigation Center residents.



Naloxone Distribution From January to date, 1,056 boxes of Naloxone were distributed at community events and trainings.

- Highlights
  - Community Events and Trainings programed to begin in FY 24-25, designed to increase knowledge of signs and symptoms of opioid-related overdoses and knowledge of naloxone as an opioid-reversal agent and change attitudes towards naloxone possession, distribution, and use post-training.
  - Naloxone Vending Machine Project. BHRS received Opioid Settlement Funds, plans to expand both the distribution and access to naloxone to at-risk individuals by purchasing and installing naloxone vending machines with the goal of decreasing opioid-involved overdose fatalities. These are self-service automated machines that do not collect individually identifying health information. The machines provide a short training video on how to use naloxone nasal spray. Naloxone vending machines will be installed in each of the 8 BHRS clinics (expected date 03/2025). This initiative not only improves access to this life-saving medication but also helps reduce barriers such as the stigma associated with obtaining naloxone.
  - Overdose Prevention Coalition Focus Groups in FY 24-25 BHRS in the beginning stages of coalition development. Over the past few months, the IMAT team has hosted a series of focus groups to listen to the concerns and needs of the community. This formative research and data collection will help capture the diverse viewpoints surrounding the overdose epidemic, engage key partners on this issue, and assist in developing a strategic and county-wide, community-based response.

Office of Consumer and Family Affairs (OCFA) Peer and Consumer Family Partners Program is designed to support the employment of consumer/client and family partners with lived experience within the county behavioral health system of care, which recognizes the special contributions and perspectives of consumers and family members and aids in case management as well as peer support. Peer Support Workers and Family Partners provide a very special type of expertise, 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 challenge and work collaboratively with our clients based on that shared experience.

To date, there are 13 Peer Support Workers/Peer Support Specialists and 11 Family Partners/Family Peer Support Specialists that work with BHRS. Additionally, per the CalMHSA registry, there are 81 certified Peer Support Specialists within San Mateo County.

The Lived Experience Education Workgroup (LEEW) and the Lived Experience Academy (LEA) are overseen by OCFA in partnership with the BHRS Workforce Education and Training Coordinator. The primary purpose of LEEW is to identify and engage lived experience clients, consumers, and family members to prepare for workforce entry, advocacy roles, committee and commission participation, and other empowering activities. This group consists of BHRS and contractor staff, lived experience staff, clients/consumers, and family members. The LEEW plans, facilitates, and oversees the LEA, which trains clients/consumers and family members with behavioral health lived experience to share their stories as a tool for self-empowerment, stigma reduction, and education of others about behavioral health challenges. Graduates then become part of the LEA Speakers' Bureau and per our BHRS Stipend Policy are paid $35 per hour to speak at BHRS trainings and events around San Mateo County. Their participation greatly enhances BHRS trainings and events and provides staff and the community a greater understanding of behavioral health.

- Highlights:
  - LEEW members actively participate in various BHRS committees and initiatives further connecting underserved populations to resources and support.
  - Members have continued to develop as leaders collaborating with entities outside of BHRS such as churches and libraries to create public events on their own.

The Parent Project® (PP) is a free, 12-week course for anyone who cares for a child or adolescent. The classes meet for three hours each week. Parents 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; improving grades and school attendance; dealing with unhealthy and/or dangerous behaviors in teens; and strengthening family relationships. San Mateo County BHRS' ODE began offering the Parent Project® courses in 2010 and updated the course in 2014 to become more culturally informed.

- Highlights
  - Since its inception in 2010, ODE has offered 91 courses and reached approximately 1,373 participants. During fiscal year 2021-2022, PP contractors served 110 participants across 6 classes with an average of 18 participants per class.
  - In FY 22-23, the Parent Project® Program conducted 9 classes with an average of 17 participants per class, reaching a total of 152 participants, and impacting approximately 106 children who were reported to reside with participants. We believe this impact is greater because caregivers impact more youth than those who reside in their homes.
  - In FY 23-24, only 3 classes were conducted, due to the loss of a contracted provider that supported the facilitation of this course. The average number of participants continued to be 17 per class, reaching a total of 50 participants. Almost all (96%, 26) survey respondents who completed the post-program survey reported learning about community resources while participating in the Parent Project® course. The most common resources learned about by respondents (n=26) were the San Mateo County Information Handbook (65%), Alcohol or Other Drug (AOD) services (62%), the Health Ambassador Program (62%), and StarVista services (62%). In addition, more than three-fourths (77%) of respondents reported that through the course, they have learned knowledge and skills to access behavioral health services.

Adult Mental Health First Aid (AMHFA) is an interactive 8-hour public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use challenges. Participants will gain an overview of mental illness and substance use disorders, learn the risk factors and warning signs, build an understanding of the impact of behavioral health issues, and review common treatment options. Those who take the course become certified as Mental Health First Aiders and learn a 5-step action plan encompassing skills, resources, and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care.

- Highlights
  - In FY23-24, BHRS ODE contracted with trained instructors from Kingdom Love and Voices of Recovery to facilitate courses. Course instructors provided 14 Adult MHFA courses in both in-person, virtual, and blended formats (blended virtual and blended in-person). There were 189 Adult MHFA applications submitted that collected demographic information of incoming course participants.

This was an increase from the prior FY, in which 124 participants from eight Adult MHFA classes completed at least one of the five forms.

- Participants were asked questions about mental health concepts before or at the beginning of the Adult MHFA class through the pre-program assessment ("pre") and after or at the end of the Adult MHFA class through the post-program assessment ("post"). Participants correctly identified true statements and false statements on the post-program assessment more consistently than on the pre-assessment for all assessment questions, indicating that the course effectively communicated educational material around behavioral health. In particular, there was an increase among participants in correctly identifying a misconception about mental illness and likeliness to commit violent crimes. Moreover, participants demonstrated increases in knowledge related to asking others about suicidal feelings, distinguishing a panic attack from a heart attack, and understanding common mental health disorders.

Youth Mental Health First Aid (YMHFA) is a 6–8-hour training funded by the Mental Health Services Act (MHSA) and offered by the San Mateo County's Behavioral Health & Recovery Services Office of Diversity & Equity (BHRS ODE). The program trains participants to recognize risk factors and warning signs of adolescent mental health challenges, respond to crises, and provide early intervention support. In FY23-24 (July 2023-Jun3 2024), BHRS ODE partnered with Kingdom Love to deliver 11 YMHFA courses in person, virtual, and blended formats. The training incorporates culturally relevant examples and resources, equipping participants to support underserved populations and improving access to timely care. YMHFA reduces stigma by sharing recovery stories and connects participants with local behavioral health resources to support referrals. By partnering with agencies serving marginalized groups, such as incarcerated youth, the program addresses disparities in mental health care access. With participants from diverse backgrounds, YMHF broadens community impact, empowering individuals to provide hope, support, and linkages to care for youth in need.

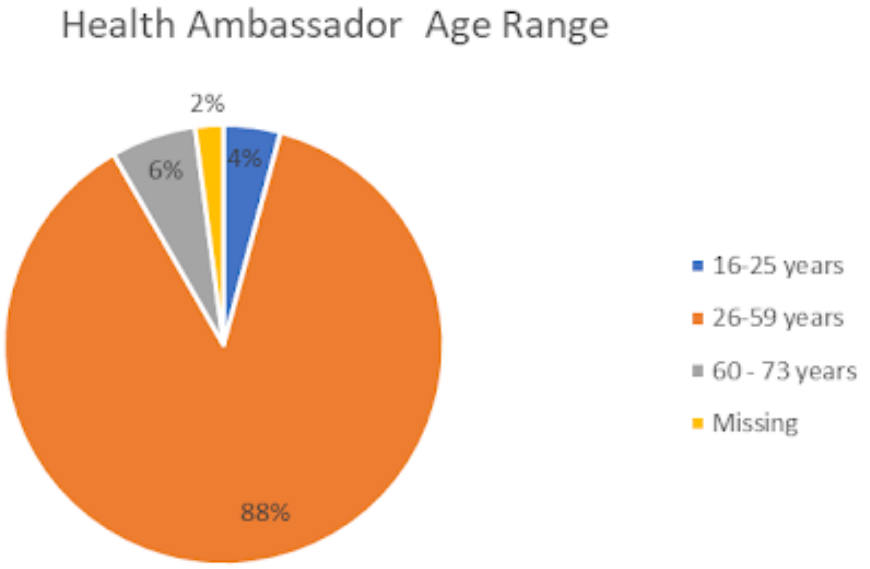
- Highlights
  - **In FY23-24, the YMHFA Program focused on expanding services to cities with significant marginalized populations and heightened support needs, including Half Moon Bay, Redwood City, East Palo Alto, and South San Francisco.**
  - YMHFA served 153 individuals this fiscal year. Among respondents, 15% (24 out of 156) reported residing in San Mateo, followed by 11% each in East Palo Alto (17 out of 156) and Redwood City (17 out of 156). Additionally, 20% (31 out of 156) identified as behavioral health services clients, family members of clients, or both.
  - YMHFA measures key ODE indicators, including Cultural Identity/Humility and Access to Services. Among participants, 85% reported a better understanding of how mental health and substance use challenges affect different cultures, while 86% felt their identity, cultural background, and experiences–including race, ethnicity, gender, sexual orientation, and religion–were affirmed by the program. Additionally, 98% of participants indicated that they gained knowledge and skills to access behavioral health services through their participation.

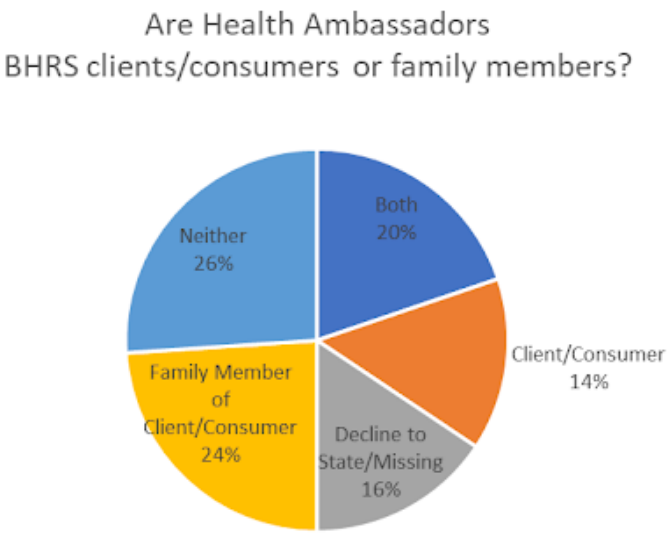
Health Ambassador Program (HAP) was developed as a response to feedback from the graduates of the Parent Project© who wanted to continue learning about how to appropriately respond to behavioral health issues and get involved within their communities and the broader BHRS decision-making processes. After completion of the Parent Project©, individuals continue to increase their skills and knowledge in behavioral health and substance use-related topics by completing 4 additional community education programs such as MHFA certification training, the 12-week National Alliance on Mental Illness (NAMI) Family to Family program, the Photovoice Course, the Applied Suicide Intervention Skills Training (ASIST), The Be Sensitive Be Brave Suicide Prevention Training and/or a Wellness Recovery Action Plan (WRAP) workshop. Health Ambassadors are also encouraged to become advocates in Stigma-Free San Mateo and be part of the BHRS Health Equity Initiatives. In this work, individuals engage in outreach, education, and dialogue with members of our communities to reach our goal of a stigma-free County and increasing access to behavioral health care. Becoming a Health Ambassador can potentially lead to opportunities to work and volunteer amongst other dedicated individuals; teach both youth and adult courses in their community; assist in identifying unmet needs in their community and help create change; or become a Community Worker/Family Partner.

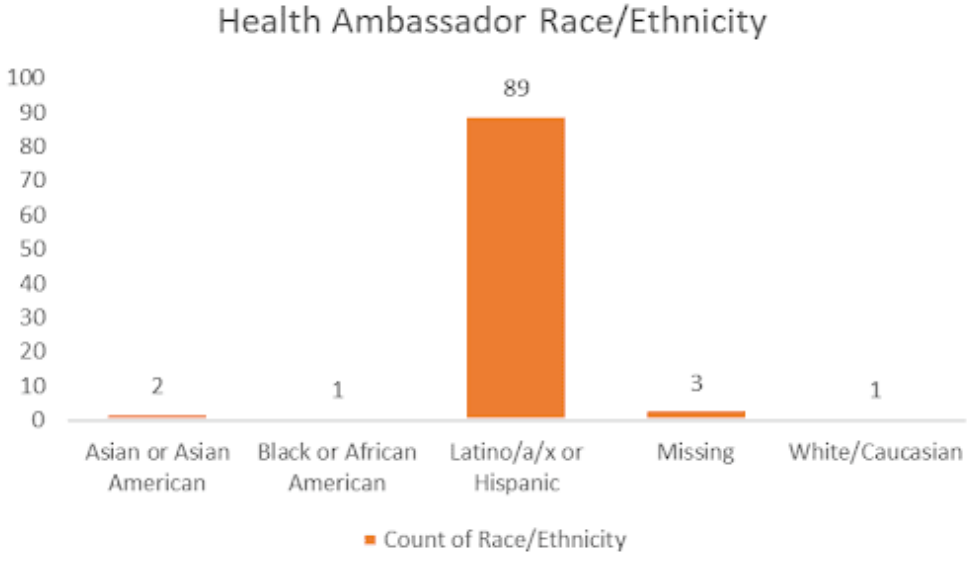
- Highlights
  - In FY 21-22, HAP regained a program coordinator and worked on a series of community events to support with COVID response efforts. Additionally, with the new program coordinator ongoing, regular HAP meetings have resumed, providing support, resources, and opportunities to our current Health Ambassadors.
  - In FY 22-23, HAP received the Tony Hoffman Award for its extraordinary impact on individuals with mental illness. During the pandemic, Health Ambassadors provided essential outreach and support. They launched multilingual campaigns, including PSAs in Spanish, Tagalog, Tongan, and Zapotec, promoted behavioral health resources, and hosted virtual community events. Ambassadors also conducted door-to-door outreach in San Mateo, East Palo Alto, Redwood City, and Half Moon Bay, distributing masks and critical resources. Their ongoing efforts in local laundromats, grocery stores, and food centers served vulnerable communities.
  - In FY 22-23, there was an increase in participation in a variety of events and interventions. There was also a focus on building the Health Ambassador's capacity to comprehensively provide BHRS information to the public and to provide information back to BHRS on the client/consumer experience, such as being part of focus groups for the MHSA 3-Year Community Planning Process and the Behavioral Health Commission on Children & Youth Services Committee.
  - Improvements in data collection also allowed for trends to be identified to better inform future activities and resources. There are currently 65 ambassadors who are active and provide varying support for BHRS services, outreach, and early interventions.
  - Working with a contractor to improve data collection & identification of trends: HAP had the opportunity to work with, a consulting group, to develop a database to track the social determinants of health of ambassadors and those that come into contact with the program- prospective Ambassadors.

- Highlights
  - HAP led work to initiate adaptation of the Cultural Humility 101 & SOGI trainings in Spanish for HAP and monolingual Spanish community members.
  - In FY 23-24, HAP celebrated the graduation of 13 new Health Ambassadors, marking the first in-person ceremony since 2019. The evening featured an awards ceremony, a program slideshow, and key highlights such as 119 unduplicated clients served, 21,000 individuals reached, 45 resource tables supported, hosting 10 behavioral health wellness training sessions, and leading 4 focus groups, including the Retired Congresswoman Jackie Speier Foundation, MHSA 3-Year Plan, Youth Commission Roadmap, and State Suicide Prevention Campaign.
  - HAP held 13 trainings, with a total of 192 duplicated participants, and 96 unduplicated.

Demographic data for participants of the Health Ambassador Program workshops & Trainings
FY 23-24







Storytelling Program emphasizes the use of personal stories as a means to draw communal attention to behavioral health and wellness. While reducing stigma and broadening the definition of recovery, workshops consider social factors such as racism, discrimination, and poverty. Participants are asked to share their stories through words, photos, drawings, personal mementos, and even music. The stories shared have been both personal and powerful, creating a sense of connection, and for others, they've been transforming. ODE continues this powerful storytelling work with Photovoice and Behavioral Health Graphic Novel creation. ODE partners with community-based organizations, schools, faith-based organizations, correctional institutions, and other sectors of the community to offer these storytelling opportunities. These stories help shed light on important social issues including stigma and empower others with lived experience to share their stories. In response to staffing shortages, this program is now offered in a limited capacity and through Health Equity Initiatives, such as the African American Community Initiative's event in May of 2021 "Hope for Change" with ODE support. The Lived Experience Academy graduates also presented and shared their experiences, by sharing the graphic novel "#BeTheOneSMC: Where there is life, there is hope" during May Mental Health Awareness Month events.

- Highlights:
  - In response to staffing shortages, this program was on hold during FY 21-22.
  - In FY 22-23, a new program coordinator was hired to support the storytelling/photovoice program. The coordinator had the opportunity to meet with the previous coordinator to understand program logistics and implementation challenges. In Fall 2023 the new coordinator received training to facilitate these sessions and began work to update program data collection tools.
  - In FY 23-24, two additional facilitators were trained in Photovoice to expand the program across BHRS and SMC. Additionally, evaluation forms, the program plan, and logistics were updated, incorporating considerations for behavioral health support and information provided throughout the course.

Outreach Workers (also known as promotores/health navigators) connect with and facilitate access for marginalized populations through culturally and language-appropriate outreach and education and provide linkage and warm hand-off of individuals to services. Outreach Workers are usually members of the communities within which they reach out to. They speak the same language, come from the same community, and share life

experiences with the community members they serve. Outreach Workers use a variety of methods to make contact and connect with the community. From group gatherings in individuals' homes to large community meetings, making direct contact with the target audiences, warm hand-offs, and conveying crucial information to provide community support and access to services. The East Palo Alto Partnership for Behavioral Health Outreach employs Outreach Workers within the Latinx, African American, Pacific Islander, and LGBTQ+ communities. The North County Outreach Collaborative employs Outreach Workers within the Chinese, Filipinx, Latinx, Pacific Islander, and LGBTQ+ communities.

MHSA Community Program Planning (CPP) process engages in ongoing community input opportunities. MHSA CPP includes training, outreach, and involvement in planning activities, implementation, evaluation, and decisions of clients and family members, broad-based providers of social services, veterans, alcohol and other drugs, healthcare, and other interests.

- Highlights:
  - The updated MHSA Three-Year Plan included the perspective of over 400 individuals including clients and family members, community members, and leaders representing diverse geographical, ethnic, and cultural backgrounds, contracted providers, County staff, and other partner agencies across health, social services, education, and other sectors.

Goal 3: Strategic Partnerships - Strengthen and create new meaningful partnerships in the community to maximize reach and impact on equitable behavioral health outcomes.

- Strategy 1: Create and sustain partnerships that build on shared lived experience, cultural identities, and/or geographical service areas.
- Strategy 2: Create programs and partnerships that advance an effective model of integration of mental health, physical health, and substance abuse services.
- Strategy 3: Create and enhance partnerships with key non-traditional stakeholders.
- Strategy 4: Develop a communication plan focused on the impact and urgency of behavioral health equity work to strengthen the community, including non-traditional partners, buy-in, and engagement in the work.

Activities and programs that support the Strategic Partnership:

- Diversity and Equity Council (DEC) and the Health Equity Initiatives (described in Goal 2 above) are made up of BHRS staff, consumers, contracted providers, community leaders, and members and work to

ensure that topics concerning diversity, health disparities, stigma reduction, 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 state-mandated Cultural Competence Committee.

Alcohol and Other Drug Prevention Partnerships (described in Goal 2 above).

- Partnerships with San Mateo Medical Center Federally Qualified Health Center (FQHC) allow for collaboration with FQHC's to identify patients presenting for healthcare services that have significant needs for mental health services. Ravenswood FQHC provides a means of identification of and referrals for the underserved residents of East Palo Alto with Serious Mental Illness (SMI) and Emotional Disturbance (SED) to primary care-based mental health treatment or specialty mental health services.
    - Highlights:
        - 386 total clients served

Primary Care Interface focuses on identifying persons in need of behavioral health services in primary care settings, thus connecting people to needed services. BHRS clinicians are embedded in primary care clinics to facilitate referrals, perform assessments, and refer to appropriate behavioral health services when deemed necessary.

- Highlights:
    - Is now embedded in five primary care clinics throughout the County.
    - 617 unduplicated individuals were served in San Mateo County.

Community Outreach Collaboratives (Described in Goal 2 above) are based on the key model of community-based organization collaboration. Strong collaborations with local community-based agencies and health and social service providers are essential for cultivating a base of engaged community members. Organizations leverage their influence, resources, and expertise, especially in providing services that address the 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. North County Outreach Collaborative populations of focus are Filipinx, Pacific Islander, Latinx, Chinese, and LGBTQ+ communities. East Palo Alto Partnership for Behavioral Health Outreach's population of focus are marginalized ethnic, linguistic, and cultural communities in the region including Latinx, Pacific Islanders, African American/Black, and LGBTQ+ communities of all ages.

- Highlights:
  - In 2022-2023
    - North County Outreach Collaborative served 4,573 clients.
    - East Palo Alto Partnership for Behavioral Health Outreach served 946.

The Pride Center: LGBTQ+ individuals are at increased risk for behavioral health challenges given their experience with stress related to subtle or overt acts of homophobia, biphobia, and transphobia, and as such, need access to service providers and resources that are reflective and sensitive of their experiences and needs. The center is a collaboration of multiple agencies that will work to assist high-risk LGBTQ+ individuals through peer-based support, with the goal of becoming a centralized resource for behavioral health services. The center promotes interagency collaboration, coordination, and communication, which will lead to increased access to behavioral health services among LGBTQ+ individuals, and ultimately, improved behavioral health outcomes.

- Highlights:
  - The first in-person therapy group since the pandemic was held and it was a Multisexual Therapy Group that helped reduce multisexual stigma and increased pride among participants.
  - Counseling services were offered as well as training and education, outreach, peer support groups, and hosted a number of events.
  - In FY 23-24:
    - The Pride Center served 147 clients and 12,287 individuals
    - The Legal Name and Gender Change Workshop served 82 individuals, with 100% reporting being “very Satisfied” with the workshop.
    - In partnership with Outlet, the center made over 800 points of contact with the community, fostering a supportive and inclusive environment for queer youth and their families/support networks.
    - Held 4 SOGIE 101 training sessions for BHRS staff, training 105 individuals.
    - Served 677 individuals through the Pride Center Peer Support Groups.
    - Tabled at 39 in-person events and interacted with 3,217 community members.

Goal 4: Policy & Systems Change - Influence organizational-level policies and institutional changes across San Mateo County agencies to positively impact behavioral health outcomes.

- **Strategy 1:** Identify policies, practices, and systemic changes needed to become a genuinely multicultural organization.
- **Strategy 2:** Identify key outcome indicators for behavioral health equity including internal policies and practices.
- Assess, prioritize, and implement the National CLAS Standards across the department and contracted agencies.

Activities and programs that support the Policy & Systems Change:
Multicultural Organization Development (described in Goal 1 above)
Government Alliance on Racial Equity (described in Goal 1 above)
Cultural and Linguistic Appropriate Services (CLAS) Implementation

- Highlights:
  - CLAS requirements in all contracts: As described in Criterion 3, Contractor Requirements, in 2012 ODE developed benchmark criteria for all BHRS contractors that provide client services to develop and submit cultural competence plans that focus on improving the quality of services and advancing health equity.
  - Language Access Services (Refer to Criterion 7) includes translating materials in threshold languages Spanish, Tagalog, and Chinese, a language line that is available 24/7 for over-the-phone interpretation services, and a process for scheduling in-person language interpreters including ASL.

Criterion 4: County Mental Health System Client/Family Member Criterion

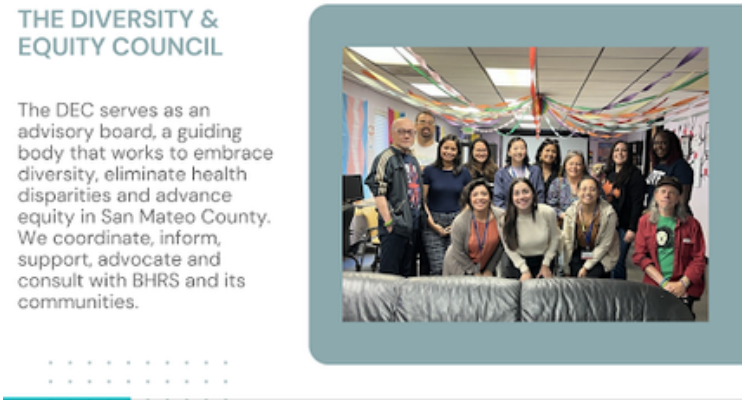
Diversity and Equity Council

Criterion 4: Describe the exchange of information within different levels of the organization as well as between the organization and the community, target population, and partner organizations.

a. Policy and procedure regarding Cultural Competence Committee and how it reflects community, management and line staff
b. Organizational chart, list of cultural competence committee members and affiliation to cultural competence
c. Can include advisory committee(s) to the CCC

The Diversity and Equity Council (DEC), one of our Health Equity Initiatives, works to ensure that topics concerning diversity, health disparities, and health equity are reflected in the work of San Mateo County's behavioral health services. The Council serves as an advisory board to assure San Mateo County BHRS policies are designed and implemented in a manner that strives to decrease health inequities and increase access to services. The formation of the DEC can be traced back to 1998 when staff members formed the state-mandated Cultural Competence Committee.

This committee later became the Cultural Competence Council in 2009, which played an integral role in the formation of the BHRS Office of Diversity and Equity. The DEC has been involved in many of the opportunities to bring discussions of cultural humility in our work.



It also serves as the umbrella of the HEIs, co-chairs of the other initiatives, and members are encouraged to attend the DEC to receive new resource information, to view presentations about County and BHRS initiatives as well as presentations that include data that pertains to health disparities in behavioral health. The DEC is made up of BHRS staff, clients, family members, contracted providers, community leaders, and members and works to ensure that topics concerning diversity, health disparities, stigma reduction, and health equity are reflected in the work of SMC BHRS. The DEC encourages the participation of consumers/clients and family members by providing stipends or honorariums for ongoing participation. The DEC also serves as an umbrella organization for the HEIs, encouraging HEI co-chairs and members to attend and benefit from the aforementioned activities in addition to increased networking opportunities, insights into work happening across other HEIs and throughout the county, and, most importantly, hearing directly from providers, individuals we serve, and their family members.

Mission, Vision & Objectives

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

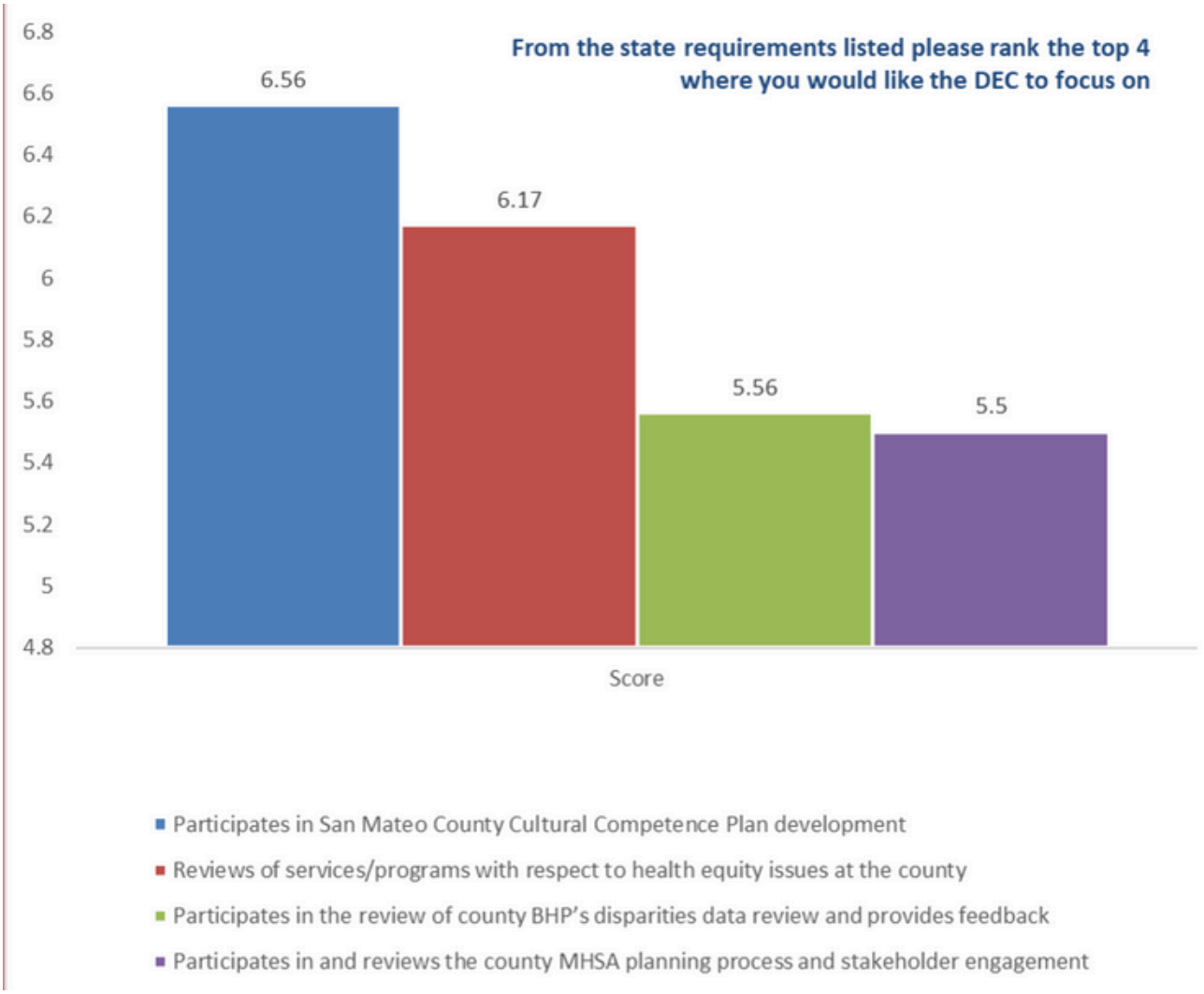
- a space for collaboration and guidance for the Health Equity Initiatives.
- a forum for cultural competence questions from community-based organizations.
- a hub of information and resources for community members committed to advancing equitable behavioral health care.

The council currently has 143 members, 52% are BHRS or County staff, 35% represent Community-based Organizations and 7% identify as community members, 6% are HEI members or others. The average number of attendees per virtual meeting is 24.

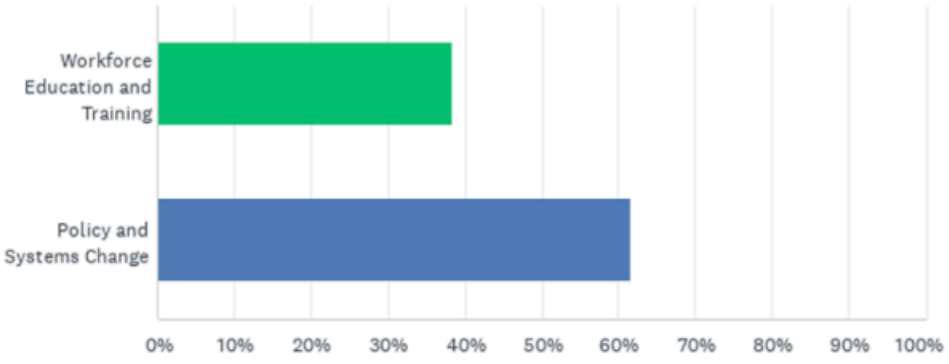
Highlights and Accomplishments

Some of the highlights from this year include working with The County's Office of Racial and Social Justice to provide input on the SMC Equity Ordinance that passed in May of 2024 and will be implemented in January 2025. The input that was gathered directly affected the ordinance and members were able to reassure the importance of the ordinance as well as the type of changes and activities that should be supported by the county Board of Supervisors to continue our journey towards a more equitable County. With the input of members and the support of the community, this ordinance was successfully passed. Another highlight was providing feedback on divisional policies regarding the integration of Peer Support Workers within BHRS. Another highlight was working with a CSIP intern who led an introspective project that allowed the membership to grow closer and learn more about each other and what brought this diverse group of people to the behavioral health field. Finally, the DEC is looking forward to implementing its HEI strategic work plan this upcoming year. Below are the areas that were prioritized by DEC members during our strategic plan development.

DEC Member's Priority Areas Reported Over the Fiscal Year



If you had to choose one area to prioritize for immediate action, which would it be?



More broadly, the DEC also serves to reinforce the role of the DEC as a part of policy and systems change, and strengthens the exchange of information between the DEC, QIC, and the HEIs and the Director.

Health Equity Initiatives

Health Equity Initiatives (HEIs) were created to address access and quality of care issues among underserved, unserved, and inappropriately served communities. HEI representatives attend the DEC to ensure cross-sharing and learning, collaboration, bring forward concerns and issues from San Mateo County's most marginalized communities, and brainstorm systemic solutions. Each of the HEIs addresses health disparities, inequities, and stigma by working collaboratively to bring together behavioral health professionals, clinicians, organizations, and stakeholders on a regular basis to provide outreach, programs, and advocacy toward meaningful solutions for communities.

Eight HEIs are representing specific ethnic and cultural communities that have been historically underserved:

- African American Community Initiative (AACI)
- Chinese Health Initiative (CHI)
- Filipino Mental Health Initiative (FMHI)
- Latino Collaborative (LC)
- Native & Indigenous Peoples Initiative (NIPI)
- Pacific Islander Initiative (PII)
- PRIDE Initiative (PI)
- Spirituality Initiative (SI)

HEIs implement activities that are intended to:

- Decrease stigma
- Reduce health disparities
- Increase access to culturally informed quality care
- Support workforce development
- Educate and empower community members
- Support wellness and recovery
- Build culturally responsive services

Previous to 2020, the HEIs were managed by a Senior Community Health Planner who held a limited-term position and whose time with ODE ended due to the specifications of the contract.

After that, the ODE Director took over management of the HEIs while thrust into emergency response due to the COVID-19 pandemic and social unrest. The members, co-chairs, and staff were greatly impacted by the COVID-19 pandemic not only professionally but also personally as each person was confronted with many layers of grief. In 2022, there was another HEI coordinator hired who was able to take on the transition from emergency response to returning to more standard work. In mid-2023, a permanent Program Coordinator II was brought onto the team and has supported the HEIs in a number of ways, including co-leading the HEI strategic work plan development, supporting the various events as well as creating change in policies and practices that optimize administrative processes.
The HEIs continue to face challenges in recruiting county staff members to serve as co-chairs, reportedly due to capacity constraints and workload demands. The current Program Coordinator serves as the interim co-chair of both the Latino/a/x Collaborative and the Pacific Islander Initiative. During the last year, 1,262 clients were reached through meetings, and 7,617 were reached through trainings and events. The HEIs also worked collectively to improve outreach materials by updating initiative-specific brochures to be distributed during community events and activities.

HEI Highlights for FY 23-24
African American Community Initiative (AACI)

AACI held two events this past year which included the Black History Month and Juneteenth celebrations. Throughout the past few years, AACI has sought to foster deep relationships and connections among its members. Each of the events hosted included art, centering on community and resources, and health screenings from African American Medical Residents from Stanford University. Additionally, the initiative brought to the attention of the ODE and BHRS director the lack of African American Clinicians within our organization. Through numerous meetings and collaborations, these dialogues led to numerous system changes in our hiring and recruitment efforts, which were supported by our Health Chief. Specifically, BHRS leadership launched its first culturally informed recruitment brochure, where experience and knowledge of working with African American community members were highlighted. Additionally, the list of recruiting sites where the organization places job postings was expanded to include more diversity. Our ODE team also supported our hiring managers in having a question bank of DEIB questions and encouraged diversity (race/ethnicity, gender, LGBTQ, discipline) on all hiring panels. This work led to going from one African American clinician in 2022 to nine in May of 2023! AACI also hosted two trainings, Putting Hands on.. Intimate Partner Violence in Black/African American Community and Evidence-Based Practices.

Chinese Health Initiative (CHI)

CHI held a Lunar New Year in-person meeting alongside a number of workshops including “What I Wished My Parents Knew about Mental Health” workshop in collaboration with the Chinese Community Association of Belmont, Redwood Shores, and San Carlos as well as "Love Does Not Hurt: Domestic Violence Awareness Seminar" workshop conducted by CORA and Star Vista. The initiative also hosted a training on ***Mentorship as an Intervention.*** They were able to take proactive steps and launch a survey for their membership where they gathered feedback on different workshop topics to offer and gather information on current membership needs.

Additionally, they advocated at the March 2024 Board of Supervisors meeting for more awareness of the Chinese Community, they also engaged with North East Medical Services (NEMS) as advisory members for their Music Therapy program (MHSA Innovation). Furthermore, the initiative co-chairs and a long-time member, spoke on Sing Tao Radio Mandarin Channel on youth behavioral Health, CHI offerings and programs, and suicide prevention.

Filipino Mental Health Initiative (FMHI)

This year FMHI focused on creating more in-person opportunities for members and the broader community to gather, connect, and share resources. During Kapwa Soul Sessions that took place during Filipinx-American History Month and May Mental Health Month, they were able to integrate culturally-affirming practices including storytelling, mindfulness practices, and learning about resources. They also were able to create space during these sessions to discuss the socio-political and global stressors that have impacted marginalized communities. This year was focused on creating safe and brave spaces for folks to dialogue about distressing issues while also promoting diverse behavioral health support options.

FMHI supported the Alliance for Community Empowerment (ALLICE), a Filipino American anti-domestic violence advocacy group, during its 20th Anniversary Gala. This year, the initiative also began planning the 2024 Summer Youth Summit, a culturally attuned and affirming space for Filipinx/a/o youth ages 14-24. The summit will offer experiential workshops and activities focused on behavioral health & wellness, leadership development, career exploration, and ethnic studies. Additionally, FMHI collaborated with the SMC Board of Supervisors to support a proclamation recognizing Asian American, Native Hawaiian, and Pacific Islander Month.

Latino/a/x Collaborative (LC)

Over the last few years the LC has increased its focus on community input and becoming a hub for information sharing, as well as building a broader membership base. They have had growing consistent attendance and have also participated in a number of tabling opportunities, as well as hosted a successful Sana, Sana, 10th anniversary event in South San Francisco as well as a Cesar Chavez event in collaboration with Voices of Recovery.

These events provided BHRS resources, health screenings, workshops culturally relevant artistic expressions, and keynote speakers to share messages around wellness and resiliency. They also continued to have guest speakers offer additional educational and health resources as well as promoted cultural humility opportunities, implemented language access, and supported members in learning about behavioral health services (eg: KARA, BHRS ACCESS Call Center, Suicide Prevention, etc) during monthly meetings. This work was reinforced outside of regular meetings with the LC encouraging membership to attend community trainings such as Applied Suicide Intervention Skills Training (ASIST). During Hispanic Heritage Month, they were honored with a Proclamation and had the opportunity to present on Hispanic Heritage for the first time to the City of Belmont.

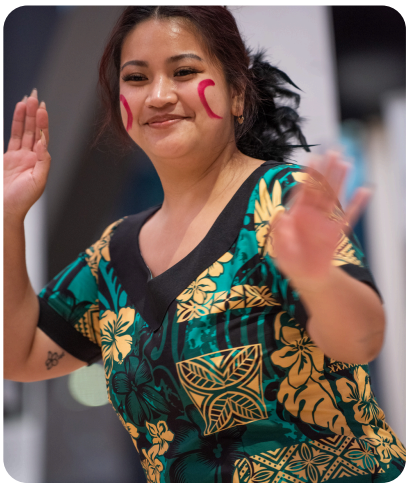
Native Indigenous Peoples Initiative (NIPI)

The highlights from NIPI include hosting a Native Heritage Month event, and a Native Heritage gathering as well as continuing to increase awareness of the prevalence and risks of behavioral health challenges in Native American/Indigenous communities & the barriers to seeking treatment.

NIPI also provided a workshop using Sound Bath in a clinical setting as well as medicinal drumming to best meet the needs of the community. Additionally, they are working on a project that teaches the differences between community-defined and evidence-based practices (EBPs). NIPI offers opening blessings of the four directions at events and gatherings for all of our HEIs and BHRS, while also tending to a medicinal garden and NIPI space within the SMC Phoenix Garden. This space has become a gathering place for the initiative, hosting ceremonies and meetings throughout the year. In addition to fostering community, it serves as a place of stewardship, where we care for the land and provide education on wellness.

Pacific Islander Initiative (PII)

The Pacific Islander Initiative (PII) has remained committed to reducing stigma and increasing awareness and resources around behavioral health and suicide prevention within Pacific Islander communities. Over the past year, PII supported key events such as the Sister to Sister: Ride with the Waves Leadership Conference and the Be Sensitive, Be Brave Suicide Prevention training, helping disseminate BHRS resources and access information. The initiative's co-chairs, in collaboration, were honored with the AANHI Heritage Month proclamation from the SMC Board of Supervisors.



PII also hosted the Journey to Empowerment: Arts and Voices Exhibit and supported community-focused events, including the 5K Turkey Trot, Pacific Islander Wellness Gathering, and Essence of Mana Village Walk, where participants engaged in wellness activities and learned about SMC behavioral health resources. In 2023, the initiative experienced leadership transitions, with new leadership from Samoan Solutions stepping in. The initiative is still seeking a second co-chair, with the HEI Coordinator serving as interim co-chair. To ensure sustainability, PII has worked to establish systems of operation and promote opportunities for data collection through community input. These efforts reflect their ongoing dedication to empowering the Pacific Islander community and enhancing access to behavioral health resources.

Pride Initiative (PI)

The Pride initiative has seen great growth throughout the last few years with such high community and local government official support of the Pride Parade and Celebration. This event, the largest of its kind in San Mateo County, offers attendees access to BHRS information and resources. Featuring over 30 resource tables, it showcases local community-based organizations providing information on social supports. As the Bay Area's largest sober, pet- and family-friendly event focused on behavioral health, it plays a vital role in reducing stigma, promoting wellness resources, and offering opportunities for health screenings. The event continues to grow, and reach diverse community members within the LGBTQ+ population including transgender men/women, gender non-conforming, and gender non-binary folks as well as more representation of race/ethnicities. Additionally, this initiative has changed its agenda to also include program presentations from community-based organizations, to learn what LGBTQ+-oriented services are available in the community. The initiative also collaborates with the LGBTQIA+ Commission, the Pride Center, CoastPride, and other community organizations to honor Transgender Day of Remembrance. This event featured an altar, a reading of the names of transgender individuals who have been murdered and served to raise awareness, reduce stigma, and share BHRS resources.

Spirituality Initiative (SI)

SI continued to provide support to its members, as well as held a number of events including Healing Connections Open Mic, as well as the Annual Interfaith Day of Prayer for Behavioral Health, and hosted a, “Telling Our Own Stories” training that focused on recovery as a spiritual journey. They also had monthly presenters as well as opened and closed each of their meetings with a healing poem, prayer, or wellness quote. The SI also continued to work closely with CBOs as well as continued to ensure that consumer perspective is incorporated in initiative leadership. The initiative collaborated with the San Mateo County Office of Equity and Social Justice to host an anti-hate webinar titled Honoring Our Shared Humanity: Countering Islamophobia and Antisemitism. Additionally, the initiative supported numerous events by providing tabling, resources, and BHRS support.

Community-Informed Culturally Responsive Improvement Process

This process was created in 2018, and throughout the years has been used on a wide variety of issues that are reported by community members, and then action is taken by ODE. It was designed to make culturally responsive improvements to the greater behavioral health system. It also serves to reinforce the role of the DEC as a part of policy and systems change and strengthens the exchange of information between the DEC, QIC, the HEIs, and the BHRS Director. This exchange of information then leads to continuous quality improvement of services. A wide range of issues have been addressed using this model including, creating spaces for mothers and families in the county to process, response efforts including supporting parents, youth, and a local school after one of the students died by suicide. ODE and HAP provided onsite support to school staff and Latinx families following the incident including to the mother that lost her child. This work led to families impacted wanting to become Health Ambassadors and continue their learning and involvement with BHRS. Additionally, San Mateo County was struck with another tragedy that involved a response to a mass shooting incident in Half Moon Bay. The ODE team and Director provided guidance on a culturally informed response for Latinx and Chinese communities, addressing behavioral health needs, language access, appropriate housing, and ongoing support services. The ODE Director assisted in coordinating a collaborative response including various departments, community-based organizations, and Stanford.

Criterion 5: County Mental Health Plan Culturally Competent Training Activities

Criterion 5: Describe the organizations efforts to ensure that staff, and service providers have requisite attitudes, knowledge, skills, ability to deliver culturally competent services

a. Narrative summary of steps taken to provide cultural competence trainings to staff in last 3 years
b. List of CCC goals, objectives, activities, trainings and learning series Analysis of effectiveness of CCC trainings such as pre/post test results

Trainings in the area of cultural humility are designed to reduce health disparities in our community, provide instruction in culturally and linguistically competent services to improve services, increase service access, and build capacity and understanding by partnering with community groups and resources. Trainings are also created and implemented by the Health Equity Initiatives.

A number of trainings were implemented by the Health Equity Initiatives, including:

- Putting Hands on… Intimate Partner Violence in Black/African American Community
- Evidence-Based Practices
- Mentorship as an Intervention
- Cultural Humility 101
- Sound Bath in Clinical Settings
- Be Sensitive Be Brave

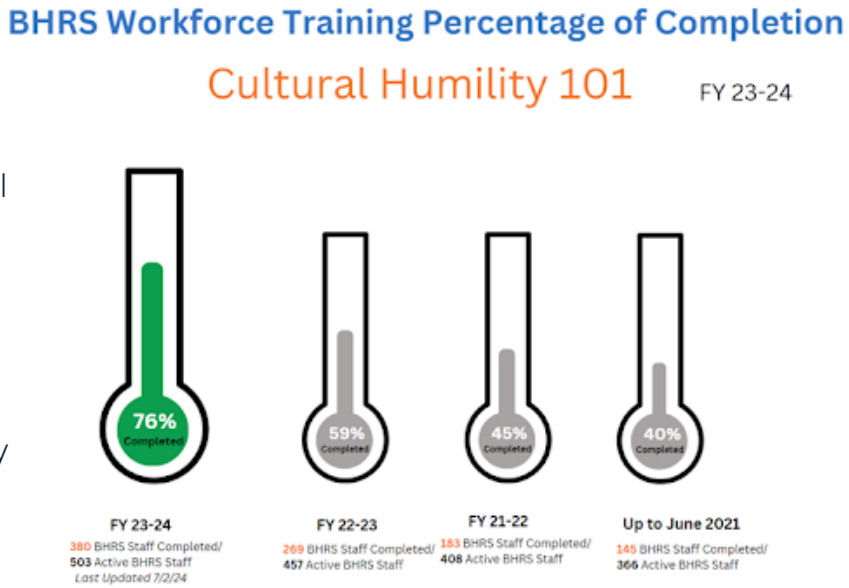
The Workforce Education and Training (WET) Team of the Office of Diversity & Equity provides programs that build the capacity of the workforce, community providers, and consumers and family members primarily through training/education/development. It is imperative for underserved, marginalized community members and populations to have timely access and links to services provided by the county and for our workforce to be skilled in culturally responsive and trauma-informed practices. These communities include ethnic/racial communities, community members with limited English proficiency, and members of the LGBTQ+ communities. However, there are sometimes barriers that may hinder the timely access to services. Some of those barriers might include a lack of language services, issues around cultural humility, lack of knowledge of trauma-informed care practices, and/or recovery as a lifestyle. WET activities help to reduce stigma and discrimination by training providers and community members. Most workforce education activities have an indirect impact however, without it, members of the community may suffer a 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 services. The WET department tracks two important equity measures

(1) Percent of staff that have taken at least 3 Harvard Implicit Association Tests

(2) New staff members being trained in Cultural Humility 101 within the first 90 days of employment.

Cultural Humility 101 Training



All BHRS staff are required to complete Cultural Humility 101 as per our Policy 18-01: Cultural Humility, Equity, and Inclusion Framework established in February 2018. Since 2017, 759 BHRS staff have completed the Cultural Humility Training. Dr. Melanie Tervalon previously delivered a system-wide 3-hour training on Cultural Humility. These trainings are now provided by the Cultural Humility Community of Dialogue Cohort (CHCOD). A biyearly intensive Training of Trainers (TOT) was completed in the 2022-2023 fiscal year to expand the pool of trainers with 5 new members that include both BHRS and contract staff. The TOT format and materials were updated during fiscal year 21-22 to include more current information and activities, with the guidance and support of Dr. Melanie Tervalon. There was a significant increase in training participation from 94 in FY 21-22 to 171 in FY 22-23 to 321 in FY 23-24. With our Health Ambassador Program, the CHCOD also created a subcommittee in 2023 to begin working on the Spanish adaptation of our CH 101 curriculum, with the intention to pilot the course next fiscal year.

Working Effectively with Interpreters in a Behavioral Health Setting

Since the inception of this training in 2010, BHRS has trained a total of 455 staff. There has been a slight decrease in the number of staff that have been able to take this training due to a change in training provider in FY 23-24. New staff are informed of the requirement to attend “Working with Interpreters in a Behavioral Health Setting” during New Hire Orientation.

Fiscal Year	Cultural Humility 101 (# of participants)	Working Effectively with Interpreters (# of participants
2021-2022	94	74
2022-2023	171	46
2023-2024	321	0 (refer to Criterion 7)

Challenges

Some challenges with the trainings have been facilitator availability, staff engagement, and Zoom fatigue. The Cultural Humility Cohort often troubleshoots to find ways to engage the staff deeply with the material including the addition of mixed media such as videos to the training. Investing in the Training-of-Trainers (TOT) was crucial to ensuring more people are able to train staff. This upcoming fiscal year the cohort will be focusing on updating data collection tools e.g.: pre and post-tests for this training and continue the transition to hosting trainings in person. There were previously several staffing challenges within the WET team, but with the recent hiring of a Director and training support staff, they are now able to collaborate with the team to ensure the successful coordination and delivery of trainings. In addition, a guide for participants taking virtual trainings was developed using the principles of Cultural Humility as a foundation. The Cultural Humility Group started work at the end of this fiscal year to prepare for another TOTs for next FY.

Cultural Humility 2.0 Training

A team of Cultural Humility trainers and the ODE Director have come together to collaborate with Dr. Melanie Tervalon to create and launch Cultural Humility 2.0. This new training will focus on reviewing the framework of cultural humility and additionally allow participants to practice their skills, implement the skills in their professional interactions, learn about each other through interactive activities, and continue their lifelong learning. This training is currently being developed and we are hopeful for a 2025 launch date.

How to be an Effective Interpreter Training

This interpreter training (focused on behavioral health needs) continues to be inactive due to contractual challenges with language providers, the greatest challenge being that BHRS would have to cover the cost for all interpreters' time to take this training. In 2023, approval was granted by one of our language assistance services providers to add an introductory document/information on BHRS to their existing compliance checklist for interpreters. Specifically, for our in-person interpreters, this would allow them to become familiar with SMC practices prior to being scheduled and attending an interaction with a BHRS client. This will be implemented in FY 24-25, as the BHRS Language Access Liaison continues to work closely with County language contractors to adapt their practices to the behavioral health setting.

Sexual Orientation and Gender Identity Training

BHRS ODE rolled out the Sexual Orientation and Gender Identity (SOGI) training and data collection tools in 2017. Since then, this work has continued to be important in collecting baseline data and being able to analyze gaps that could then lead to a reduction of health disparities experienced by LGBTQ+ folks by normalizing conversations about aspects of their identities that have a direct impact on their health. Currently, this work is supporting the standardization of how information is collected to better serve our LGBTQ+. The population assessment highlights significant health disparities affecting LGBTQ+ individuals. Through this training, we aim to enhance the inclusivity and quality of services while improving data collection and analysis to identify and address existing gaps.

Fiscal Year	SOGIE (# of participants)	Implicit Bias(# of participants
2021-2022	140	357
2022-2023	123	44
2023-2024	105	69

Implicit Bias Training

As part of our MCOD work and staff feedback, this training was created and rolled out in collaboration with a partnering organization in FY 21-22. This training was also part of our BHRS equity metrics. These trainings help staff identify implicit biases and how they affect interactions and communications with others. During the training they also explore personal biases using the Harvard Implicit Bias Test and then discuss the influence of biases on their work. Opportunities for these trainings are also being extended via the DEC, as part of their identified strategic goals to advance workforce education and development. The DEC is working closely with the WET team to provide implicit bias training opportunities in FY 24-25, and in this way also support BHRS' contracted providers in meeting their annual cultural competence training requirement.

Difficult Conversations Training

Another training topic under development was reported as a need by BHRS staff and is focused on having difficult conversations in the workplace. In 2024, the ODE team began working collaboratively on developing and preparing to roll out a new training around holding difficult conversations for the BHRS workforce. This training aligns with the BHRS Multicultural Organization Development Plan (MCOD) and will be delivered through an equity- and trauma-informed lens. The training is designed to equip workforce members with skills and strategies to navigate challenging conversations which include DEIB components with clarity, cultural humility, and professionalism. Attendees will learn concrete, step-by-step approaches to identifying potentially difficult conversations and effectively understanding, preparing for, and conducting them. Upon completing the training, participants will gain skills to enhance communication effectiveness, promote understanding, incorporate cultural considerations, and foster a more harmonious work environment. The training will be available to the workforce at the end of FY 24-25.

Cultural Considerations: Responding Multi-Culturally with CLAS via Cultural Complexities in Assessment, Diagnosis and Engagement

As part of its MCOD and CLAS initiatives, the WET team worked to secure this training in response to the increasing need for behavioral health providers to effectively navigate cultural complexities in clinical practice. Successful behavioral health outcomes rely on accurate clinical assessment, diagnosis, treatment planning, engagement, and service delivery. As the diversity of communities seeking services continues to increase, providers must be equipped to navigate these complexities from the start of clinical

engagement. This training presents a cultural framework designed to help clinicians systematically address the unique needs of individuals, families, and communities, ensuring a more effective and culturally engaged approach to assessment, diagnosis, and treatment planning.

Race, Health, and Equity Training

This training was implemented in 2019 and in 21-22, the training had been taken by 951 health workforce members. This training is brought to us by the Health Government Alliance on Race and Equity (GARE) cohort. This cohort is part of a greater national network of government working to achieve racial equity and advance opportunities for all. The training covers structural racism, the history of the US, and how it affects racial inequities, as well as where we go from here. A 21-Day Racial Equity Challenge was also launched to accompany this training, this challenge has been hosted 4 times and had 36 participants.

Fiscal Year	Race, Health and Equity (# of participants)
2021-2022	416
2022-2023	250
2023-2024	29

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Additional Trainings

The GARE Race, Equity, and Health Training provides a space to deepen our collective understanding of the roots and consequences of racism. Post-training evaluations from FY 23-24 show that 90% of health workforce members increased their understanding of existing inequities and the role of racism as a cause. Additionally, 62% reported greater comfort discussing racial equity, and 82% gained new knowledge about resources and training options. The 2024 GARE survey revealed that 92.7% of health respondents found racial equity training and workshops useful, while 97.4% reported feeling comfortable talking about race. As a follow-up to this training, the 21-Day Challenge was created. It addresses the critical issue of racial equity, with all challenge content available virtually. The goals of the 21-day racial equity

challenge is to: deepen understanding of racism, privilege, and equity; engage in meaningful conversations about racism and equity in the workplace; and foster actions, perspectives, and collaboration that accelerate progress toward racial equity in our workplace. BHRS ODE and the HEIs supported two 21-Day Challenges: one in observance of Native American Heritage Month and another during Pride Month.

In Fiscal Year 2023-24, BHRS also supported the development and launch of a new pilot training for BHRS and Aging and Adult Services managers and supervisors titled **Guidance and Training for Supervisors and Managers: Supporting Staff Amid Implementation of SMCH Policy A-44.** This training emerged from a comprehensive process involving Health staff and focus groups aimed at understanding experiences of racism and intersecting biases faced by employees while working in the community or with clients. The findings led to a series of recommendations, including the need for structured guidance and training to help supervisors, managers, and colleagues effectively support staff when such incidents occur. The pilot training is designed to inform the broader implementation of this training across Health. Its goal is to foster a shared culture of safety where conversations about racial equity are normalized, and staff feel empowered to speak up, seek support, and collaboratively address challenges. This effort is part of ongoing work to create an equitable, inclusive workplace that prioritizes belonging and continuous improvement. In the first, month 44% BHRS staff were trained with more training opportunities programmed for next FY.

San Mateo County Office of Equity and Social Justice All Staff Trainings: The County's commitment to equity is reflected in its comprehensive countywide training initiatives. These programs are designed to deepen understanding of key equity concepts and promote more inclusive practices across all County operations. In FY 23-24, County staff had the opportunity to participate in the Foundational Equity Training: Cultivating More Equitable and Inclusive Communities. Supported by the County Executive, this training aimed to establish a shared understanding of equity and create conditions that advance equity in every aspect of County work. Looking ahead, the Office is preparing to roll out a new training, Advancing Equity: Understanding Sexual Orientation, Gender Identity, and Expression. This program will equip staff to engage clients and colleagues with dignity and respect, fostering a culture of inclusivity. Additionally, the Office has introduced the Equity and Belonging: Fundamentals Learning Badge to encourage staff to participate in other DEIB (Diversity, Equity, Inclusion, and Belonging) training opportunities across the County.

Criterion 6: Describe the extent to which the agency and its members participate in the community as well as what degree the community are actively engaged in agency activities.

a. MHSA workforce assessment (ie staffing classification and bilingual capability)
b. Analysis of workforce assessment and compare with general population (census, medical, poverty)
c. Summary of how we will target and grow a multicultural workforce in the future

Criterion 6: County Mental Health Systems Commitment to Growing a Multicultural Workforce

Behavioral Health Career Pathways Efforts

The Multicultural Organizational Development (MCOD) is an organizational change framework utilized by BHRS to advance equity, diversity, and principles of cultural humility and inclusion in the workplace. The past three years have been dedicated to building a better infrastructure and updating the MCOD action plan to include trauma-informed practices to support the advancement of this framework. In FY 22-23, a new Program Coordinator was brought on board to support MCOD implementation and progress. Their primary focus was to build staff engagement and meet with previous Executive Sponsors of the work to understand the success and challenges of implementing the original MCOD Plan activities.

Staff engagement opportunities included an “MCOD Tour” relaunched and updated in 2023 to reintroduce the MCOD purpose, plan and discuss current needs with BHRS workforce. The anonymous evaluations conducted during these presentations provided key information to understand workplace climate and staff-identified priorities. Second, informal “Meet n’ Greet” meetings began to create an opportunity for staff to learn about DEIB activities and broader efforts across our organization. Some of the topics covered included Language Access resources, introduction to BHRS Workforce Education & Training, and Introduction to Prevention & Early Intervention (PEI) programs like the Parent Project© and Photovoice. These meetings were not only informative but also created opportunities for BHRS staff to actively engage in PEI activities.

One opportunity that grew out of these activities was for BHRS clinicians to become trained facilitators in the Loving Solutions curriculum. A Parent Project© junior course that targets unwanted child behaviors in children ages 5 to 10 years old, by utilizing the same principles from Parent Project© and adapting them to fit the needs of parents and caregivers of younger children. With this added group of facilitators, this course will be made available to BHRS clients in 2025 and will become part of a clinician's clinical toolbox.

Another area of priority was the continued alignment with the Trauma & Resiliency Informed Systems Initiative (TRISI) & County DEIB efforts. The ODE Director and MCOD Program Coordinator joined the TRISI cohort, County Health GARE group, Trauma Learning Collaborative, and County Core Equity Team to better align BHRS equity efforts, work collaboratively, and inform our MCOD action plan updates. In FY 23-24 an official merge occurred between TRISI and MCOD, the Program Coordinator began working with a TRISI consultant and larger cohort to integrate TRISI principles into the updating of the MCOD action plan 2.0. Work began by comparing the feedback gathered from staff during the MCOD presentations and the results from the 2023 Trauma-Informed Organizational Practices Assessment (TIOA) and Employee Engagement.

The information was presented to BHRS leadership in March 2024 to identify next steps and possible changes to the MCOD structure. The MCOD coordinator also began meeting with members of the Office of Improvement and Innovation to stay up to date with BHRS' areas of priority and alignment. An MCOD steering committee has been approved and members will be identified in 2025 to begin working on specific action items and tracking metrics. Simultaneously while we continued to work on updating the action plan, some action items identified in the first plan were elevated and advanced by our Health System administration. Examples of this include the development of the Diversity, Equity, Inclusion & Belonging Recruitment Checklist. BHRS worked with the Health Administration team to create first, a Health-wide recruitment interview "Question Bank."Then, collaborated to create a hiring/recruitment checklist that includes DEIB

MCOD Feedback	TIOA Feedback
"Addressing staff concerns about **safety** should be paramount. All staff should feel **comfortable** in sharing concerns about **equity and inclusion**-- if that's not happening, that is a really serious problem."	"The common challenges across the categories included **burnout**, **secondary trauma**, understaffing, lack of support (to include mental health support), lack of **psychological safety**, lack of collaboration or communications (between people, departments, or leadership), top-down leadership.."

questions into a County Health hiring checklist. An interactive tool was created in direct response to BHRS staff and client feedback on the challenges experienced when recruiting and hiring diverse staff. This checklist was piloted with BHRS hiring managers in Summer 2024, with the goal of expanding to the rest of the San Mateo County Health System in the coming year. Another example of this Health wide reach includes the development of San Mateo County Health Policy A-44, implemented in December 2023, and subsequent leadership training on Behavior Expectations for Clients, Patients, and Visitors. Also, a project that began within BHRS after conducting an assessment that identified the need for guidelines to ensure a safe, secure, respectful, and healing environment for everyone, including patients, clients, visitors, providers, and staff. Both cases demonstrate the far reach of the MCOD framework and activities beyond BHRS and the strong collaborative partnerships established within our broader system of care. This work has had ripple effects throughout the county, informing other divisions, departments, and the County equity efforts, including informing our County Health Social and Racial Equity Action Plan (SREAP) and creating system change. Specifically, through DEIB work completed in BHRS, we have supported the SREAP areas of training, engaging workforce, cultural consultation, Lunch and Learns around language access, GARE Seed Lab (communications), Cultural Humility Trainings within 90 days of hire, annual BHRS Cultural Poll, 21-day challenge.

Recruitment and Retention Opportunities

In partnership with CalMHSA, the WET Team offered opportunities to support retention efforts through the Education Loan Repayment Program (ELRP) and retention bonuses. These programs were designed to provide financial incentives to retain qualified, eligible employees within San Mateo County's Integrated Behavioral Health Care system. Recipients who met the eligibility criteria for either program committed to a 12-month service obligation. These financial incentive strategies are an integral component of the Statewide MHSA WET plan. The Educational Student Loan Program (ELRP) offered staff loan repayments to individuals identified by their positions that are hard to fill or retain within the clinical practice setting. Staff retention bonuses were focused on staff who mirror the ethnic, cultural, and linguistic backgrounds of the communities they serve. With over 190 applications submitted overall for both programs, the team was able to award its highest amount of awards to workforce members with each awardee receiving $7,500.

Total BHRS employees awarded: 100

- Retention Stipends: 73
- Educational Student Loan Program Awards: 27

Affinity Groups for Staff

A pilot program was launched in November 2022 of six staff affinity groups. These groups are intended to enhance a sense of belonging in the work place, especially for colleagues that experience marginalization. These groups were offered monthly and included groups for staff that identify as: Asian/Pacific Islander, Black, Latinx, LGBTQIA+, have disabilities, and White Allies.

Additional Efforts to Growing a Multicultural Workforce

In response to staff feedback and the objectives outlined in the **BHRS Multi-Cultural Organizational Development (MCOD) plan**, Behavioral Health & Recovery Services (BHRS) began developing a Special Assignments policy. Special assignments will be projects outside an employee's regular duties designed to align with their career goals, agency priorities and initiatives, and succession planning. These assignments will connect employees with the broader organization to work on shared objectives, offering opportunities to develop new skills, collaborate with others, engage more deeply in their work, and increase job satisfaction and longevity. They will allow individuals to make meaningful contributions in areas they are passionate about or skilled in, without detracting from their day-to-day responsibilities. This initiative will support BHRS's commitment to advancing diversity, equity, inclusion, belonging, and trauma-informed systems. By fostering transparency and collaboration in decision-making and policy development, the policy will ensure that those most impacted have meaningful opportunities to participate, as emphasized in the MCOD plan.

BHRS established a dedicated committee to create a recruitment pathway for recently graduated students, allowing them to apply for BHRS positions while in the process of obtaining their registration with the Board of Behavioral Sciences (BBS). Historically, our system faced challenges retaining these individuals, as registration was a prerequisite for applying to social work or marriage and family therapy positions. This new pathway will enable BHRS to engage and retain talented graduates, providing them with an opportunity to contribute to the workforce while completing their registration, ultimately strengthening our ability to meet the needs of the communities we serve.

In May 2024, the BHRS ODE Director participated in the **Student Success Panel** at Palo Alto University, alongside two other psychologists. The Director shared insights with current students pursuing bachelor's, master's, and doctoral degrees about community behavioral health and careers within county organizations. The presentation aimed to inspire students to explore various professional opportunities while highlighting BHRS internship and workforce offerings.

Cultural Stipend Internship Program (CSIP)

*T*he WET team of the Office of Diversity & Equity oversees the management and implementation of the CSIP program. This program provides an opportunity for BHRS clinical interns to pair with a specific Health Equity Initiative (HEI) and develop projects focused on the demographics of their respective HEI. CSIP recipients are selected based on 1) expressed interest in and commitment to cultural awareness and social justice in the community and clinical settings 2) personal identification with marginalized communities 3) and/or lived experience with behavioral health conditions. Priority is also considered for those interns with non-English language capacity and cultural identity with that language. During FY 23-24, four students submitted applications for CSIP consideration. Of the four candidates, all were selected based on their qualifications and dedication to advancing BHRS' efforts at creating a more inclusive community.

Below are highlights from the last round of CSIP projects:

- Diversity and Equity Council- "Retrospection": This project was intentionally chosen to encourage a reflective approach to assist in identifying the considerations that brought individuals to this specific point in their journey. The purpose of the project was to highlight the identities, cultural backgrounds, and collective experiences of the council members. Additionally, this project helped to illuminate stigma, encourage collaboration, and highlight individual passions while normalizing diversity.
- Native and Indigenous Peoples Initiative – "Sound Bath Healing." This introduced Sound Baths as a tool for clinicians to serve community members and was an exciting addition to SMC's care delivery approaches. By encouraging a relaxing and meditative state, this healing method creates an opportunity to align the Vagus nerve.
- Spirituality Initiative – "The Medicine Wheel": The Lakota Medicine Wheel was introduced as a tool to strengthen recovery for those navigating substance misuse concerns. This tool helped community members locate additional purpose during their recovery journey within themselves. It was introduced to encourage balance, introspection, and strength in identifying areas of improvement.
- PRIDE Initiative – "SOGIE Data Collection Guide": The creation of a helpful and much-needed tool for our clinicians to hold difficult conversations regarding sexual orientation and gender identity. This project created brochures in English and Spanish and was identified as a need by our clinicians and data analysts. Upon reflecting on our data measuring demographic information, two areas showed a deficit in data collection.

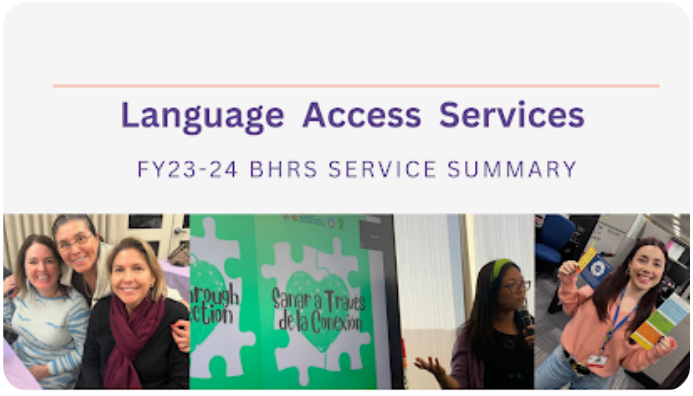
These internship efforts are largely supported by our WET Internship Coordinator, who has played a pivotal role in strengthening the internship program, fostering partnerships with local academic institutions, and creating a sustainable recruitment pathway for BHRS. The program has grown significantly and formalized its processes and procedures over the past year, which has been supported by the hiring of a limited-term WET Internship Coordinator. This role has facilitated an increase in the number of interns who contribute to our programs and strengthen our workforce. However, the limited-term nature of this position, set to expire in 2026, poses a challenge to sustaining and expanding this progress. To ensure the continued success of the program and its critical role in workforce development, we hope this position will be approved as a permanent role.

Criterion 7: County Mental Health System Language Capacity

Criterion 7: Describe the delivery or facilitation of a variety of services offered equitably & appropriately to al cultural groups served.

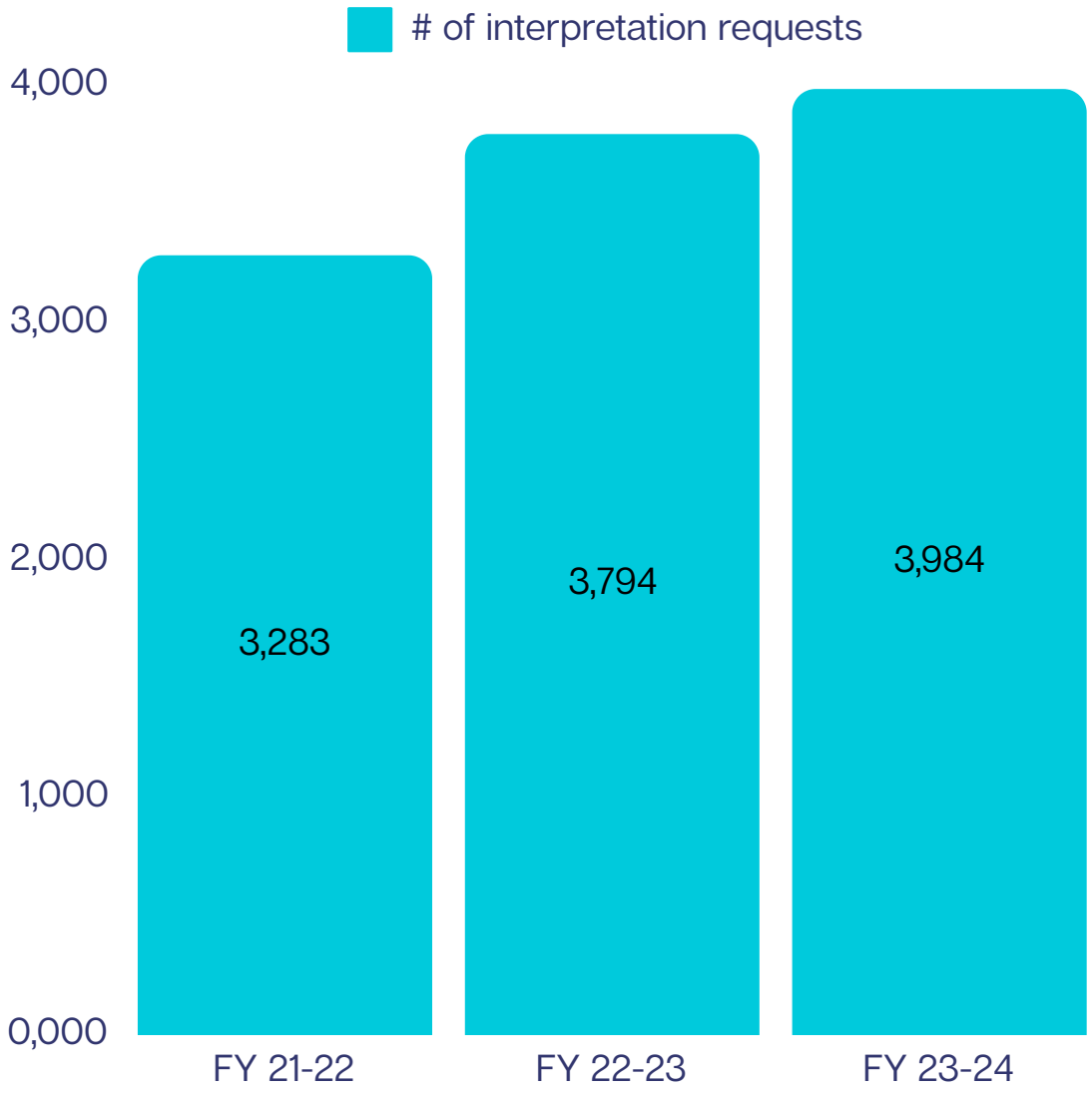
The County of San Mateo's increasing foreign-born population continues to be linguistically diverse. More than 46% of the County population five years of age and older spoke a language other than English at home; of this population, 45% spoke English less than “very well”. The California legislature requires DHCS to implement requirements for language group concentration standards through its contracts with Medi-Cal managed care counties. In addition, counties must ensure equal access to health care services for limited English proficient (LEP) members through the provision of high-quality interpreter and linguistic services, and that translated written informing materials must be provided to all monolingual or LEP members that speak the languages identified by DHCS for the county service area.

As of July 2021, DHCS informed the County of San Mateo that according to the language group threshold standards, the county would be required to provide translated materials in Spanish, Chinese (Mandarin and Cantonese), and Tagalog.[23]



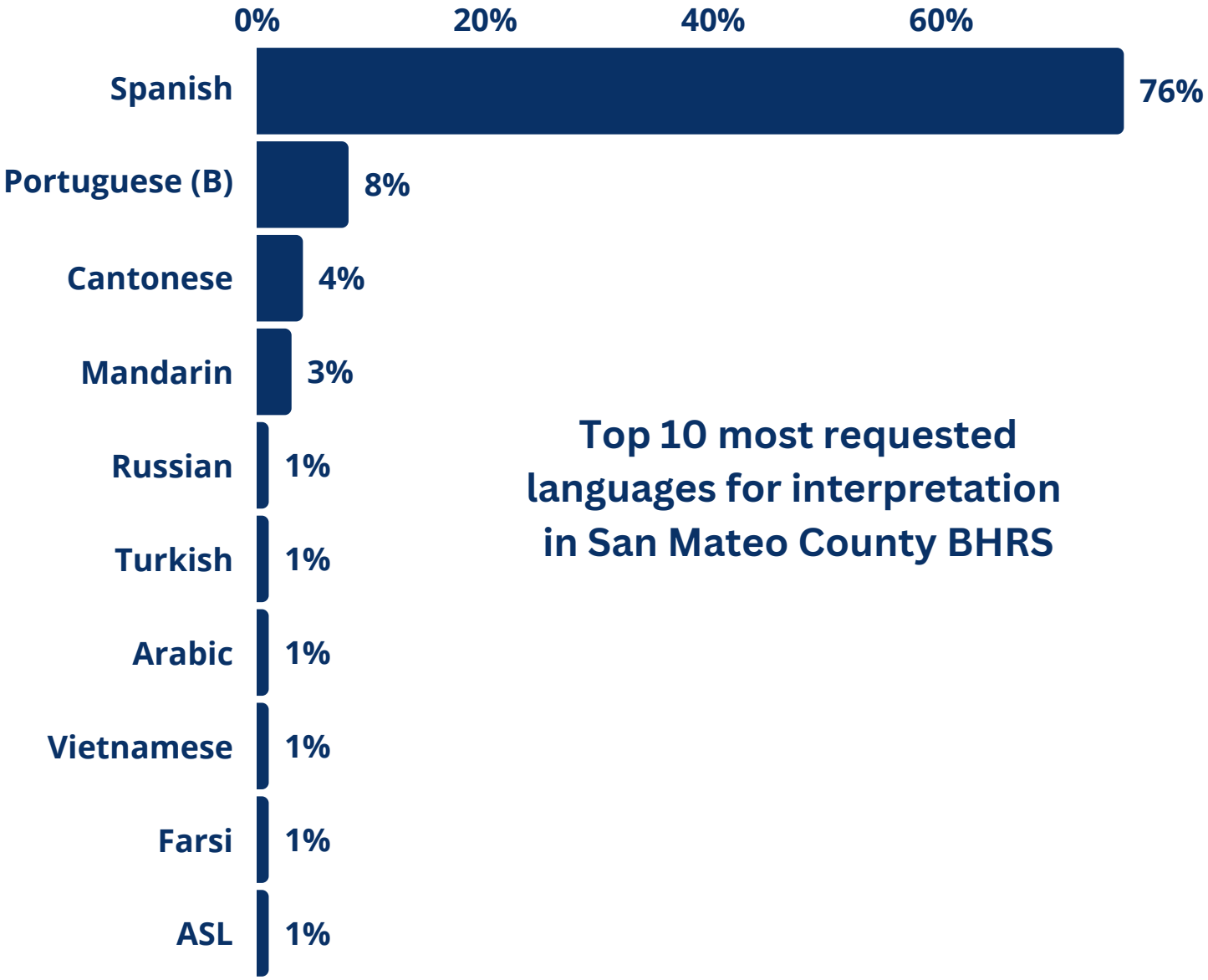
In addition, our partners at the Health Plan of San Mateo identified Russian would also be included in the required languages. The Health System identified Tongan and Samoan as priority languages based on a growing number of clients served. and emerging languages such as Arabic, Burmese, Hindi, and Portuguese. In compliance with federal and state regulations, the County of San Mateo Behavioral Health and Recovery Services (BHRS) Language Assistance Services (LAS) program provides health system staff with in-person, video remote and telephonic interpretations services and translation of written materials to enrollees and potential enrollees at no cost.

In FY 2023-2024, BHRS saw 3,984 unique requests for interpretation services, of which, 2% were for video remote interpretation, 12% for in-person, and 86% for telephonic interpretation. There were 36 unique requests for translation of written materials. A total of 32 different languages were requested for interpretation during interactions with BHRS. Spanish continues to be the most requested language at 76% and for the first time Turkish and ASL made the top ten list for most requested languages. BHRS has also seen a continued increase in Brazilian Portuguese speakers over the last three years. To meet the language needs of our diverse communities, BHRS continues to work closely with County Health leadership to ensure we have access to various resources. We work collaboratively with other County Health Divisions to troubleshoot issues and improve utilization.



For our workforce, we are reinstating our required “Working Effectively with Interpreters” training, after a year-long hiatus. This training was paused in FY 23-24 while we worked to identify a new facilitator, in Spring 2024 we secured a contract with the National Latino Behavioral Health Association to provide this training and another one to support existing bilingual staff working within BHRS. In addition, BHRS is also working to support our contracted providers to expand their language access capacities. BHRS will be launching a pilot to connect specific contractors that support SUD services, with our telephonic interpretation services to promote usage and client access to care.

BRHS Top 10 Languages



Language Justice Workgroup

of the Cultural Competency, Equity, and Social Justice Committee (CCESJC)

In 2024 BHRS became co-chair of the Language Justice Workgroup which is a subgroup of the Cultural Competency, Equity and Social Justice Committee (CCESJC), a committee of the County Behavioral Health Directors Association (CBHDA). The mission of this workgroup is to work with counties across the state to learn, guide and promote best practices of language access to ensure equitable behavioral health care for Limited English Proficient (LEP) individuals. In 2025, this group will be working on a broader language plan that provides guidance on the assessment, modalities, notices, training, and evaluation of language access services.

Criterion 8: County Mental Health System Adaptation of Services

Criterion 8: List and include brief description of county's client driven/operated recovery and wellness programs (ie centers, drop in centers, client-run programs etc.) and which of these programs are racially, ethnically, culturally, and linguistically specific

a) Describe beneficiary problem resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve grievance and

Client Driven Programs

Internal BHRS Programs

- Older Adult System of Integrated Services (OASIS): OASIS serves a client population that is aging, increasingly fragile, and medically complex. OASIS clients come into the program with multiple co-occurring conditions related to physical health, cognitive impairment, substance use, functional limitations, and social isolation in addition to their serious mental health conditions. This requires more hands-on case management support and assistance to enable these clients to remain living in a community-based setting. The case management provided also necessitates greater collaboration among the OASIS psychiatrists and primary care providers due to complex medical conditions and comorbidity with their serious mental health conditions.
- Health Ambassador Program (described in criterion 3)

BHRS funds several client-driven programs in the community including:

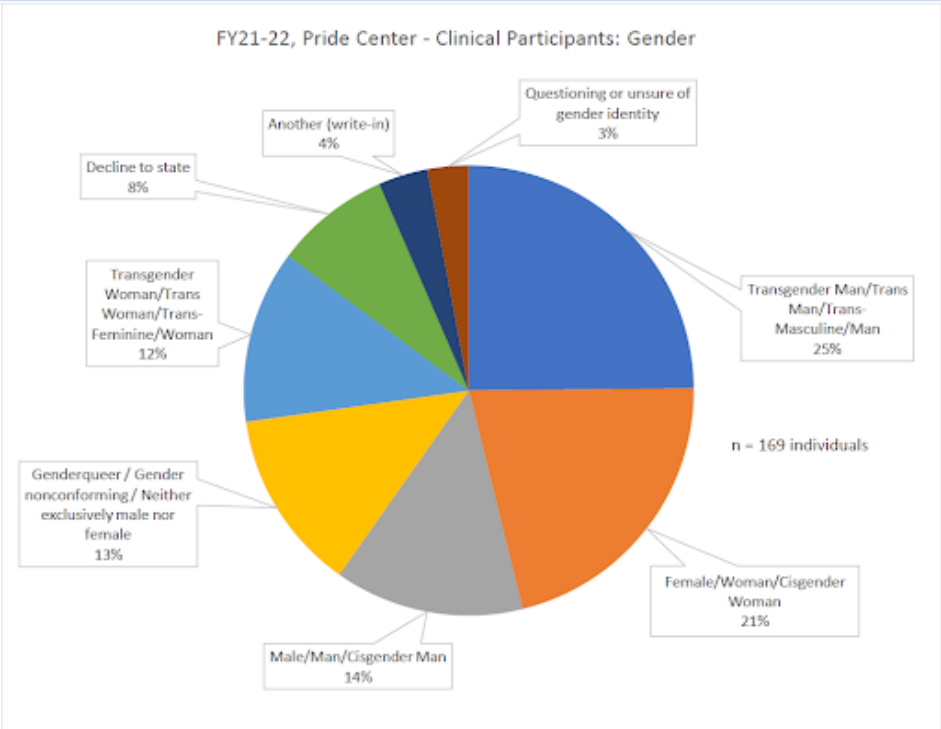
- Senior Peer Counseling Services: These services are provided by Peninsula Family Service, which recruits and trains volunteers to serve homebound seniors with support, information, consultation, peer counseling, and practical assistance with routine tasks such as accompanying seniors to appointments, assisting with transportation, and supporting social activities. The Senior Peer Counseling program has been expanded to include Chinese, Filipinx, and LGBTQ+.
- The Health Ambassador Program- Youth (HAP-Y): The Health Ambassador Program for Youth (HAP-Y) engages youth aged 16-24 in training and workshops focused on behavioral health and mental wellness. This program aims to empower young adults to serve as behavioral health ambassadors within their communities, helping to reduce stigma, raise behavioral health awareness, advocate for change, and share vital resources. To prepare youth for this role, HAP-Y offers a comprehensive 14-week training program that includes psychoeducation and suicide prevention workshops. In the current fiscal year, HAP-Y served 47 unique participants and reached 1,167 individuals through various program components. Evaluations revealed that 100% of participants agreed the program "provided me with knowledge and skills that I will continue to use." This year marked a significant milestone with the first in-person cohort since 2019, allowing HAP-Y to expand its reach to the Coastside community.

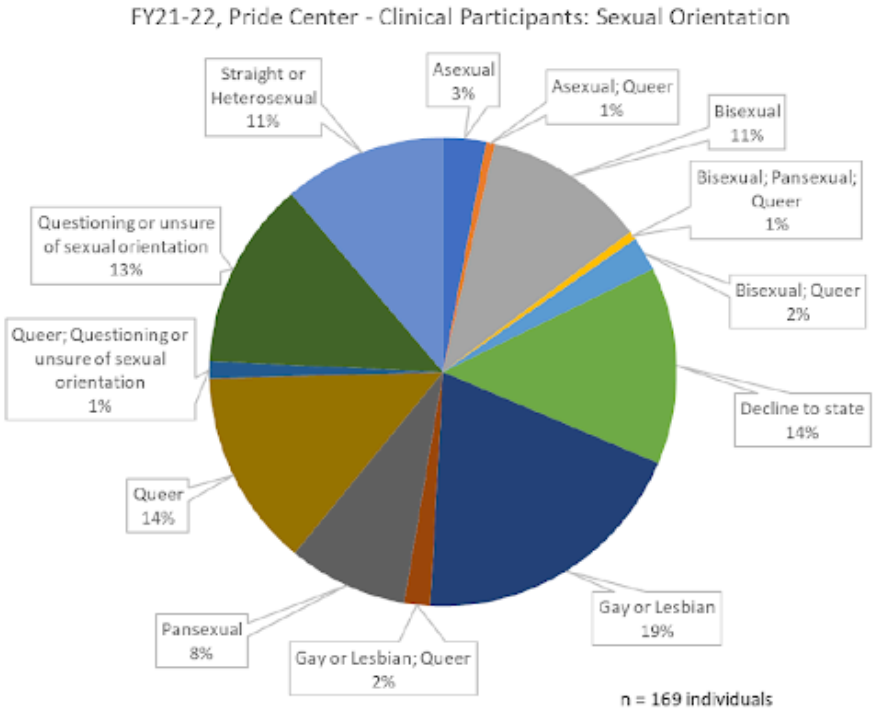
The San Mateo County Pride Center

- The San Mateo County Pride Center, led by StarVista in collaboration with Outlet of Adolescent Counseling Services and Peninsula Family Service, fosters a safe, inclusive, and affirming environment for individuals of all ages, sexual orientations, and gender identities. Its mission is to support personal growth, health, and thriving through education, counseling, advocacy, and community support. By providing behavioral health services, resource navigation, and social and educational programming, the Pride Center addresses the disproportionately high rates of depression, anxiety, suicidal thoughts, substance use, homelessness, and discrimination faced by the LGBTQ+ community. Its holistic, collaborative approach reduces stigma while improving access to and quality of behavioral health services. Some highlights include, obtaining support by a grant from Kaiser Permanente Northern California Community Benefit Programs, the Pride Center launched the Resource Roadmap campaign to support transgender, gender-diverse, and nonbinary individuals. Additionally, in partnership with Mission Hospice, the center hosted an LGBTQ+ grief group, further expanding its vital programming.
- Client Information and Demographics can be found on the next page.

SMC Pride Center: Client Information and Demographics

Referral Information	
Total number of referrals received to the program	182
Total number of referrals that resulted in program enrollment (number engaged)	107
For programs with a clinical primary program component ONLY:	
Average duration of untreated mental illness	Data not available
Average length of time between referral date and enrollment date	37 Days
Minimum length of time	1 Day
Maximum length of time	219 Days





California Clubhouse

- The California Clubhouse is a peer-led community-centered organization where adults with behavioral health challenges can go every day during business hours to work on overcoming obstacles they face. It offers support, training, education, employment, healthy social interactions, and positive reinforcement through collegial relationships and work.

Edgewood Drop-In Centers (DIC), North and South

- Full-Service Partnership (FSP) Wraparound operated by Edgewood Center for Children and Families offers: 1) a comprehensive FSP Turning Point program provided to children, youth and their families; 2) comprehensive FSP Turning Point program and Drop-In Centers provided to transition-age youth (TAY) and their families; and 3) integrated FSP Short-Term Adjunctive Youth and Family Engagement (SAYFE) wraparound services provided to children, youth and transition-age youth within the BHRS outpatient, Therapeutic Day School and the regional behavioral health clinics. FSP Wraparound services are based on clients' individual needs and goals, with a commitment to do "whatever it takes" to help them progress toward recovery, health, and well-being.

Outreach Collaboratives

For FY2023-2024, SMC BHRS providers reported that there were 8,928 attendees at all outreach events, which reflects a 62% increase in total attendance compared to FY2022-2023 (which saw 5,519 attendees). The attendance at group outreach events increased by 72% between FY2022-2023 and FY2023-2024. The attendance at individual outreach events showed a modest increase of 10%, with an additional 90 attendees served in FY2023-2024 than in FY2022-2023.

- North County Outreach Collaborative (NCOC): NCOC consists of five partner agencies: Asian American Recovery Services (AARS), Daly City Partnership (DCP), Daly City Youth Health Center (DCYHC), Pacifica Collaborative (PAC)and StarVista (SV). The NCOC aims to connect people who need support around mental health, alcohol/other drug treatment, medical, and other social services. The NCOC is constant in reducing stigma and discrimination of mental illness along with alcohol and other drug issues by increasing awareness of available resources through education and creating access to care for those in the community who are underserved.

NCOC continues to establish and nurture effective relationships with culturally and linguistically diverse community members to assist in increasing Behavioral Health and Recovery Services capacity and performance in addressing the specific needs of their various populations located in the North Sector of San Mateo County such as Filipinx, Pacific Islander, Latinx, Chinese, and LGBTQQ.

- In FY 23-24, AARS partnered with other Pasifika organizations and community leaders to host these monthly events. Their goal is to build community by providing safe/brave spaces and having cultural activities and conversations regarding various topics and help share resources and make connections and referrals. Some community facilitators and topics were PasifikaByDesign-Stop the Hate Anti Racism Campaign, MANA-Movie Night, Pasifika Urban Roots-Shadow Work, AMU- Murder Mystery, MANA-Movie Night, Heal & Paint, SF Hep B Free, Hep B Awareness and Weaving, SCDC – Wellness and Music, PIONEERS LIT Council(Youth Lead)- Heal & Paint Nurturing the VA, Pacific Islander Initiative- Art & Voices Exhibition.
- In FY 23-24, DCP offered workshops on how to reduce stigma and discrimination regarding mental health. Workshops are done within their communities and schools when needed. Workshops are being offered on-site and virtually, based on preference. At DCP, they offer services at no cost to clients. The ability to provide this service makes it one less barrier that clients face. All clients are given tools to help them better work through behavioral health issues that they are facing.
- In FY 23-24, DCYHC created a position for a Behavioral Health Manager that works closely with their Intake Coordinator to streamline the referral process. DCYHC created a refined system for their referral process that resulted in more referrals coming from their community and increased the number of individuals established at their center. All clients are contacted, and appointments are made within a week of receiving the referral. DCYCH kept track of timely access on their Avatar electronic health records system.
- In FY 23-24, the PAC and Pacifica Resource Center worked together to ensure that underserved populations receive referrals and timely linkages to services. PRC's Houseless on the Coast team implements consistent outreach to folks living in RV's, vehicles, and encampments in Pacifica. The consistency of this outreach, over time, creates a trusting relationship with the outreach workers and allows for information to be shared without fear or mistrust.

- Pacifica School District provides fiscal oversight of the Pacifica Collaborative contract and is now regularly providing information to the parents and student body of Pacifica School District. PSD also refers families to services at the Pacifica Resource Center that include linkages to food, rental, and housing assistance. Addressing the mental health needs of children and families helps to address the many health disparities that can arise from untreated mental illness including prolonged suffering, homelessness, and school dropout rates. The outreach efforts to the Chinese community are two volunteers from the Pacifica Resource Center who are available to interpret for both Mandarin and Cantonese speakers. There are set times during the week when they are available, and appointments are scheduled accordingly. Phone appointments have allowed families to be connected to services through these interpretation services. Promotion of the Chinese Referral Line includes postcard-sized cards at food distribution sites and in the curbside book pickups at the Pacifica Libraries, 200 cards were distributed throughout the past fiscal year. Additionally, Covid-19 printed materials about testing and vaccination resources were included in food distribution boxes, in-person congregant senior lunch programs, and through the library. Lastly, links to services were shared during collaborative meetings, on social media, and through youth-led Podcasts.

<u>The East Palo Alto Partnership for Behavioral Health Outreach (EPAPBHO)</u>

- 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 worked in collaboration with El Concilio of San Mateo County (ECSMC), Free at Last (FAL), and ‘Anamatangi Polynesian Voices (APV).
- EPAPBHO partners facilitate connections between people who may need mental health and substance abuse services or other social services and relevant programming and/or treatment by:
  - Performing initial screening and engaging potential clients.
  - Provide brief interventions to engage clients.
  - Refer members who may need behavioral health services to appropriate agencies in the SMC BHRS system of care for assessment and follow-up treatment as needed.

- Additionally, for most clients, continued support is needed to encourage participation in follow-up treatment. On many occasions, this means providing transportation when the services are outside of the East Palo Alto community, making a phone call as a reminder and as needed, accompanying individuals to sessions.
- In FY 23-24, APV recognized that a multi-level approach to addressing the issues experienced by youth and young adults (in-school students and out-of-school) has been the intervention needed to succeed in serving families. As yet another successful, intervention provided by Mamadee ‘Uhila is her work at the Juvenile system in the County. Mamadee has been working with young people who have been referred to her by County Probation to provide intervention for these young men and their families. With her cultural/linguistic intervention, Mamadee has been successful in serving young men and their families and connecting them to other programs in the community.
- ECSMC continues to excel in engaging community members, identifying their behavioral health needs, and connecting them with services. For example, a single mother of two visited ECSMC after her electricity had been shut off for two days. She was understandably worried and concerned because her food had spoiled. An ECSMC Case Worker promptly assisted her in submitting a LIHEAP application, resulting in her electricity being restored within a few hours. She was also connected with Nuestra Casa and the Ecumenical Hunger Program (EHP) for meals and groceries to support her family in the coming weeks. Grateful for the assistance, she expressed significant relief. During their work with her, staff also recognized an opportunity to connect her with behavioral health counseling, and she was successfully referred for additional support.
- FAL continues to support individuals on their recovery journey, offering ongoing assistance to those managing co-occurring conditions or mental health challenges. FAL maintains a strong partnership with the East Palo Alto System of Care, which includes the Ravenswood Community Health Center, EHP, and the East Palo Alto Community Counseling Center. Staff members provide vital support to individuals transitioning from residential treatment, helping them find employment, connecting them with SLE housing or shelters, and facilitating reunification with their families when appropriate.

The Barbara A. Mouton Multicultural Wellness Center (The Mouton Center/TMC)

- Since the pandemic, TMC gradually opened its programming hours and activities to the community during last fiscal year and has since, expanded

programming this year. A great success for The Mouton Center is the launching of Wellness Wednesdays for the community in May 2023. Wellness Wednesdays are sessions that are open to the community to come and focus on their wellness while enjoying a healing activity. Topics and activities have included painting, candlemaking, journaling, sharing one's narrative, musical breathing, coloring one's calm, etc. During one of the sessions, a TMC client shared his excitement about returning to the wellness center, expressing gratitude for the opportunity to participate. He mentioned feeling consistently welcomed and relaxed whenever he attends, highlighting the positive impact of the center on his well-being.

The Coastside Collaborative

- During FY23-24, the regular attendees at Coastside Collaborative meetings included representatives from Youth Leadership Institute (YLI), El Centro, La Costa Adult School, City of Half Moon Bay, Cabrillo Unified School District (CUSD), Ayudando Latinos a Sonar (ALAS), and Community Alliance to Revitalize Our Neighborhoods (CARON). The collaborative implemented a Google Group and Shared Drive to facilitate mutual resource sharing among members, helping to streamline communication and collaboration within the Coastside Collaborative. YLI coordinated various presentations and workshops that emphasized opportunities for multisector and cross-collaboration. These included sessions from La Costa Adult School on the community schools grant updates on the Cabrillo Unified School District's workforce housing project, mold prevention strategies, Half Moon Bay's Downtown Streetscapes Project and the Opportunity Center of the Coastside, and youth internship opportunities available during the summer. This next fiscal year, the Coastside Collaborative aims to boost resident and youth involvement by increasing participation in meetings and initiating more projects, while improving visibility through events and outreach efforts. They plan to strengthen engagement from Coastside organizations by increasing outreach efforts, enhancing member commitment, and advancing health equity initiatives. Key activities include organizing events like the Wellness Festival and Farmworker Bike Event, increasing outreach through partnerships and a shared calendar, and tracking participation with SMART metrics. Additional goals include reaching more residents and youth, preparing to include youth on the steering committee by the beginning of next fiscal year, and growing Collaborative membership.

Anti Stigma Initiatives

- Behavioral Health Awareness and BeTheOne SMC Campaign. The BeTheOneSMC is San Mateo County's anti-stigma initiative and aims to eliminate stigma against mental health and/or substance use issues in the San Mateo County community. #BeTheOneSMC can mean many things to different people. #BeTheOneSMC's main message is that you can be that ONE who can make a difference in reducing stigma and promoting wellness in the community.

Primary program activities and/or interventions provided include:

- Annual May Mental Health Month (MHM) Observance: This is one of the biggest mental health observances of the year for San Mateo County. San Mateo County aligns with the statewide efforts and 2024 theme "Heal Through Connection." The 2024 May Mental Health Month (MHM) consisted of the following:
  - Planning Committee which provided guidance and oversight for the MHM activities in San Mateo County. Planning committee members included clients/consumers, family members, county staff, and community-based organization staff. Planning committee meetings convened from February 2024 to June 2024.
  - Advocacy Days are various days in April and May where community members can make public comments and advocate for behavioral health at local city and county meetings that proclaim May MHM and some local governments also light their building in green for May MHM.
  - Mini-Grants and Event Support is an opportunity for County and community partners to apply for a modest amount of monetary funding ($200-300) and event support for their May MHM event. The process includes application, selection, event support, deliverable review, and fund disbursement.
    - Event Support includes
      - Input/ideas on event theme, programming, communication/outreach, and logistics (up to 2 hours consultation).
      - Speakers with lived mental health and/or substance use experience.
      - Digital stories for screening.
      - Photo voices for exhibits.
      - Event templates (flyer, presentation slides, chat script).
      - Event promotion on website and social media (Facebook, Twitter, blog, and email networks).
      - Interpretation/translation with SMC Health Contractors.

    - Communication Campaign which promoted May MHM through the below communication channels.
    - The website included a schedule of events, ways to get involved, and resources for behavioral health.
    - The social media campaign included social media posts across San Mateo County Health Facebook, Instagram, Twitter, and BHRS Blog. Among Facebook, Instagram, and Twitter, the hashtags #SMCAgainstLoneliness and #MayMentalHealthMonth were featured and shared by organizations and individuals.
    - Email Blasts – Weekly email blasts were distributed to behavioral health staff, community partners, and community members.
    - Outreach Materials – Outreach/promotional materials included t-shirts, tote bags, lanyards, pop keychains, ribbons, and printed materials created by County and state.
- CARE Court began in San Mateo County on Monday, July 1, 2024. The Community Assistance, Recovery, and Empowerment (CARE) Act is a new law that provides community-based behavioral health services and supports to those living with untreated schizophrenia spectrum or other psychotic disorders through a new civil court process. It is designed to disrupt the revolving door of homelessness, short-term hospitalization, and incarceration for those with untreated serious mental illness. The evidence-based program will connect eligible adults in crisis to a CARE Agreement or Plan, which may include comprehensive treatment, housing, and supportive services for 1 year and may be extended for up to 12 additional months if needed. CARE will serve people who need help most and work with clients and their families to help them towards recovery so they can remain in our community and thrive.
- CalAIM Beginning in March through November of 2024, BHRS staff and providers completed monthly trainings necessary to implement CalAIM, the reformation of the Medi-Cal system, into practice. In addition to the trainings, resources have been set for staff, from monthly updates on the internal BHRS newsletter, and direct lines of communication to provide TA, to CalAIM specific intranet page with training information and videos.
- Mobile Crisis Team In 2024 the San Mateo County Mobile Crisis Response Team launched 24/7 service anywhere within San Mateo County. Over the past year, the team has responded to over 80 clients during behavioral health crises.

OCFA grievances

The BHRS Office of Consumer and Family Affairs (OCFA)supports the grievance process, they aid in resolving concerns about individual rights related to BHRS services provided, as well as with contract providers. The average days to resolution are 39.3 days, with the longest being 103, which is an increase from the last 3-year plan where the longest time was 89 days and the average was 24 days. Grievance categories span access, to abuse, neglect, and exploitation, as well as timely response and customer service with the largest category being quality of care. The OCFA team holds an equity lens when reviewing and resolving grievances analyzing data by race, ethnicity, and language points.

FY 22-23, 93 grievances were received, and the grievances for mental health decreased, however, they increased for AOD and decreased for youth. The highest proportion of grievances was for Medi-Cal recipients and the highest category of grievances was for quality of care. Latinx clients filed the most grievances.

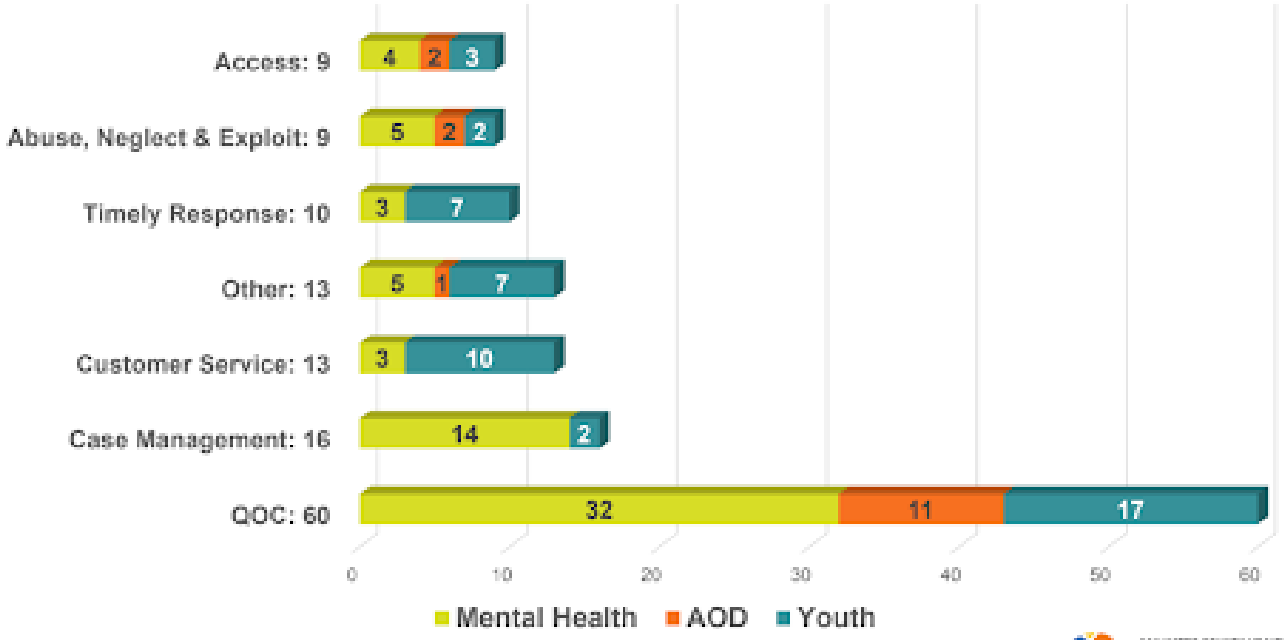
The improvements that were made because of the grievances were:

- ACCESS reviewed and edited their script to explore additional resources.
- AOD also contracted an agency to improve discharge.
- AOD detox programs improved procedures and training requirements.
- Canyon Oaks Youth Center updated its internal grievance process that meets Medi-Cal requirements.

Please refer to the grievance category data and ethnicity of clients filing grievances on the next page.

OCFA grievances Data

Grievance Categories



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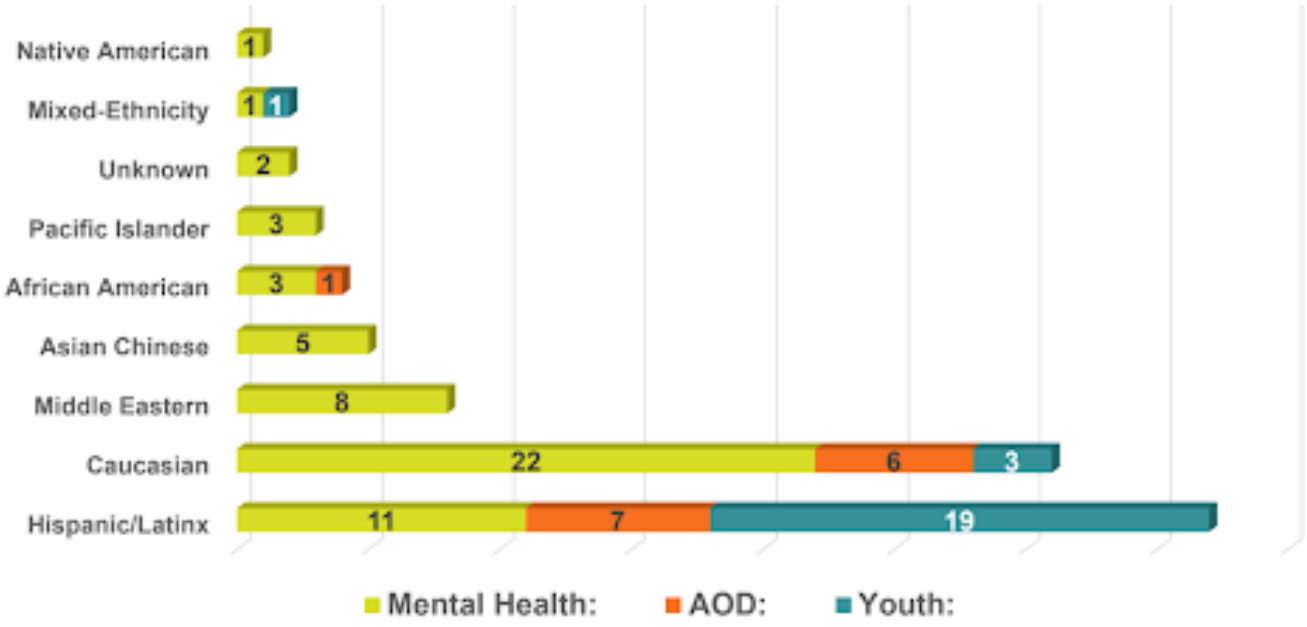
Ethnicity of Clients Filing Grievances



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.OCFA provides support for the following programs:

- **Peer and Consumer and Family Partners**: (Described in more detail under Criterion 3)
- **The Lived Experience Education Workgroup (LEEW)/Lived Experience Academy (LEA):** (Described in more Detail Criterion 3).

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The work, progress, and integration of DEIB and trauma-informed care, along with system changes in our BHRS efforts, are a direct result of our invaluable partnerships. While there are too many to name, we express our deepest gratitude to each of you for supporting our behavioral health system of care, our workforce, and, most importantly, those who face barriers to accessing culturally responsive care and the individuals we are privileged to serve.

APPENDIX 2. MHSA ANNUAL UPDATE MATERIALS AND PUBLIC COMMENTS

Mental Health Services Act (MHSA)

Behavioral Health Commission Meeting

March 5, 2025

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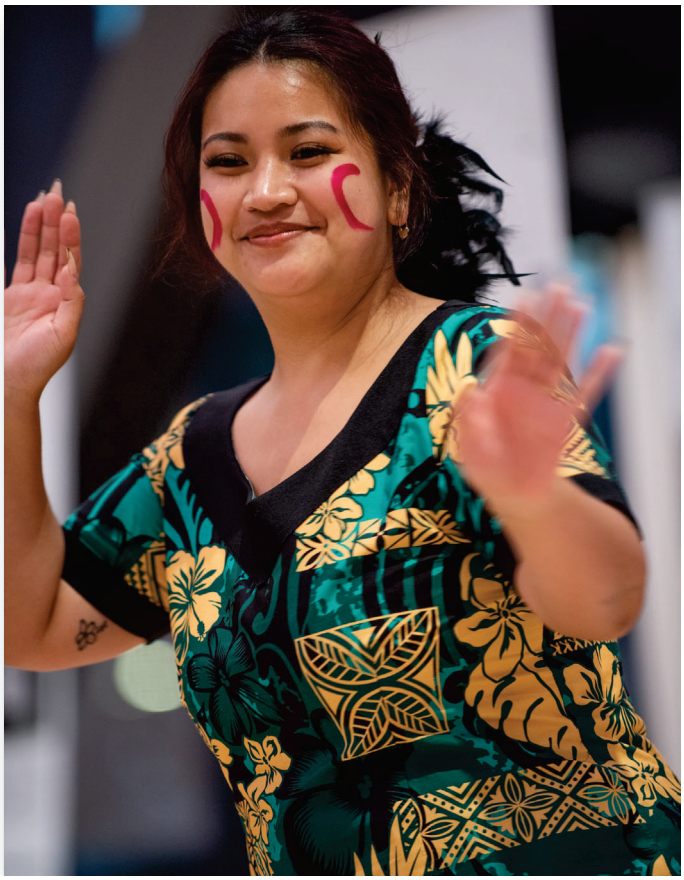
Agenda

1. Prop. 1 – BHSA Transition Community Program Planning Process
2. MHSA Annual Update, FY 2024–25



BHSA Community Program Planning Process

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BHSA Transition Timeline

Preparation
Apr-Dec 2024

- Statewide Workgroups
- Request For Proposal (RFP) – Organizational Needs Assessment, Project Management, Implementation Assistance, Community Program Planning (CPP) Process
- County Public Health Community Health Improvement Plan – MH Workgroup

Transition Planning
Jan 2025-Sep 2025

- Kick-Off BHSA Taskforce and CPP Process – Needs Assessment, Strategy Development, Community Input
- Implement Restructure Recommendations from Organizational Needs Assessment

Plan Development
Oct 2025-Jun 2026

- Develop Three-Year Integrated Plan
- Behavioral Health Commission 30-Day Public Comment and Public Hearing (March-April 2026)
- Board of Supervisor Approval

BHSA Launch
July 1, 2026

- *Current programs funded by MHSA remain as is through June 30, 2026*

Community Program Planning (CPP) Process

CPP Activities	Timeline
BHSA Taskforce Implementation (April, June, August, October)	
BHSA Taskforce Promotion	Jan-Feb 2025
BHSA Taskforce Launch & CPP Process Framework	April 2025
Needs Assessment – Review of Data/Reports + Survey	April-June 2025
Strategy Development – Staff and Community Input Sessions	July-September 2025
Integrated Three-Year Plan Development	
Plan and Budget Development	Sep 2025 – Jan 2026
Final Input and Approval	
MHSA Steering Committee*	February 2026
BHC 30-Day Public Comment	March 2026
BOS Approval	May 2026

** Subscribe to and visit the MHSA website, www.smchealth.org/mhsa, "Announcement" tab for most up-to-date information*

MHSA Annual Update

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MHSA Components

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)
Education, training and workforce development to increase capacity and diversity of the mental health workforce

Capital Facilities and Technology Needs (CFTN)
Buildings and technology used for the delivery of MHSA services to individuals and their families.

1% tax on personal income over $1 million
San Mateo County: $41.2M annual 5-year average through FY 2022-23

MHSA Planning Requirements

- Three-Year Plan & Annual Updates

What's in a 3-year Plan?
Existing Priorities
New Priorities
Expenditure Projections

What's in an Annual Update?
Program Specific Data and Outcomes
Implementation and Planning Updates
Changes to the 3-Year Plan

- Community Program Planning (CPP) required
  - 30-Day Public Comment Period & Public Hearing – BHC meeting
  - Approval by the Board of Supervisors

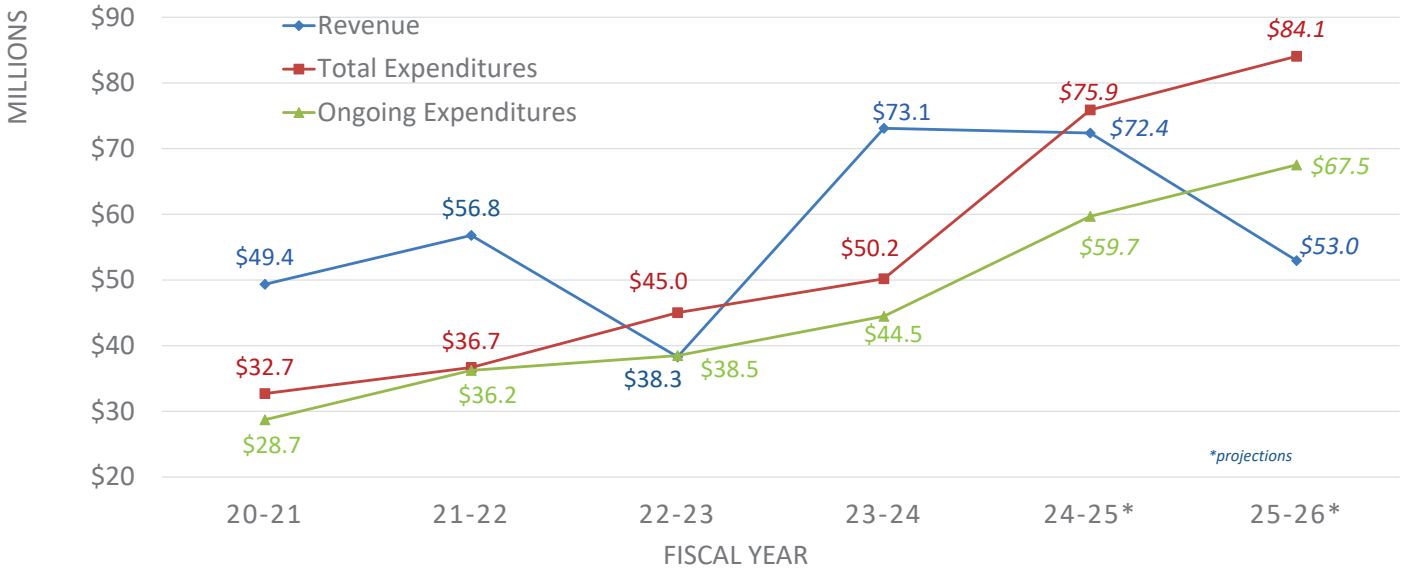
Annual Update Timeline

- **February 28th:** Posting of the MHSA Annual Update
  - www.smchealth.org/MHSA, under "Announcements" tab
- **March 5th:** Vote to open 30-day comment period
- **April 2nd:** Vote to close public comment period + public hearing
  - ➢ BHC Meetings: https://www.smchealth.org/general-information/bhc-public-meetings

How to Give Public Comment

- Verbally at the BHC meetings:
  - Quick Tips – How to Give Public Comment at a public meeting
  - www.smchealth.org/general-information/bhc-public-meetings
- Online Form:
  - www.surveymonkey.com/r/MHSAPublicComment
- Email to mhsa@smcgov.org /
  - optional form can be downloaded from www.smchealth.org/MHSA
- Phone message at (650) 573-2889

MHSA Revenue & Expenditures



Three-Year Plan Priorities to Continue

- $34.1M One-Time Spend Plan through FY 2025-26
  - Supportive housing units
  - Building infrastructure (clinic purchase, renovations)
  - Behavioral Health Community Infrastructure Program (BHCIP) grant match
  - System transformation (contractor incentives, youth crisis continuum of care, communications, early childhood trauma informed network)
- Ongoing funding priorities
  - Full Service Partnerships (FSP)
  - Workforce Education and Training (WET) – student loan repayment, retention, career pathways
  - Prevention and Early Intervention (PEI) – substance use prevention, crisis response, outreach expansions

Program Outcomes

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BEHAVIORAL HEALTH & RECOVERY SERVICES

Community Services and Supports (CSS)

Clients Served

FSP Adult/OA	FSP C/Y/TAY	Substance Use	OASIS	Criminal Justice	Dual Diagnosis	Children/ Youth	Other System Dev	Peer Supports	Outreach to Clients
350	171	307	146	47	271	1,022	1,823	632	247

"It's made changes with my family, with my daughters in this case, we have had better communication. The change has been that we have a better relationship, more interaction."

- Parent of a Youth FSP Client

"The California Clubhouse has been great for me! It has provided structure to my days and allowed me to keep my work skills sharp while allowing me to engage and interact with others in a supportive and low stress but productive work environment."

- CA Clubhouse participant

Client Outcomes - Direct Tx Programs

Emergency Utilization

Employment

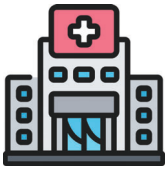
Goals Met

Housing

Connection*

Criminal Justice

Hospitalization



Substance Use

Education

**To be added next FY based on input from client focus groups*

Post-Intervention Outcomes

Homelessness	↓	**Adult and Older Adult FSP:** 35% (n=118) of Adults and 17% (n=24) of Older Adults reported an incident of being unhoused (i.e., homeless or emergency shelter) after the first year enrolled in FSP compared to 41% and 21% prior to enrolling, respectively.
Criminal Justice Involvement	↓	**Pathways Program:** 21.9% (n=33) of clients were taken into custody after being admitted to the program, compared to 93.9% before admission.
Employment - Engagement	↑	**Adult and Older Adult FSP:** 5% (n=118) of clients reported active employment since joining the program, compared to 1% before enrolling.
Education – School Suspensions	↓	**Child and TAY FSP:** 8% (n=238) of Children and 2% (n=284) of TAY reported a school suspension incident after the first year in FSP compared to 20% and 10% after the year prior to enrolling in FSP, respectively.

"I can't ask for better team members for me to recover from being homeless and everything else. And they've been very helpful... and it seems like they know what they're doing and I can reach out to them anytime."

- Adult FSP Client

"My Family Partner has been a great support for me and my family. I have three children receiving mental health services, and my Family Partner is always open to listening to my concerns. She also helps me connect with the school staff and obtain resources to maintain housing for my family. I am very grateful for my Family Partner's support and her responsiveness to my calls."

- Caregiver/participant

Post-Intervention Outcomes

Substance Use	**Adult and Older Adult FSP:** 31% (n=152) of Transition Age Youth, Adults and Older Adults reported active substance use after the first year enrolled in FSP compared to 63% prior to enrolling.
Emergency Service Utilization	**Board & Cares**: 0% (n=78) of clients had a psychiatric emergency episode three months after program admission compared to 24% three months before enrollment. **Homeless Engagement Assessment and Linkage (HEAL)**: 0% (n=108) of clients had psychiatric hospitalizations and/or psychiatric emergency services (PES) admission post contact compared to 69% pre contact with HEAL. **Prenatal to Three Initiative**: 0% (n=581) of clients had a psychiatric emergency episode three months after program admission compared to 92% three months before enrollment.
Individual Goals Met	**Adult Resource Management (ARM)**: 64% (n=58) of clients discharged from Intensive Case Management completed their goals or remained an active client.

Client Story (ARM):

A 54-year-old male client diagnosed with schizoaffective disorder and amphetamine use disorder was referred to intensive case management services after receiving an eviction notice from a supportive housing service. After reviewing the referral details, an ARM case manager worked diligently to build a trusting relationship with this client and his mother, providing legal resources, psychoeducation, and linkages to substance use treatment providers, among other services. With support from this case manager, the client worked with his treatment team. The client has recently participated in the California Clubhouse. He enjoys assisting others when he is there and would also like to pursue higher education in the future, as he has a passion for art and is engaging in artistic hobbies

Prevention and Early Intervention (PEI)

Clients Served

	Ages 0-25	Early Intervention	Prevention	Recognition of Early Signs of MI	Access & Linkage to Treatment	Stigma Reduction and Suicide Prev
FY 23-24	801	310	2,002	335	9,736	20,879

"It was really in depth and provided great information on identifying potential signs of suicide and how we can support individuals experiencing suicidal thoughts."

- Be Sensitive Be Brave for Suicide Prevention Training participant

"I feel blessed to have taken the classes in this program and to have obtained this accomplishment and the wonderful training I received, which has served me well in my daily life. I have been able to share my knowledge and care with those who need me the most, including my family and part of my community with whom I interact. Thank you so much to this great Health Ambassadors program and the entire team!"

- Health Ambassador Program (HAP) participant

Outcomes – PEI Programs

Knowledge, Skills

Empowerment

Connection

Emergency Utilization

Behavioral Health

Access

Stigma

Cultural Humility/Identity

Community Advocacy

Post-Intervention Outcomes

Knowledge, Skills	↑	**YMCA Mindfulness-Based Substance Abuse Treatment (MBSAT):** 90% (n=45) reported that they learned that trauma affects physical, emotional, and mental well-being. **HAP-Youth (HAP-Y):** 100% (n=37) reported that they now have knowledge and skills about behavioral health that they can use in their lives
Stigma	↓	**Mental Health Month:** 82% (n=179) agreed or strongly agreed that they are MORE likely to believe people with mental health and/or substance use conditions contribute much to society.
Empowerment	↑	**Health Ambassador Program (HAP):** 97% (n=36) are more confident in their ability to advocate for themselves and/or their child/children.
General Behavioral Health	↑	**Pride Center:** 86% (n=35) of clients assessed post-clinical intervention for depression and post-clinical intervention for anxiety, experienced a reduction in symptoms. **Primary Care Interface:** 87% (n=123) agreed or strongly agreed that they are better able to manage their symptoms and participate in daily life.

"My experience with presentations was greatly beneficial to myself, being able to show facts to others and enlighten not only them but myself is a great experience. Before I was unsure, but after I was more confident about my ability to share this knowledge."

- HAP-Y Participant

Post-Intervention Outcomes

Cultural Identity/ humility	↑	**Cariño Project:** 86% (n=37) reported that due to their participating in this program, they feel more connected to their culture. **Health Equity Initiatives, Latino Collaborative, Sana Sana Colita de Rana!:** 98% (n=58) strongly agreed or agreed that their identity, cultural background, and experiences were affirmed by the event.
Access	↑	**Suicide Prevention Committee**: 88% (N=24) of event/training participants reported that through their participation, they learned knowledge and skills that they can use to access behavioral health services.
Emergency Utilization	↓	**(re)MIND early psychosis:** 95% (n=79) experienced a reduction in hospitalizations; both number of days and number of episodes.
Connection	↑	**Older Adult Peer Counseling:** 58% (N=26) of individual therapy clients and 81% of group clients (n=17) reported that as a result of participating in the program, they feel supported.
Community Advocacy	↑	**Health Ambassador Program for Youth (HAP-Y):** 100% (n=37) of youth reported that due to this program, they can contribute to other people's learning about behavioral health.

"With the bipolar expertly managed, I am now free to dream big, once again. I am currently writing a memoir about my recovery journey, which I hope to get published in the next 1-1.5 years. I am teaching yoga, dance, and fitness at community and corporate gyms, as well as high schools.[...] I am leading a full life and have such a bright future ahead. It's an ongoing journey, but I will carry everything I've learned these past 4 years into the rest of my life. Thank you for giving me my life back. I am forever indebted to you all."
- (re)MIND participant

"I have come a long, long way from when I started receiving services at the Pride Center. From doubting/denial of self, deep sense of shame, regret, and sorrow. To, now being comfortable owning my identity, and gender, and moving past the deep gulfs of sorrow. I am confident that I would still be wondering why I was miserable, and unable to move forward in life without this life changing help. I still have a long road to walk, but the hardest steps have been taken, and I am much more confident about the path that I have ahead. It's still scary, but I am a different person. A deep gratitude to Drae, and to the Pride Center. See you soon."
"Through therapy sessions, I've been able to deal with anxiety and stress much better than in the beginning."

- Pride Center Counseling Client

Implementation Highlights

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSA Outcomes Workgroup: Updated Definitions

Overall recommendations:

- Holistic, person-centered measures of connection, wellbeing, and resilience.
- Focus on strength-based indicators (through social or person-centered approaches) versus deficit-based, crisis-focused indicators (through current medical models).
- Look at the interconnectedness among indicators as these indicators do not work in isolation and one or more indicators may influence the outcomes of others.

Innovation Projects

4 New INN Approved Jan-Feb 2025

- allcove Half Moon Bay
- Peer Support for Peer Workers
- Pet Fostering/Care for Housing Stability
- PIVOT – Medi-Cal eligibility infrastructure

6 Active INN Projects, Annual Reports Available

- Kapwa Kultural Center & Café
- PIONEERS Program Recovery Connection
- Music Therapy
- Adult Residential In-home Support Element (ARISE)
- Mobile Behavioral Health Services for Farmworkers

Thank you!

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SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

MHSA FY 2025-26 MHSA Annual Update

30-Day Public Comment Process - Public Comments Received

Substantive Comments[1]

No substantive comments received by closing of the public comment period on 3/5/2025.

Public Comments and Questions

Public comment received via email/online form

- **Comment:** I am writing as a consumer of mental health and recovery services for over 40 years. I have been in San Mateo County for at least half of those. I am concerned that many of the quality programs have been getting cut without viable options to turn to as a result. With the fee to service changes clients and staff members alike have had high turnovers in program closures. I personally have watched my intensive out-patient program, StarVista's Women's Enrichment Center, abruptly end its vibrant support services in February 2025, leaving all of us to scatter and grieve all over northern California. As we have found an insufficient women's program in Sitikie, several of our support groups have felt poorly handed off and transitioned, resulting in substance relapse and other types of behavioral emotional evasion tactics. There have also been closures for the candidates at San Mateo's only DUI court ordered classes that StarVista oversaw in Pacifica, as well as, St. Vincent de Paul's residential safe house, Catherine Center since December 2024. I am concerned after watching the decline of Caminar secure and lock it's lobby to clients and learning today that Telecare is also Fee to Service billing. I fear that I will lose services again. Please do not let this happen!
- **Comment:** Dear Members of the Behavioral Health Commission, I am writing to share my personal experience and advocate for the allocation of funding to support individuals with severe mental illness (SMI) at home as an alternative to psychiatric hospitalization.

  Recently, I faced a crisis while managing daily life with schizoaffective disorder and caregiving for my spouse, who is recovering from a stroke. During this time, the stress of maintaining household chores and caregiving became overwhelming, highlighting the urgent need for accessible, in-home assistance for individuals like myself. While psychiatric units provide essential care in acute situations, many of us can benefit from alternative support that preserves the dignity and comfort of remaining in our homes.

  I strongly urge the commission to consider expanding funding for services that facilitate rest, recovery, and assistance in a home setting. Programs that provide in-home chore assistance, caregiving support, and mental health services could significantly reduce the burden on individuals and families navigating mental health challenges. Investing in home-based services not only promotes stability and wellness but also reduces reliance on psychiatric units, creating a more compassionate and cost-effective system of care.

  Your consideration of this initiative would make an immense difference in the lives of individuals and families in need, enabling us to thrive within the familiarity and security of our homes. I appreciate the opportunity to share my perspective and thank you for prioritizing the well-being of our community.

[1] MHSA legislation requires that the MHSA Three-Year Program and Expenditure Plan include a summary of any substantive public comments received (that may require a change to the plan) and if applicable, include recommended revisions to the plan.

BHC meeting (4/2/2025), vote to close public comment period on 4/5/2025 and public hearing.

- No questions or public comments

BHC meeting (3/5/2025), opening of public comment period.

- **Question:** How do we interpret deficit?

  Response: In the graph where the revenue was lower than anticipated expenditures that was intentional because every year there has been unspent dollars, so we are creating an over revenue budget to continue tapping into the unspent. For programs under MHSA that are longer going to be funded under prop 1, we are looking for alternative source of funding. Particularly a focus on realignment.

- **Comment:** I have attended a lot of events at the Kapwa Kultural Center and that center is so important to me, and I wanted to just acknowledge its great work and hope other programs can come out of the innovation projects.

- **Comment:** I'm a proud Samoan American and also work for a community-based organization. The reason why funded programs such as PIONEERS and Essence of Mana are needed is because they show the importance of mental health and mental wellness through people from my culture. It has made a tremendous impact in my life. Essence of Mana has helped me reconnect with my daughter and break generational trauma. Me and my family's lives are better because of these programs.

- **Comment:** I am a Tongan student here at CSM. I'm part of the program Asian American Recovery Services, and I believe MHSA should continue to fund programs like PIONEERS because the program has been supporting my mental health and social anxiety. They helped me take the first step in seeking help. I have made tremendous progress. PIONEERS gave me a sense of belonging and their encouragement and care have made all the impact on my journey.

- **Comment:** I am a case manager for PIONEERS. Our program serves youth and transitional aged youth. So, I'm here to state how imperative it is that this funding continues to go to programs like PIONEERS that truly serves populations that are historically severely underserved and underrepresented. In less than two years, PIONEERS has been able to serve around 80 Pacific Islander students and expose them to behavioral health services where otherwise they would not have been. We collected data that shows the mental health of our long-term students has improved significantly because oof our culturally competent services, so it's obvious that we need to ensure that the funding to programs like ours continues.

- **Comment:** I am currently a student here at CSM. I am part of the PIONEERS program at AARS where they serve our Pacific Islander community in San Mateo County. I believe that MHSA should continue to serve programs like PIONEERS because without it a child like me couldn't feel seen. It wasn't until college that I could see people who look like me, have experiences like me telling me that it is possible to go beyond these childhood traumas. If it weren't for programs like PIONEERS, then a lot of brown kids like me would not have been seen. A program like PIONEERS is honestly home for me.

- **Comment:** I am the project coordinator of our PIONEERS program. PIONEERS stands for Pacific Islanders, Organizing, Nurturing, and Empowering Everyone to Rise and Serve. That is exactly what we do throughout San Mateo County with our youth and transitional age, youth, as you've heard many or not many, but a number of our students speak on. We serve our Pacific Islander community through our culturally centered mental health workshops, case management, community engagement and leadership trainings. We are now on our 6th cohort and have served about 80 Pacific Islander students who express the need

for spaces like pioneers, where they feel comfortable, safe seen, and valued, where they recognize that their voices matter, and the way to nurturing relationships within their lives is prioritizing, nurturing their mental health. I believe MHSA should continue to fund programs such as pioneers so we can continue to provide support that greatly impacts the lives of our youth and allowing us to destigmatize mental health within the Pacific Island community a struggle that we've been having for many, many years, and this will help us to further connect students to mental health services, which is what we've been doing for about 2 years now.

- **Comment:** I believe MHSA should continue to fund programs like PIONEERS because if it wasn't for PIONEERS I would never have given mental health acknowledgement and would still be stuck in the toxic environment along with the mindset that I used to be in. PIONEERS has helped me in so many ways. If it wasn't for PIONEERS I would not be here.
- **Comment:** I'm speaking today because our families, our elders and our youth need to be heard as a Samoan woman who has witnessed mental health challenges in the community and in her own backyard. It is imperative that we continue to fight for innovative resources, that support and address behavioral health disparities among the unserved and underserved. We need to find and fund more prevention programs like PIONEERS and Essence of Mana. Their public comments are testimonies that our programs work and are needed now more than ever, especially in the light of the ongoing mental health crisis. There have been many barriers for accessing mental health services for far too long, and as service providers, it is our duty to ensure that the most vulnerable in our communities are protected. We need to do better because our communities deserve better. This is our time to take action, to demand change. As I echo all who have gone before me today we ask that you not just hear us, but stand with us to make sure to serve, defend, and uplift the people who need it most.

APPENDIX 3. FUNDING SUMMARY BY COMPONENT

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Budget

Fiscal Year 2025-26

Service Category	Community Services and Supports (CSS) Program	BHRS Staff/Agency	TOTAL FY 25-26
Full Service Partnership (FSP)	**Children and Youth (C/Y)**		
	Integrated SAYFE	Edgewood	$975,488
	Comprehensive C/Y "Turning Point"	Edgewood	$2,631,978
	Out-of-County Foster Care	Fred Finch	$188,938
	Transition Age Youth (TAY)		
	Enhanced Education (TAY)	Caminar	$219,882
	Comprehensive TAY "Turning Point"	Edgewood	$2,855,814
	Adult & Older Adult		
	Adult and Older Adult FSP + Flex Fund	TBD	$8,124,440
	Embedded South County FSP	Mateo Lodge	$158,836
	Care Courts FSP	TBD	$2,473,460
	Housing Supports		
	TAY Supported Housing	Mental Health Association	$511,073
	Adult/Older Adult Housing	TBD	$4,609,260
	Board and Care	Various	$3,170,627
	Short-Term Residentials	Samaritan House	$110,536
	Adult/Older Supported Housing Services	Mental Health Association	$402,621
		TOTAL FSP	**$26,432,951**
General System Development (GSD)	**Substance Use Integration**		
	Substance Use Providers	Various; BHRS Staff	$959,914
	Substance Use Residentials (Youth and Adults)	HR360; TBD	$670,109
	Recovery Support Services	VoR	$258,409
	The Cariño Project – Substance Use Services	ALAS (El Centro)	$121,500
	Older Adult System of Care		
	OASIS; hoarding resources	BHRS Staff, SF Center for Compassion	$1,218,916
	Older Adult Peer Couseling (50% CSS)	Peninsula Family Services	$200,496
	Criminal Justice Integration		
	Pathways, Court Mental Health	BHRS Staff; MHA	$131,933
	Criminal Justice Restoration and Diversion	BHRS Staff	$250,000
	Pathways, Housing Services	Life Moves	$127,549
	Other System Development		
	Pre-to-Three Initiative	BHRS Staff	$721,423
	Puente Clinic	BHRS Staff	$560,224
	Trauma-Informed Interventions (NMT)	Various; MHA	$944,850
	EBP Clinicians	BHRS Staff	$1,069,982
	School-Based Mental Health	BHRS Staff	$328,888
	Crisis Management + Serenity House	BHRS Staff; Telecare	$1,694,404
	Peer and Family Partner Support		
	Peer Workers and Family Partners	BHRS Staff	$2,385,505
	OCFA Stipends	MHA; BHRS	$60,671
	Multicultural Wellness Center	One EPA	$233,140
	The California Clubhouse	California Clubhouse	$413,523
	HOPE, Peer Support + Leadership	Heart and Soul, TBD	$1,297,738
	Primary Care Integration		
	Primary Care Interface (20% CSS)	BHRS Staff	$145,779
	Ravenswood Family Health Center (40% CSS)	Ravenswood	$18,895
	Infrastructure Strategies		
	IT and Support Staff	BHRS Staff	$1,115,319
	Communications + Language Services	Various	$257,138
	Contractor's Association	Caminar	$229,715
	CSS Evaluations	AIR (.9), PWA, AHDS	$635,104
	CSS Planning	Various	$187,344
	CSS Admin	BHRS Staff	$957,615
		GSD	**$17,196,084**
Outreach and Engagement (O&E)	Family Assertive Support Team (FAST)	Mateo Lodge	$379,212
	Coastside Multicultural Wellness (20% CSS)	ALAS	$91,438
	Adult Resource Management (ARM), Collaborative Care Team	BHRS Staff	$2,350,645
	HEAL Program - Homeless Outreach	BHRS Staff	$172,536
	SMC Pride Center (35% CSS)	StarVista	$347,339
		TOTAL O&E	**$3,341,170**
		GRAND TOTAL CSS	**$46,970,205**
		Percent FSP (51% required)	56%
		Percent CSS (80% target)	**80%**

Workforce Education and Training (WET)			
	System-wide Training	BHRS Staff; Various	$1,600,000
	Recruitment/Retention Program	CalMHSA; Various	$680,000
	Training for/by Consumer (LEA, Advocacy Academy, Peer Leadership)	OCFA; Various	$300,000
		TOTAL WET	**$2,580,000**

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Budget

Fiscal Year 2025-26

Capital Facilities and Technology Needs (CFTN)			
	Client Devices	T-Mobile Government	$330,000
	Apps (PDT, Wysa)		$300,000
		TOTAL CFTN	$630,000

Prevention and Early Intervention (PEI)			
Service Category	Program	BHRS Staff/Agency	TOTAL FY 25-26
Prevention & Early Intervention	Early Childhood Community Team (ECCT)	StarVista	$627,000
	Community Interventions for School Age & TAY		
	Trauma-Informed Services for Youth	Latino Commission; Puente de la Costa Sur; StarVista; YMCA	$553,850
	Brief Intervention Model (INSPIRE)	DCYHC	$104,500
Prevention	Trauma-Informed Systems (Ages 0-5)	First5 SMC	$156,750
	Community Outreach, Engagement and Capacity Building		
	Substance Use Prevention	ALAS; BACHAC;Tauluma for Tongans; the Social Changery	$422,316
	Office of Diversity and Equity	BHRS Staff	$613,273
	Health Equity Initiatives	Co-chairs; BHRS Staff	$357,389
	Health Ambassador Program	BHRS Staff	$148,657
	Health Ambassador Program - Youth	StarVista	$308,544
	Parent Project	OneEPA, StarVista, CARON; BHRS Staff	$206,646
Recognition of Early Signs of MI	Youth and Adult Mental Health First Aid	OneEPA, StarVista, Kingdom Love, National Council	$356,794
Stigma Discrimination and Suicide Prevention	Digital Storytelling and Photovoice	BHRS Staff; YLI	$236,196
	Mental Health Awareness; Stigma Reduction	BHRS Staff; CalMHSA	$218,239
	SMC Suicide Prevention Roadmap	BHRS Staff; CalMHSA	$248,239
Early Intervention	SMART	American Med Response West	$140,583
	Primary Care Based (80% PEI)	BHRS Staff; Ravenswood	$623,584
	Early Psychosis - (re)MIND + BEAM	Felton Institute	$1,140,036
	Crisis Hotline	StarVista/Telecare	$1,393,254
Access & Linkage to Treatment	North County Outreach	HealthRight 360	$386,650
	East Palo Alto Outreach	One EPA	$235,882
	Coastside Community Engagement (80%PEI)	ALAS; YLI	$377,169
	SMC Pride Center (65% PEI)	StarVista	$645,059
	allcove Youth Drop-In Center	Peninsula Health Care District	$522,500
	Older Adult Peer Counseling (50% PEI)+ Outreach	Peninsula Family Service	$580,788
	PEI Admin	BHRS Staff	$914,196
	PEI Planning	Various	$230,763
	PEI Evaluation	RDA, AIR (.10),Alison	$264,609
		GRAND TOTAL PEI	$12,013,465
		Percent Ages 0-25 (51% required)	56%
		Percent PEI (20% target)	**20%**

Innovations (INN)			
	PIONEERS	HR360 AARS	$304,435
	Adult Residential In-home Support Element (ARISE)	Mental Health Association	$330,000
	Mobile Behavioral Health - Farmworkers	Ayudando Latinos a Sonar (ALAS)	$485,000
	Music Therapy for Asian/Asian Americans	NEMS/Creative Vibes Therapy	$274,118
	Recovery Connection Drop-In Center	Voices of Recovery	$590,664
	Peer Support for Peer Workers	TBD	$150,000
	Pet Fostering for Housing Stability and Wellness	County Health, PHPP/BHRS MOU	$290,000
	allcove Half Moon Bay	CoastPride	$500,000
	PIVOT - developing capacity for MediCal billing	TBD	$1,000,000
	Admin/Overhead	BHRS	$310,000
	INN Evaluation	RDA; AIR; CCPA (Joyce Chu)	$365,100
		TOTAL INN	$4,599,317

Obligated Funds			
	Total Reserve		$28,362,318
	Innovation Encumbered		$9,554,128
	WET Encumbered		$2,240,000
	One-Time Spend Plan (CFTN)		$6,140,000
	One-Time Spend Plan (Housing)		$10,500,000
	One-Time Spend Plan (System Transformation)		$3,102,900
		TOTAL Obligated	$59,899,346

		Total Ongoing Budget	$66,792,987
		One-Time	$19,742,900
		MHSA GRAND TOTAL BUDGET	**$86,535,887**

FY 2025-26 Mental Health Services Act Annual Update
Funding Summary

County: San Mateo

Date: 3/13/2025

	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 2025/26 Funding						
1 Estimated Unspent Funds from Prior Fiscal Years	30,612,112	18,349,879	11,356,032	1,351,719	2,493,453	5,355,145
2 Estimated New FY 2025/26 Funding	39,568,506	9,892,127	2,603,191	0	0	0
3 Transfer in FY 2025/26[a/]	0	0	0	2,580,000	6,152,626	0
4 Access Local Prudent Reserve in FY 2025/26	0	0	0	0	0	0
5 Estimated Available Funding for FY 2025/26	70,180,618	28,242,006	13,959,223	3,931,719	8,646,079	5,355,145
B. Estimated FY 2025/26 MHSA Expenditures	60,573,105	12,013,465	4,599,317	2,580,000	6,770,000	0
G. Estimated FY 2025/26 Unspent Fund Balance	9,607,513	16,228,541	9,359,906	1,351,719	1,876,079	5,355,145

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2025	5,355,145
2. Contributions to the Local Prudent Reserve in FY 2025/26	0
3. Distributions from the Local Prudent Reserve in FY 2025/26	0
4. Estimated Local Prudent Reserve Balance on June 30, 2026	5,355,145

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 2025/26 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: San Mateo

Date: 3/13/2025

	Fiscal Year 2025-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1 Children and Youth FSP	4,140,200	3,796,403	343,797	0	0	0
2 Transition Age Youth FSP	3,474,267	3,075,695	398,572	0	0	0
3 Adults and Older Adults FSP	15,995,929	10,756,736	5,239,193	0	0	0
4 Housing Supports	9,027,664	8,804,117	223,547	0	0	0
	-		0	0	0	0
	-		0	0	0	0
	-		0	0	0	0
	-		0	0	0	0
	-		0	0	0	0
	-		0	0	0	0
Non-FSP Programs				0	0	0
1 Substance Use Integration	2,009,932	2,009,932	0	0	0	0
2 Older Adult System of Care	1,448,397	1,419,411	28,986	0	0	0
3 Criminal Justice Integration	680,481	509,481	171,000	0	0	0
4 Other System Development	6,209,564	5,319,771	889,794	0	0	0
5 Peer and Family Supports	4,591,388	4,390,579	200,809	0	0	0
6 Primary Care Integration	299,648	164,675	134,974	0	0	0
7 Infrastructure Strategies	1,602,172	1,602,172	0	0	0	0
8 Outreach & Engagement	3,810,130	3,341,170	468,961	0	0	0
9 Housing (One-Time Spend Plan)	10,500,000	10,500,000	0	0	0	0
10 System Transformation (Previously called infrastructure Strategies) (One-Time Spend Plan)	3,102,900	3,102,900	0			
	0					
	0					
	0					
	0					
	0			0	0	0
CSS Administration	957,615	957,615	0	0	0	0
CSS Planning	187,344	187,344	0	0	0	0
CSS Evaluation	635,104	635,104	0	0	0	0
CSS MHSA Housing Program Assigned Funds	0	0	0	0	0	0
Total CSS Program Estimated Expenditures	68,672,737	60,573,105	8,099,632	0	0	0
FSP Programs as Percent of Total Ongoing	61.25%	56%				

FY 2025/26 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: San Mateo

Date: 3/13/2025

	Fiscal Year 2025-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention & Early Intervention						
1 Early Childhood Community Team	627,000	627,000	0	0	0	0
2 Community Interventions for School Age and TAY	658,350	658,350	0	0	0	0
PEI Programs - Prevention						
1 Trauma Informed Systems (Ages 0-5)	156,750	156,750	0	0	0	0
2 Community Outreach, Engagement and Capacity Building	2,056,824	2,056,824	0	0	0	0
PEI Programs - Early Intervention						
1 Early Onset of Psychotic Disorders	1,140,036	1,140,036	0	0	0	0
2 Early Crisis Interventions	1,533,837	1,533,837	0	0	0	0
4 Primary Care/Behavioral Health Integration	623,584	623,584	0	0	0	0
PEI Programs - Recognition of Early Signs of MI						
1 Youth, Teen and Adult Mental Health First Aid	356,794	356,794	0	0	0	0
PEI Programs - Access and Linkage to Treatment						
1 Outreach Collaboratives	622,532	622,532	0	0	0	0
2 Coastside Communit Engagement	377,169	377,169	0	0	0	0
3 SMC Pride Center	645,059	645,059	0	0	0	0
4 allcove Youth Drop-In Center	522,500	522,500	0	0	0	0
5 Older Adul Peer Counseling & Outreach	580,788	580,788	0	0	0	0
PEI Programs - Stigma and Discrimination Reduction						
1 Storytelling Program	236,196	236,196	0	0	0	0
2 Mental Health Awareness	64,451	64,451	0	0	0	0
PEI Programs - Suicide Prevention						
1 Sucide Prevention Inititive	94,451	94,451	0	0	0	0
PEI Administration	914,196	914,196	0	0	0	0
PEI Planning	230,763	230,763				
PEI Evaluation	264,609	264,609				
PEI Assigned Funds - CalMHSA	307,576	307,576				
Total PEI Program Estimated Expenditures	12,013,465	12,013,465	0	0	0	0

FY 2025/26 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: San Mateo

Date: 3/13/2025

	Fiscal Year 2025-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1 PIONEERS	304,435	304,435				
2 Adult Residential In-home Support Element	330,000	330,000				
3 Mobile Behavioral Health - Farmworkers	485,000	485,000				
4 Music Theray for Asian/Asian Americans	274,118	274,118				
5 Recver Connection Drop-In Center	590,664	590,664				
6 Peer Support for Peer Workers	150,000	150,000				
7 Animal Care for Housing Stability	290000	290,000				
8 allcove Half Moon Bay	500000	500,000				
9 PIVOT - MediCal billing	1,000,000	1,000,000				
10 INN Evaluation	365,100	365,100				
	0	0				
	0	0				
	0	0				
	0	0				
	0	0				
	0	0				
	0	0				
	0	0				
20	0	0				
INN Administration	310,000	310,000				
Total INN Program Estimated Expenditures	4,599,317	4,599,317	0	0	0	0

FY 2025/26 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: San Mateo

Date: 3/13/2025

	Fiscal Year 2025-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1 Training and Technical Assistance	900,000	900,000				
2 Training for/by Consumers	300,000	300,000				
3 Behavioral Health Career Pathways	165,000	165,000				
4 Financia Incentives	515,000	515,000				
	-					
	-					
	-					
	-					
	-					
	-					
	-					
	-					
	-					
	-					
	-					
	-					
	-					
	-					
	-					
	-					
WET Administration	700,000	700,000				
Total WET Program Estimated Expenditures	2,580,000	2,580,000	0	0	0	0

FY 2025/26 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: San Mateo

Date: 3/13/2025

	Fiscal Year 2025-26					
	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 (One-Time)						
1 Clinic Facilities	0	5,600,000				
	0					
	0					
	0					
	0					
	0					
	0					
	0					
CFTN Programs - Technological Needs Projects						
1 Client Devices	330,000	330,000				
2 Apps	300,000	300,000				
CFTN Programs - Technological Needs Projects (One-Time)						
1 Asset Refresh	540,000	540,000				
	0					
	0					
	0					
	0					
	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	1,170,000	6,770,000	0	0	0	0

APPENDIX 4. FSP EVALUATION REPORT, FY 2023–24

Full Service Partnership Outcomes

Findings From Fiscal Year 2023–2024

Christine Walsh, PhD; Meera Ragunathan; Laina Serrer;
Tania Dutta, MPP, PMP

San Mateo County Behavioral Health and Recovery Services

December 2024

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Contents

Exhibits

Executive Summary

The objective of this annual report is to provide a comprehensive assessment and evaluation of the Full Service Partnership program for Fiscal Year 2023 through 2024 (FY 2023–2024). Full service partnerships (FSPs) are a set of enhanced, integrated services administered through San Mateo County (SMC)-contracted providers to assist individuals with mental and behavioral health challenges. The American Institutes for Research® (AIR®) is working with SMC Behavioral Health and Recovery Services (BHRS) (hereafter the County) to understand how enrollment in FSPs promotes resilience and improves the health outcomes of individuals served. AIR conducted a mixed-methods study using both primary and secondary data sources to evaluate the FSP program in FY 2023–2024. The data sources for this annual report include: (1) self-reported survey data from clients, (2) health care utilization data from electronic health records (EHRs), and (3) in-depth client and provider interviews. Specifically, this evaluation report summarizes demographics and outcomes for individual clients enrolled in the FSP program in FY 2023–2024 and describes clients' and treatment team members' perspectives and experiences with FSP.

The County currently has four comprehensive FSP providers: (1) Edgewood Center and (2) Fred Finch Youth Center (hereafter Edgewood/Fred Finch),[1] serving children, youth, and transitional age youth (TAY), and (3) Caminar and (4) Telecare, serving adults and older adults. This year's report includes self-reported data from Edgewood/Fred Finch and Caminar since FSP inception in 2006. Telecare modified its EHR system for FSP program data in December 2018 and has encountered challenges in providing the data prior to the EHR system conversion. Due to the change, we report data for Telecare from December 2018 to June 2024 separately.

Exhibits 1 and 2 present outcomes of the FSP program in the County for children (16 years and younger), TAY (16–25 years), adults (25–59 years), and older adults (60 years and older). Self-reported FSP outcomes presented in Exhibits 1 and 2 were obtained only from Edgewood/Fred Finch and Caminar. Because of the reporting systems changes for Telecare, those data are provided in Exhibit 4.

For all outcomes, we compared the year just prior to enrollment in an FSP and the first year enrolled in an FSP. The percentage change is the change in the number of clients with the outcome of interest (e.g., homelessness, incarceration, mental health emergencies) in the year after joining an FSP relative to the year prior to participating in an FSP out of the total number of clients in that age group. For example, out of 118 adult clients, 48 experienced homelessness

[1] The self-reported data from Edgewood Center and Fred Finch Youth Center are combined into one data set; therefore, we refer to both centers as Edgewood/Fred Finch in this report to be consistent with the data.

before enrollment in FSP. This number changed to 35 in the first year following FSP, which is a 27% improvement. We first provide self-reported and EHR outcomes for adults and older adults, followed by child and TAY clients.

Self-Reported Outcomes (Caminar) for Adults and Older Adults. For adults and older adults, most self-reported outcomes improved from the year prior to enrollment to the first year enrolled in an FSP. This finding is shown in the top portion of Exhibit 1. Counts are presented in Exhibit 1 to indicate the number of clients with the outcome of interest, and percentages are presented in parentheses.

- Eight out of a combined 16 outcomes statistically significantly improved for adult and older adult Caminar clients. Fewer adult and older adult clients experienced homelessness, arrests, and mental and physical health emergencies. In addition, employment increased among adult clients.
- Among Caminar clients, no older adults reported being employed before and after they joined FSP. Fewer older adult clients (3 versus 2) reported receiving treatment for substance use disorder. However, given the smaller sample size of the older adults, caution is needed when interpreting a change with small magnitude.

Health Care Utilization (EHR Data) for Adults and Older Adults. For all combined adult and older adult clients, we detected improvements in outcomes from the year before joining an FSP compared with the first year in an FSP for all health care utilization outcomes. Compared with the year before joining an FSP, there was a

- decrease in the percentage of clients with any hospitalization,
- decrease in mean hospital days per client,
- decrease in the percentage of clients using any psychiatric emergency services (PES), and
- decrease in mean PES events per client.

These changes were all statistically significant for adults as seen in the bottom portion of Exhibit 1, while only the decreases in percentage of clients with any PES events are statistically significant for older adults.

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

FSP outcomes	Adults (25 to 59 years)			Older Adults (60 years and older)		
Self-reported outcomes	***N = 118***			***N = 24***		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Homelessness	48 (41%)	35 (30%)	-27%	5 (21%)	4 (17%)	-20%
Detention or incarceration	35 (30%)	22 (19%)	-37%*	3 (13%)	3 (13%)	0%
Employment	1 (1%)	6 (5%)	500%	0 (0%)	0 (0%)	N/A
Arrests	20 (17%)	4 (3%)	-80%*	3 (13%)	1 (4%)	-67%
Mental health emergencies	87 (74%)	33 (28%)	-62%*	13 (54%)	4 (17%)	-69%*
Physical health emergencies	50 (42%)	17 (14%)	-66%*	6 (25%)	4 (17%)	-33%
Active substance use disorder (SUD)	63 (53%)	60 (51%)	-5%	5 (21%)	5 (21%)	0%
SUD treatment	28 (24%)	33 (28%)	18%	3 (13%)	2 (8%)	-33%
Health care utilization (EHR data)	***N = 404***			***N = 85***		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Hospitalization	125 (31%)	59 (15%)	-72%*	22 (26%)	12 (14%)	-45%$^{+}$
Hospital days per client	11.1	3.7	-67%*	9.3	4.0	-57%$^{+}$
PES	211 (52%)	153 (38%)	-56%*	34 (40%)	21 (25%)	-38%*
PES event per client	1.6	1.0	-37%*	0.6	0.1	-46%$^{+}$

Notes. Self-reported outcomes do not include Telecare. SUD = substance use disorder; EHR = electronic health record; PES = psychiatric emergency services; Yr = year. The percentage difference with employment for older adults is reported as N/A because the percentage of older clients with employment was 0% in the prior year and in the year after (from 0% to 0%). Blue font indicates outcomes that significantly improved. Black font indicates outcomes that did not change or changed but the change was not statistically significant. * Indicates a change significantly different from 0 at 0.05 significance level. $^{+}$ indicates a change marginally different from 0 at 0.08 significance level.

Self-Reported Outcomes (Edgewood/Fred Finch) for Child and TAY Clients. The trends for child and TAY clients are similar to those for adult and older adult clients (as shown in the top portion of Exhibit 2), where most of the self-reported outcomes improved from the year prior to enrollment to the first year enrolled in an FSP.

- Twelve out of a combined 16 outcomes improved for child and TAY clients, of which eight improvements were statistically significant. Fewer child and TAY clients experienced homelessness, arrests, mental and physical health emergencies, and school suspensions. There was an improvement in detention or incarceration and rating of school attendance among TAY clients, but not among child clients.
- Three outcomes worsened for child or TAY clients. For child clients, there were statistically significant decreases between the year prior to FSP and the first year after FSP enrollment for both academic grades and attendance. TAY clients reported decreased academic grades during the first year after enrolling in an FSP program, but this change was not statistically significant.

Health Care Utilization (EHR Data) for Child and TAY Clients. For child and TAY clients, we detected statistically significant improvements in outcomes from the year before FSP compared with the first year of FSP for all health care utilization outcomes. Compared with the year before joining an FSP, there was a

- decrease in the percentage of clients with any hospitalization,
- decrease in mean hospital days per client,
- decrease in the percentage of clients using any PES, and
- decrease in mean PES events per client.

As shown in the lower portion of Exhibit 2, all decreases except for mean hospital days per client were statistically significant for child clients; the declines in use of PES and mean PES events per client were statistically significant for TAY clients.

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

FSP outcomes	Child (16 years and younger)			TAY (17 to 25 years)		
Self-reported outcomes	***N = 238***			***N = 284***		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Homelessness	9 (4%)	8 (3%)	-11%	33 (12%)	32 (11%)	-3%
Detention or incarceration	27 (11%)	27 (11%)	0%	38 (13%)	31 (11%)	-18%
Arrests	30 (13%)	10 (4%)	-67%*	63 (22%)	20 (7%)	-68%*
Mental health emergencies	94 (39%)	13 (5%)	-86%*	129 (45%)	29 (10%)	-78%*
Physical health emergencies	19 (8%)	1 (0%)	-95%*	58 (20%)	5 (2%)	-91%*
Suspensions	47 (20%)	21 (8%)	-55%*	27 (10%)	6 (2%)	-78%*
Grade (self-rating)	3.32	2.97	-10%*	3.19	3.11	-3%
Attendance (self-rating)	2.24	1.97	-12%*	2.46	2.49	2%
Health care utilization (EHR data)	***N = 214***			***N = 229***		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Hospitalization	10 (5%)	3 (1%)	-91%*	26 (11%)	16 (7%)	-67%
Hospital days per client	1.2	0.1	-91%	4.1	2.0	-51%+
PES	52 (24%)	23 (11%)	-56%*	93 (41%)	58 (25%)	-66%*
PES event per client	0.5	0.2	-54%*	1.1	0.7	-37%*

Notes. EHR = electronic health record; PES = psychiatric emergency services; Yr = year. Red font indicates a statistically significant negative percentage change. Blue font indicates outcomes that significantly improved. Black font indicates outcomes did not change or changed but the change was not statistically significant from the year before and the first year of enrollment in an FSP. * indicates a change significantly different from 0 at 0.05 significance level. + indicates a marginally significant different change from 0 at 0.08 significance level.

Exhibit 3 describes the hospitalization outcomes for all clients across all age groups who joined the FSP program since 2006, completed one full year or more in an FSP program, and had EHR health utilization data. Among these clients, we looked at their mean health utilization outcomes in the first year of FSP and the year prior to FSP. As shown, FSP clients had significantly improved hospitalization outcomes across all measures. Exhibits 17–20 further show reductions in hospitalization and PES health care utilization outcomes over the years since the inception of the FSP program.

Exhibit 3. Hospitalization Outcomes for All Combined FSP Clients (*N* = 932)

	Percentage/Mean (95% Confidence Interval)
Percentage of clients with any hospitalization*	
1 year before	20% (17%–22%)
Year 1 during	10% (8%–12%)
Mean number of hospital days*	
1 year before	6.9 (5.6–8.3)
Year 1 during	2.5 (1.7–3.3)
Percentage of clients with any PES event*	
1 year before	42% (39%–45%)
Year 1 during	27% (24%–30%)
Mean PES events, per client*	
1 year before	1.2 (1.0–1.3)
Year 1 during	0.7 (0.6–0.8)

Notes. PES = psychiatric emergency services. Significance testing was conducted using chi-square tests for percentages and *t* tests for means. * indicates result is statistically significant at the .05 level.

Because of the issue with Telecare's incomplete data noted earlier, we conducted a separate analysis for the self-reported Telecare data. Exhibit 4 shows self-reported outcomes among Telecare clients for the year before FSP compared with the first year with FSP. There were 152 clients in the Telecare survey data who completed at least a year of an FSP between December 1, 2018, through June 30, 2024. Our analysis combined all age groups (TAY, adults, and older adults) served by Telecare for this separate analysis due to the reduced sample size.

Exhibit 4 below shows improvements for Telecare clients in homelessness, arrests, and active substance use disorder, with all decreases in these negative events being statistically significant. No change was observed in the employment outcomes of Telecare clients. Telecare clients had poorer outcomes after joining an FSP in three outcome areas: more Telecare clients reported being detained or incarcerated or having mental and physical health emergencies in the first year of an FSP compared to the year prior to the FSP. However, the change was only statistically significant for the increased experience of mental health emergencies. The increase in self-reported mental and physical health emergencies may be explained by several factors, such as the introduction of more clients with complex medical conditions that require greater utilization of medical services. The increase may also indicate heightened awareness of mental health issues and improved access to mental health services after joining FSP, potentially

leading to increased diagnoses and intervention for previously untreated issues. More regular monitoring and crisis intervention can also detect crises earlier, leading to proactive hospitalizations. Alternatively, individuals may experience heightened mental health challenges during transitions in the first year of joining an FSP, such as reducing substance use, which may result in withdrawal symptoms and new stressors that temporarily elevate mental health emergencies. Fewer clients reported receiving treatment for substance use disorder, although the change was not statistically significant. This change may be interpreted positively if it is a result of better screening and referral to treatment when needed. We also see a significant decrease in reported active substance use, which may explain the decrease in reported treatment.

Exhibit 4. Percentage Change in Outcomes Among Telecare Clients, Year Before FSP Compared With First Year With FSP

FSP self-reported outcomes	Combined Telecare TAY, Adults, and Older Adults (*N* = 152)		
	Yr before	*Yr after*	*Change*
Homelessness	41 (27%)	10 (7%)	-76%*
Detention or incarceration	34 (22%)	42 (28%)	24%
Employment	0 (0%)	0 (0%)	N/A
Arrests	45 (30%)	17 (11%)	-62%*
Mental health emergencies	18 (12%)	54 (36%)	200%*
Physical health emergencies	15 (10%)	24 (16%)	60%
Active SUD	96 (63%)	47 (31%)	-51%*
SUD treatment	10 (7%)	8 (5%)	-20%

Notes. SUD = substance use disorder; Yr = year. Exhibit 4 indicates the change in the percentage of clients with any events, comparing the year just prior to FSP with the first year with FSP. The percentage difference with employment is reported as N/A because the percentage of clients with employment in the year before and in the year after is 0% (from 0% to 0%). Blue font indicates outcomes that significantly improved. Red (and bold) font indicates outcomes that significantly worsened. Red font indicates a statistically significant worse change in outcome. Black font indicates outcomes did not change or changed but the change was not statistically significant. * indicates a change significantly different from 0 at 0.05 significance level.

Outcomes From Key Informant Interviews With FSP Treatment Team Staff and Clients. Many FSP clients and treatment team members we interviewed said they were satisfied with the program but had specific recommendations to improve the program in the future. Exhibit 5 discusses key findings from these interviews.

Exhibit 5. Summary of FSP Treatment Team Staff and Client Interview Findings

Key Client and Treatment Team Experiences With the FSP Program	
Overall experience and satisfaction with the program	• Clients noted supportive and satisfactory experiences with the FSP program, which many attributed to positive interactions with case managers. Their goals for program participation included improving mental and physical health, maintaining sobriety, and continuing education. • Treatment team members reported satisfactory and rewarding experiences as staff members of the FSP program, attributing their satisfaction to the productive and efficient work environment. They identified the greatest needs among FSP clients to be access to counseling and psychiatric services, managing substance use, and housing assistance.
Referral process and initiation of treatment	• Clients reported positive feedback on the referral process and comprehensive assistance provided by multidisciplinary treatment teams during initial meetings. They suggested expanding awareness of the program to make it more accessible to potential clients. • Treatment team members generally described the referral and intake processes to be smooth, emphasizing the importance of the warm handoff from the referring provider. However, they noted that lack of supplemental documentation from referring providers is sometimes a challenge.
Experiences with program services and care	• Clients had positive feedback about their experience with FSP case managers and providers, particularly highlighting case manager availability, responsiveness, guidance, and resources. They expressed gratitude for how strong interpersonal connections with other treatment team members have led to positive impacts on health and well-being. However, some clients described issues with interruptions in care, lack of shared lived experiences with their case managers, difficulty scheduling sessions, and lack of personal agency in treatment decisions. • Treatment team members appreciated strong collaboration and communication within their teams, which they attributed to enhanced client care and role satisfaction. However, they identified challenges including high client caseloads, turnover, emotional demands of the work, and gaps in resources and funding that impact staff well-being and client engagement.
Impact on health and quality of life	• Clients noted improvements in their quality of life after enrolling in the FSP program. • Clients and treatment team members reported that the FSP program had a positive impact on clients' mental and physical health outcomes, interpersonal relationships, social networks, and independence.

Overall, the interviews highlight the positive influence of the FSP program on client well-being that is consistent with improvement in client outcomes seen in the quantitative data results. For example, FSP clients reported feeling more stable and independent after enrolling in the program, particularly among individuals who previously were homeless. These findings align with the increase in clients' declines in homelessness from the year prior to being in FSP and the first year enrolled.

The majority of client and provider interviewees reported being satisfied with the program; however, some noted a few areas of the FSP program that could be improved. Exhibit 6 summarizes recommendations based on these findings.

Exhibit 6. Recommendations Based on FSP Treatment Team and Client Interview Findings

Recommendations	
Recommendation 1: Improve staff retention through additional staff training, mental health resources, and incentives	• Implement a comprehensive and ongoing staff training program. • Provide accessible mental health resources like counseling, stress management workshops, Employee Assistance Programs, and mental health workdays. • Offer incentives to boost longer term retention.
Recommendation 2: Expand workforce and increase staff diversity	• Expand the number of team members, especially case managers, and redistribute some tasks to other staff (e.g., administrative assistants). • Increase the number of multilingual staff to cater to the needs of clients. • Conduct diversity and inclusion training sessions.
Recommendation 3: Increase awareness and accessibility of FSP services	• Implement more robust strategic outreach through schools and other community channels. • Encourage providers to coordinate schedules with clients and their families.
Recommendation 4: Ensure consistent team member assignments and implement notifications of team member transitions	• Establish clear guidelines for case manager assignments and prioritize consistency. • Create and disseminate a provider-level survey before new cases are assigned to assess individual case managers' strengths and workload capacities. • Develop a notification system to ensure clients and team members are promptly notified of any staff turnover, including temporary coverage arrangements.

Background and Introduction

The Mental Health Services Act (MHSA), enacted in 2005, provides a dedicated source of funding to improve the quality of life for individuals living with mental illness. In San Mateo County (the County), a large component of this work is accomplished through full service partnerships (FSPs). FSPs provide individualized, integrated mental health services; flexible funding; intensive case management; and 24-hour access to care ("whatever it takes" model) to help support recovery and wellness for persons with serious mental illness (SMI) and their families. There are currently four comprehensive FSP providers in the County: Edgewood Center and Fred Finch Youth Center (hereafter Edgewood/Fred Finch for self-reported and EHR data),[2] serving children, youth, and transitional age youth (TAY); and Caminar and Telecare, serving adults and older adults.

The County has partnered with the American Institutes for Research (AIR) to understand how enrollment in an FSP is promoting resiliency and improving the health outcomes of the County's clients living with mental illness. A combination of qualitative and quantitative data provide the basis of findings for this year's report. Specifically, two quantitative data sources are used: (1) self-reported survey data collected by providers from FSP clients and (2) electronic health records (EHRs) obtained through the County's Avatar system. In addition, this year's report includes qualitative data collected from FSP clients and treatment team members. These data comprise 35 interviews, with 12 clients and 23 treatment team members from four FSP service providers: Caminar, Telecare, Edgewood Center, and Fred Finch.[3]

Quantitative Analysis

This section provides an overview of the data sources and methodologies used to assess client outcomes in FSP programs from 2006 through June 2024. Self-reported data from Edgewood/Fred Finch, Caminar, and Telecare, as well as longitudinal EHR data from the County Avatar system, are analyzed to track changes in client well-being and hospitalizations over time.

This year's report includes self-reported client data collected by Edgewood/Fred Finch and Caminar providers since FSP inception (2006). We report the self-reported data from Telecare from December 2018 to June 2024 separately due to data challenges: Telecare changed its data reporting system for FSP program data in 2018 and continues to experience technical challenges providing the data prior to the system change.

[2] The self-reported data from Edgewood Center and Fred Finch Youth Center are combined into one data set; therefore, we refer to both centers as Edgewood/Fred Finch in this report to be consistent with the data.
[3] Fred Finch served fewer clients this year and therefore our team was unable to interview clients from this FSP provider. However, our team did interview Fred Finch team members.

For the self-reported data, providers collected initial survey data through an intake assessment, called the Partnership Assessment Form (PAF), which includes information on well-being across a variety of measures (e.g., living in a residential setting) at the start of FSP and over the 12-month "lookback" window of the year prior to FSP enrollment. Providers gather survey data on clients during their participation in an FSP in two ways. Life-changing events are tracked by Key Event Tracking (KET) forms, which are triggered by any key event (e.g., a change in residential setting). FSP clients are also assessed every 3 months using the 3-Month (3M) forms. Changes in client outcomes are gathered by comparing data at baseline from PAF forms to follow-up data from KET and 3M forms.

EHR data collected through the County Avatar system contain longitudinal client-level information on demographics, FSP participation, hospitalizations, and psychiatric emergency services (PES) utilization before and after FSP enrollment. The Avatar system is limited to individuals who obtain emergency care in the County hospitals. Hospitalizations outside of the County, or in private hospitals, are not captured.

This report presents changes in clients' self-reported and hospitalization outcomes in 2 consecutive years: (1) the baseline year, that is, the 12 months prior to enrollment in an FSP program; and (2) the first full 12 months of the client's FSP participation. Children (ages 16 and younger), transitional age youth (TAY; ages 17 to 25), adults (ages 25 to 59), and older adults (ages 60 and older) were included in the analysis if they had completed at least 1 full year with an FSP program by June 30, 2024 (the data acquisition date). Trends in EHR data are subsequently presented as an average across all years since inception of the program (2006) as well as annually, by year of FSP program enrollment.

Appendices provide details about our methodology as well as detailed findings for each outcome. Appendix A presents additional detail on residential outcomes. Appendix B provides outcomes for individual FSP providers. Appendix C provides methodology for the self-reported outcomes and EHR-based hospitalization outcomes (i.e., "quantitative methodology"). Appendix D provides methodology for the qualitative interviews (i.e., "qualitative methodology").

Self-Reported Outcomes

Overview

This section presents outcomes for 816 FSP clients across four FSP providers. The results presented in this section compare the first year enrolled in an FSP with the year prior to FSP enrollment for clients completing at least 1 year in an FSP program.

- The Caminar section presents outcomes for 118 adult (ages 26–59) FSP clients and 24 older adult (ages 60 and older) FSP clients who joined and completed at least 1 year in an FSP since 2006.[4]
- The Edgewood/Fred Finch section below presents outcomes for 238 child (ages 16 and younger) FSP clients and 284 TAY (ages 17–25) FSP clients.
- The Telecare section presents outcomes for 152 FSP clients regardless of age, including youth and TAY clients. We combine findings for all age groups when reporting findings for Telecare clients.

Telecare changed its data reporting system on December 1, 2018, and was only able to provide the data after the conversion date due to data reliability issues. Because of the incompleteness of the Telecare data, we conducted a separate analysis for Telecare's self-reported data.

In this section, we first provide a list of self-reported outcomes collected by all providers. We then present findings from the analysis of Caminar and Edgewood/Fred Finch combined data since FSP inception, followed by findings from the analysis using Telecare data since December 2018.

Outcomes Assessed

We describe the self-reported outcomes below. Most of these outcomes are aggregated by age group. Note that employment, homelessness, arrests, and incarceration outcomes are not presented for adults ages 60 or older, due to insufficient observations in this age group for meaningful interpretation.

1. **Clients with any reported homelessness incident:** measured by residential setting indicating homelessness or emergency shelter (sources: PAF and KET)
2. **Clients with any reported detention or incarceration incident:** measured by residential setting indicating jail or prison (sources: PAF and KET)

[4] Caminar's self-reported data also includes 77 TAY clients (ages 17–25); however, we excluded them from the analysis due to lack of ongoing data collection for TAY-specific outcomes.

3. **Clients with any reported employment:** measured by employment in past 12 months and date of employment change (sources: PAF and KET)[5]
4. **Clients with any reported arrests:** measured by arrests in past 12 months and date when arrested (sources: PAF and KET)
5. **Clients with any self-reported mental health emergencies:** measured by mental health emergencies in past 12 months and date of mental health emergency (sources: PAF and KET)
6. **Clients with any self-reported physical health emergencies:** measured by acute medical emergencies in past 12 months and date of acute medical emergency (sources: PAF and KET)
7. **Clients with any self-reported active substance use disorder:** measured by self-report in past 12 months and captured again in regular 3-month updates (sources: PAF and 3M)
8. **Clients in substance use disorder treatment:** measured by self-report in past 12 months and captured again in regular 3-month updates (sources: PAF and 3M)[6]

In addition, we also examined three outcomes specific to child and TAY clients:

1. **Clients with any reported suspensions:** measured by school suspensions in past 12 months (source: PAF) and date suspended (source: KET)
2. **Average school attendance self-rating:** an ordinal ranking (1–5) indicating overall school attendance with 1 indicating lower attendance and 5 indicating higher attendance; measured for past 12 months (source: PAF), at start of FSP (source: PAF), and over time on FSP (source: 3M)
3. **Average school grade self-rating:** an ordinal ranking (1–5) indicating overall grades with 1 indicating lower grades and 5 indicating higher grades; measured for past 12 months (source: PAF), at start of FSP (source: PAF), and over time on FSP (source: 3M)

Mental and Physical Health Emergencies by Living Situation. Mental and physical health emergencies are considered in conjunction with residential status for all age groups combined. Specifically, we explore the likelihood of an emergency in relation to whether the client's living situation in their first year of FSP participation is "advantageous" (i.e., living with family or foster family, living alone, and paying rent, or living in group care or assisted living) or "higher risk" (i.e., homeless, incarcerated, or in a hospital setting).

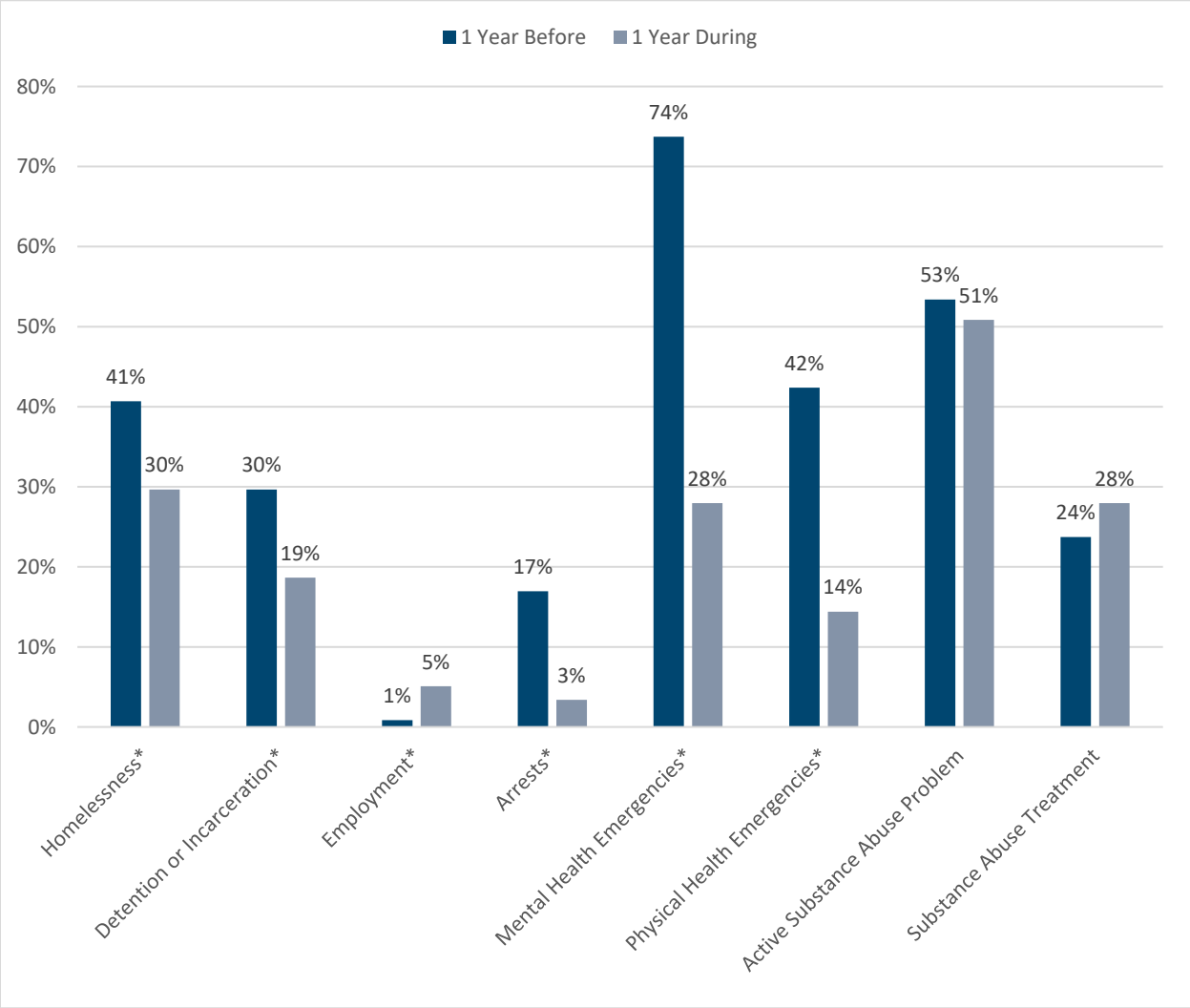
[5] Employment outcome is not applicable to child and TAY clients.
[6] If more partners reported receiving substance use disorder treatment in the year following their FSP enrollment, it may indicate that the integrated care and case management services offered through FSP connected partners with needed care. However, if more partners have substance use disorder, there would be more partners reporting receiving treatment.

Caminar

Self-Reported Outcomes by Age Group

Adults. Exhibit 7 compares outcomes for adult clients in the year prior to FSP enrollment with their first year in an FSP. Homelessness, incarceration, arrests, self-reported mental and physical health emergencies statistically significantly decreased after enrollment in FSP. Employment and reported treatment of substance use disorder increased, although only employment was significant. These findings demonstrate improvements for adult clients in the first year of FSP enrollment for all outcomes, and significant improvements for all except active substance use problems and substance use treatment.

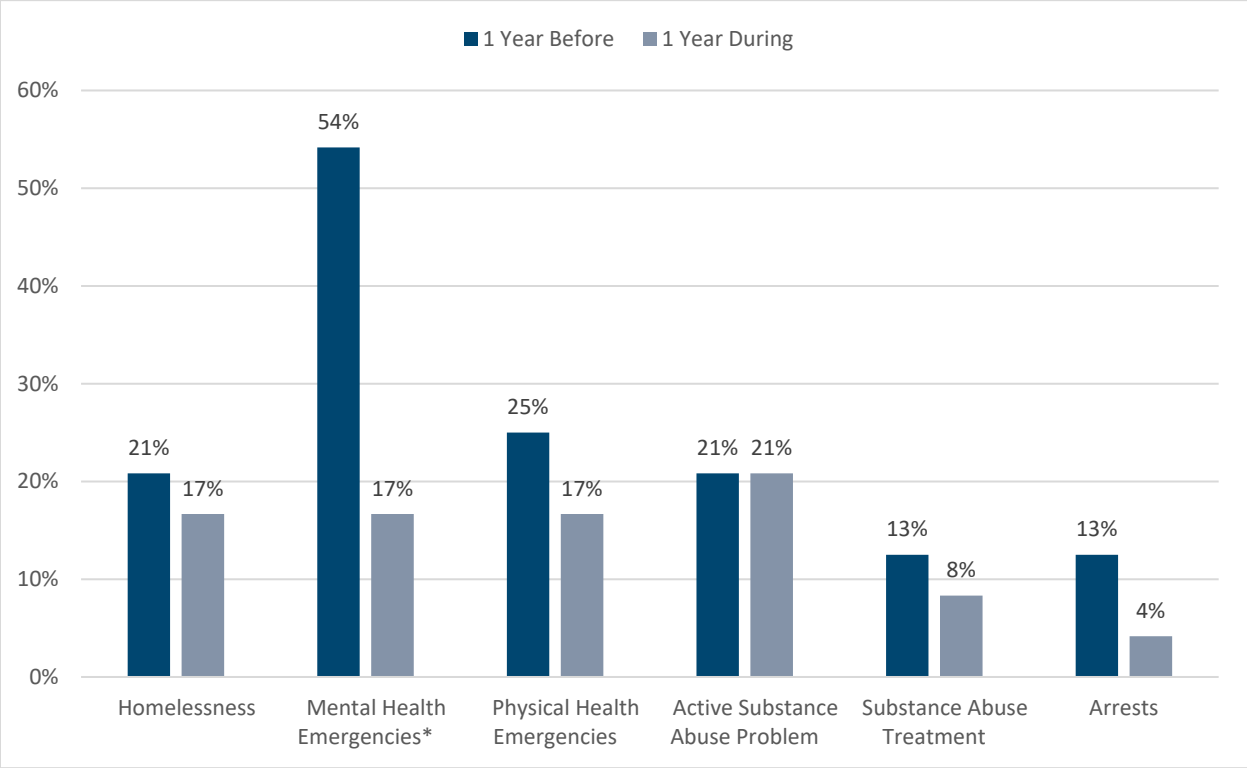
Exhibit 7. Outcomes for Adult Clients Completing 1 Year With FSP (*N* = 118)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Older Adults. Exhibit 8 compares outcomes in the year prior to FSP enrollment with outcomes reported in the first year of FSP enrollment for older adult clients (age 60 and above). Similar to adult clients, self-reported mental and physical health emergencies generally decreased. However, the decrease in mental health emergencies is the only statistically significant outcome for older adults. Each of these outcomes demonstrated improvement for older adult clients in the first year of FSP enrollment. The same number of older adults (*N* = 5) reported having an active substance use problem after enrolling in an FSP. Slightly fewer older adults (from three in the year prior to two in the first year of FSP) reported treatment for a substance use disorder during the first year of FSP enrollment compared with 1 year before. Given the small sample size, these results should be interpreted with caution.

Exhibit 8. Outcomes for Older Adult Clients Completing 1 Year With FSP (*N* = 24)

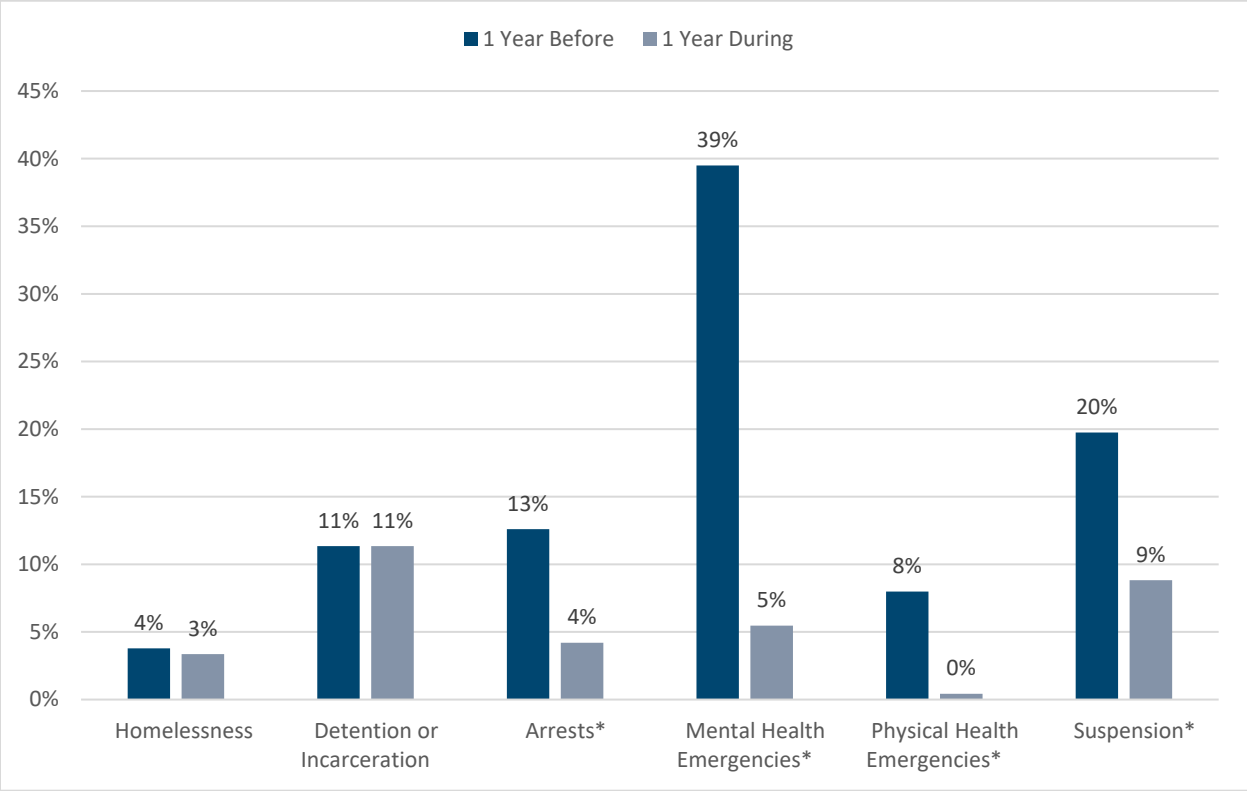


Note. Employment and incarceration outcomes are not presented for older adults due to insufficient observations in this age group for meaningful interpretation. An outcome with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Edgewood/Fred Finch

Children. Exhibit 9 shows the comparison of outcomes in the year prior to FSP enrollment with the first year enrolled in an FSP program for child clients (age 16 and younger). There was a decrease in homelessness, arrests, suspensions, and mental or physical health emergencies after enrollment in an FSP program. There is a significant decrease in the incidence of mental health emergencies from the year prior to the first year of FSP (39% vs. 5%). Conversely, detention or incarceration remained the same for children (27 incidents in the first year with FSP and 27 in the year prior to FSP enrollment). However, the incidence of arrests decreased after enrollment in FSP (10 in the first year with FSP compared with 30 in the year just prior). The decline in arrests, mental and physical health emergencies, and school suspensions are statistically significant.

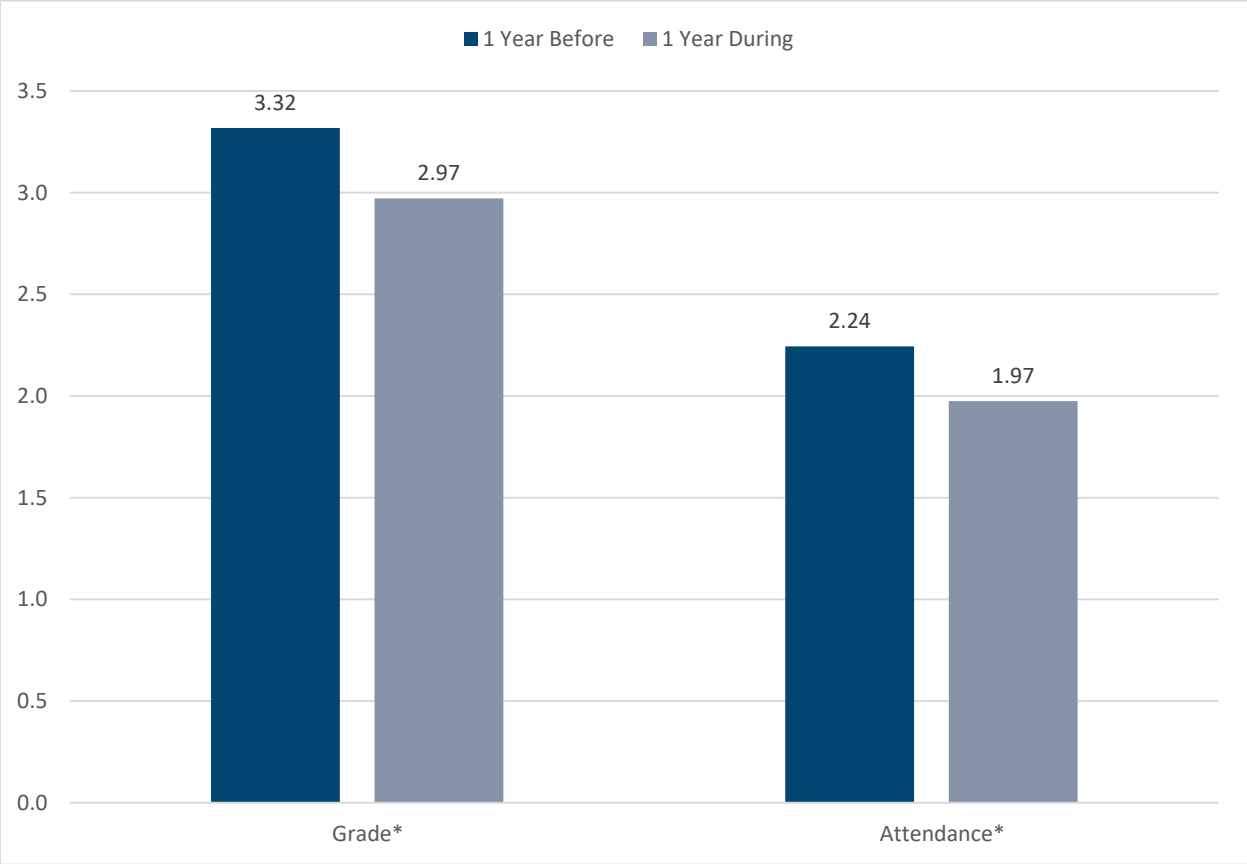
Exhibit 9. Outcomes for Child Clients Completing 1 Year With FSP (*N* = 238)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Exhibit 10 presents outcomes on self-rated school attendance and grades. School attendance and grades for child clients slightly declined after enrolling in an FSP program. These ratings are on a 1–5 scale, coded such that a higher score is better. Though relatively small, the decreases in school attendance and grades are statistically significant.

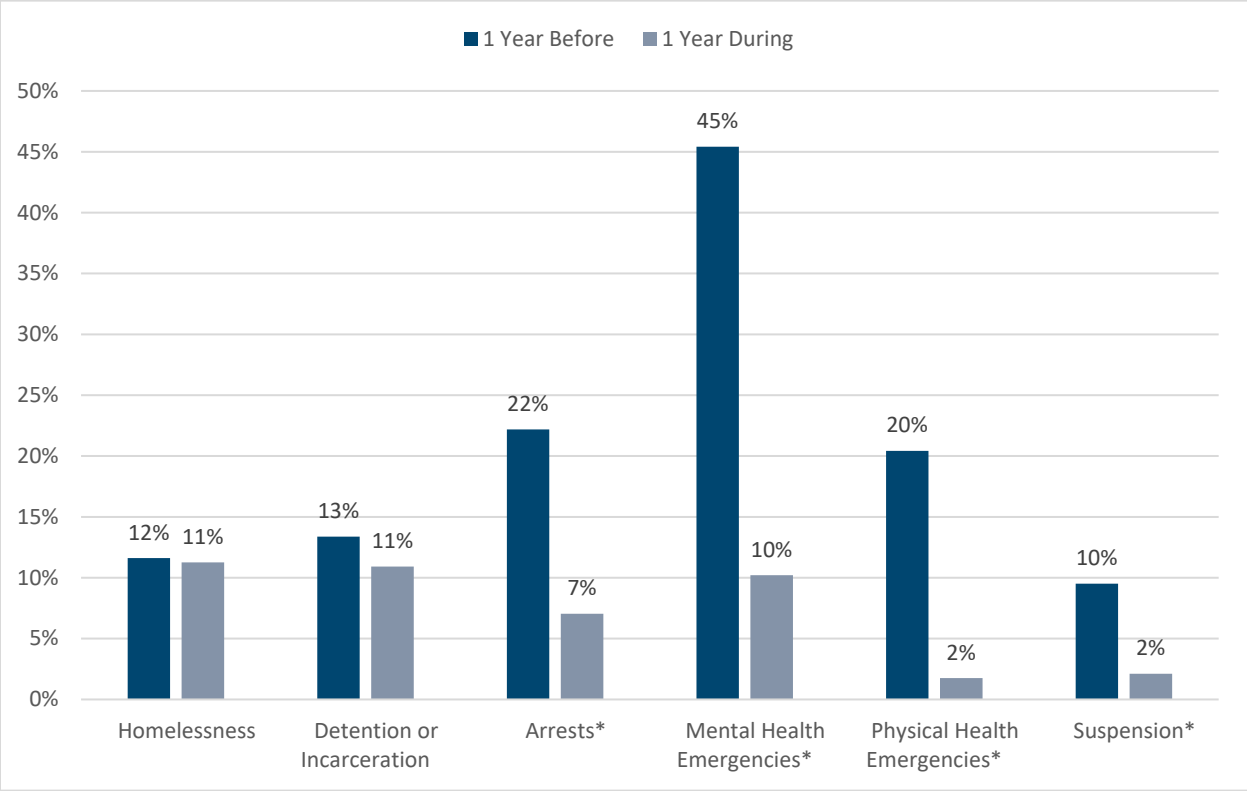
Exhibit 10. School Outcomes for Child Clients Completing 1 Year With FSP (*N* = 238)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level. The ratings are on a 1–5 scale, coded such that a higher score is better.

TAY. Exhibit 11 shows the comparison of outcomes in the year prior to FSP to the first year in the program for TAY clients.[7] All self-reported outcomes decreased (an improved status), among which improvements in arrests, mental and physical health emergencies, and school suspensions are statistically significant.

Exhibit 11. Outcomes for TAY Clients Completing 1 Year With FSP (*N* = 284)

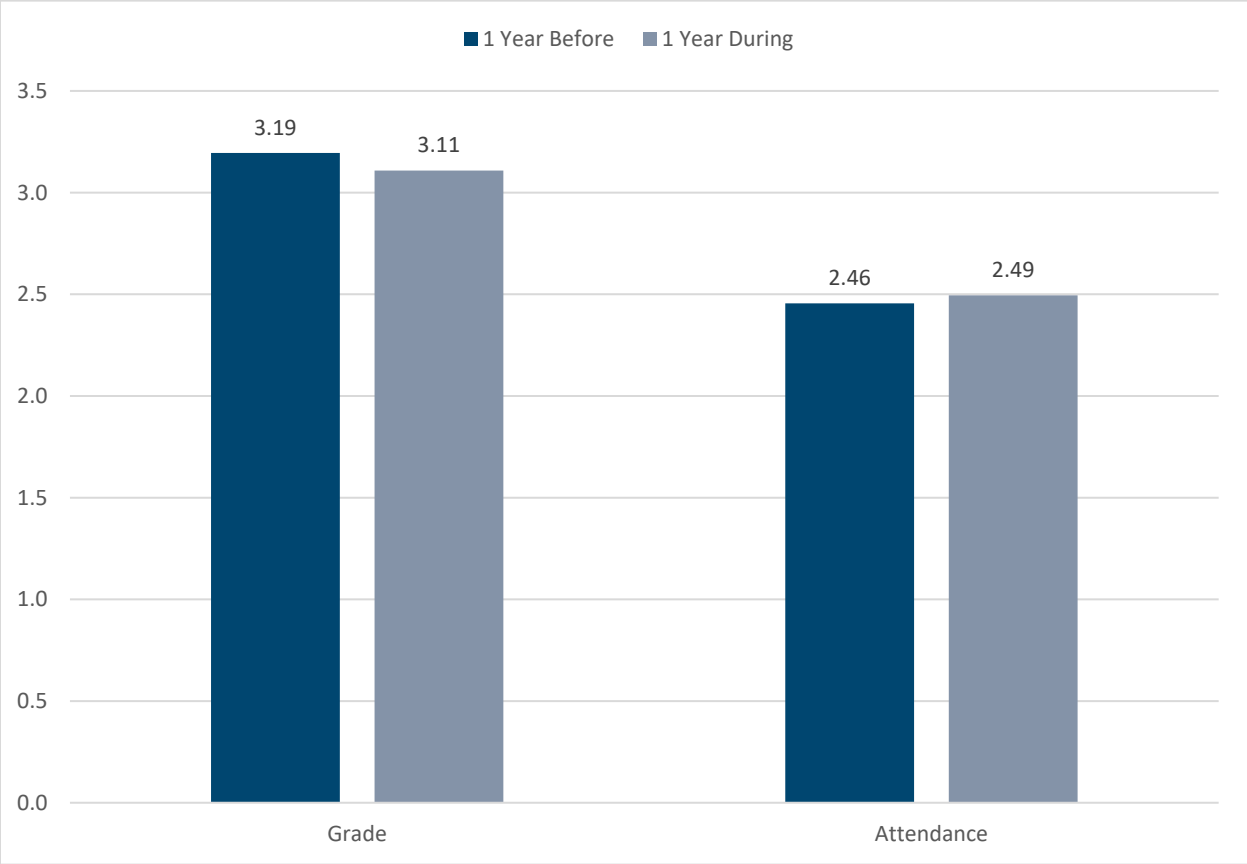


Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

[7] The older TAY partners in Caminar are excluded from these outcomes because these providers do not reliably gather TAY-specific outcomes. Note that employment as an outcome is not presented for TAY because many of these individuals are in school.

Exhibit 12 below shows outcomes on school attendance and grades for TAY clients. These ratings are on a 1–5 scale; a higher score is better. There was a small decrease in grades and a slight increase in attendance after enrollment in an FSP. Neither outcome showed a statistically significant difference after FSP enrollment.

Exhibit 12. School Outcomes for TAY Clients Completing 1 Year With FSP (*N* = 284)

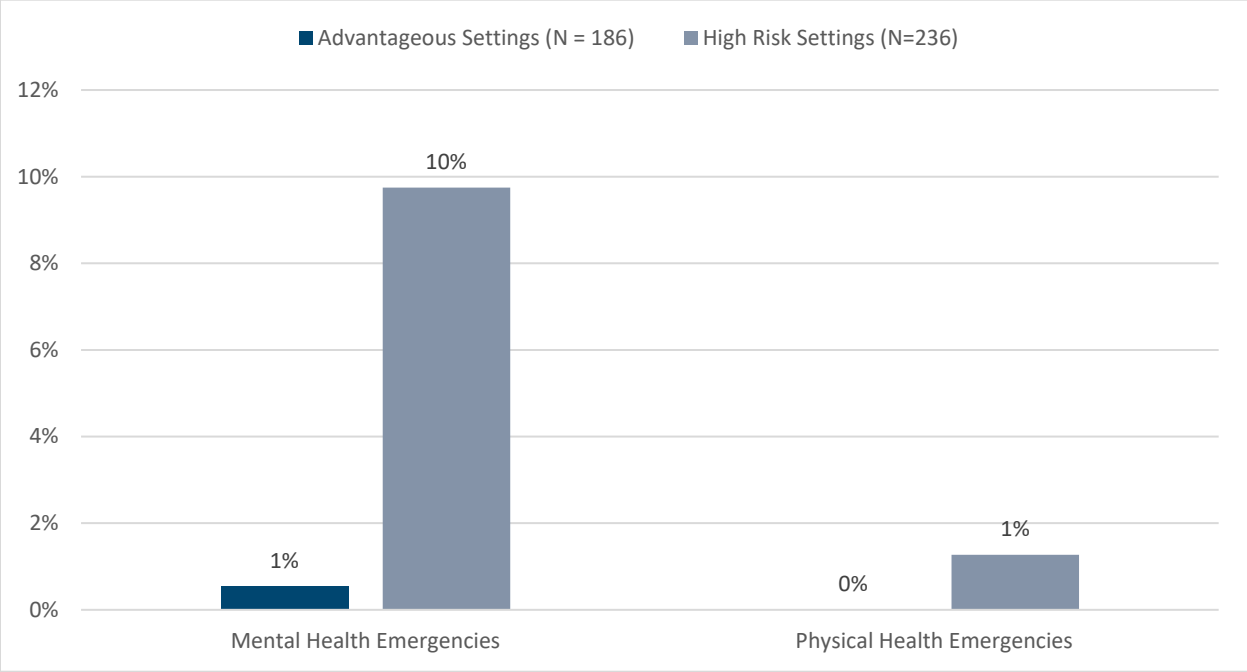


Note. The ratings are on a 1–5 scale; a higher score is better.

Mental and Physical Health Emergencies by Living Situation

Exhibit 13 shows the mental and physical health emergencies in adult and older adult clients living in advantageous versus higher risk living situations in the first year of participating in an FSP. Advantageous settings are defined as living with family or foster family, living alone and paying rent, or living in group care or assisted living. High-risk settings are defined as homelessness, incarceration, or in a hospitalized setting. As shown below, both mental and physical health emergencies were more common among individuals in a high-risk residential setting in their first year of FSP participation.

Exhibit 13. Emergency Outcomes Grouped by Residential Setting

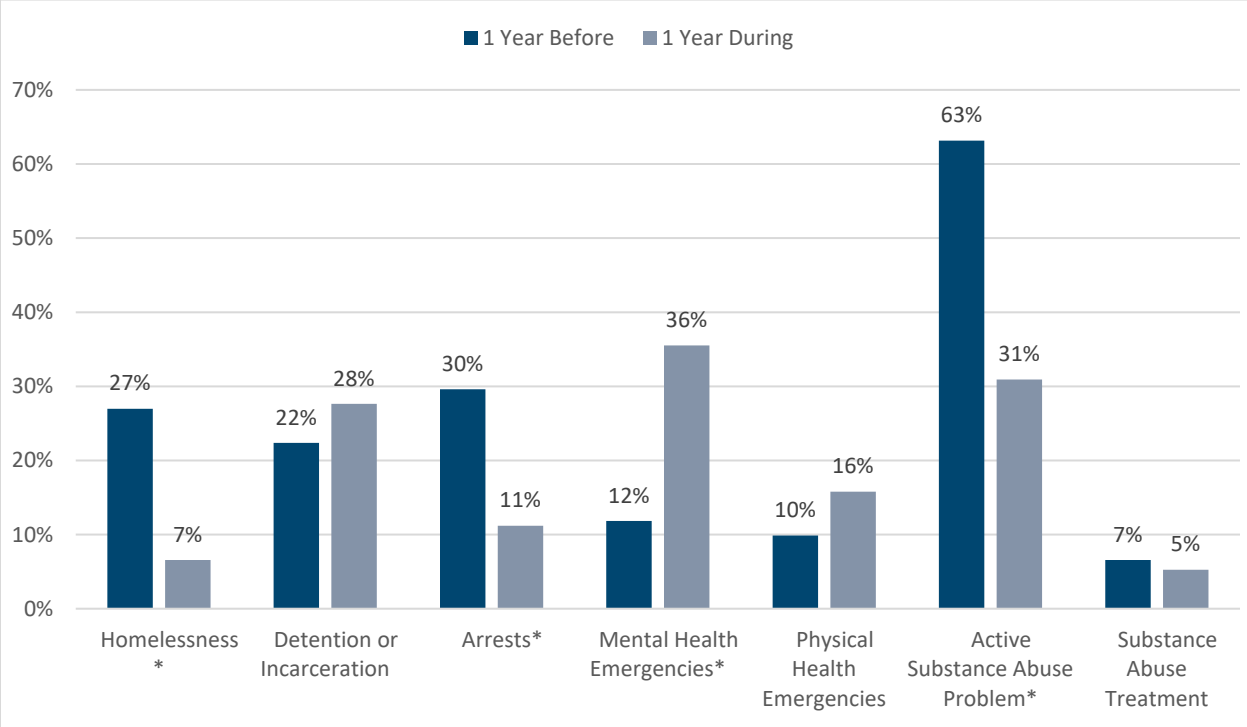


Telecare

Self-Reported Outcomes—All ages

Telecare data include 152 adult and older adult clients who have completed at least 1 year of FSP as of June 30, 2024. Because of the small sample size for Telecare, we combined findings for all age groups. Exhibit 14 shows the comparison of outcomes for all Telecare clients in the year prior to FSP enrollment with the first year in an FSP. Homelessness, arrests, and substance use disorders decreased after enrolling in an FSP, and the decreases are statistically significant. Each of these outcomes demonstrates improvements in the first year of FSP enrollment. Mental and physical health emergencies were more frequently reported in Telecare clients a year after enrolling in an FSP program, although this increase was only significant for mental health emergencies. The increase in mental and physical health emergencies may be a sign of higher engagement with health services, leading to more diagnosis and acute treatment as previously untreated issues become visible. Detention or incarceration was also slightly higher a year after enrolling in an FSP program, but the increase is not statistically significant. Additionally, fewer Telecare clients reported receiving treatment for substance use disorders 1 year during the FSP program compared with 1 year before enrollment. However, we also see a significant decrease in reported active substance use, which may explain the decrease in reported treatment. There were no data for changes in employment.

Exhibit 14. Outcomes for Telecare Clients Completing 1 Year With FSP (*N* = 152)

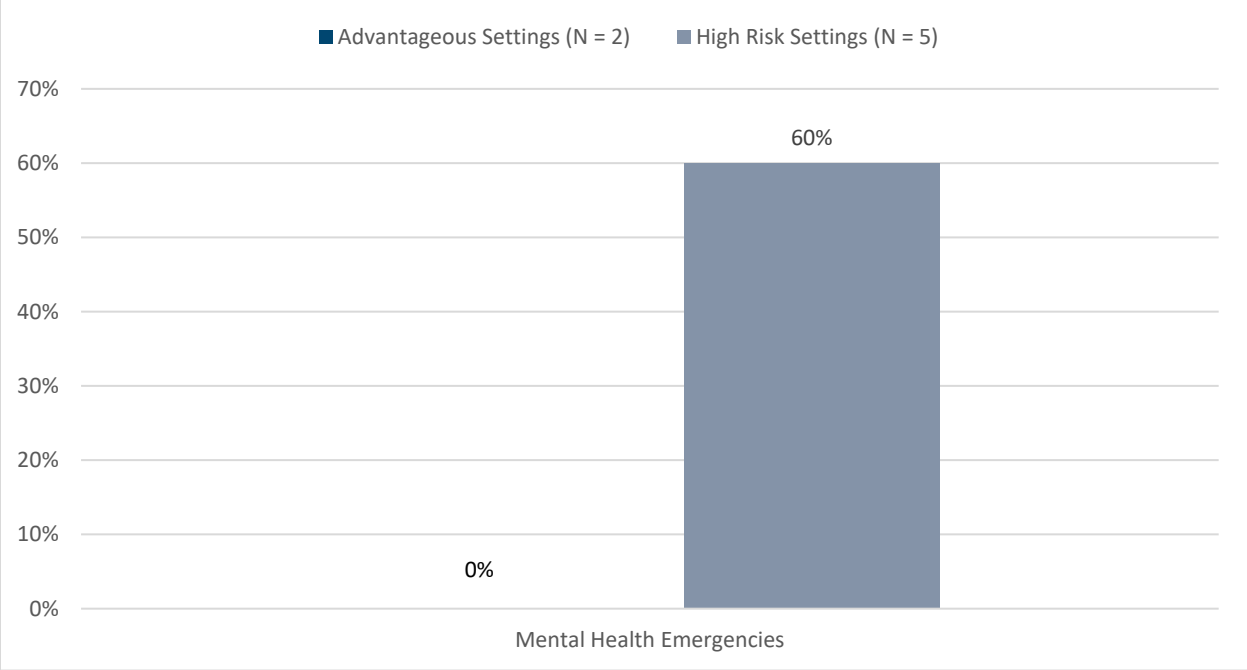


Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Mental and Physical Health Emergencies by Living Situation

Exhibit 15 shows the mental and physical health emergencies in adult and older adult clients living in advantageous versus higher risk living situations in the first year of an FSP. Mental health emergencies only occurred in individuals who lived in at least one high-risk residential setting in their first year of FSP participation, with 60% reporting a mental health emergency. Meanwhile, there were no physical health emergencies reported for adult and older adult clients living in a high-risk residential setting or in advantageous situations. However, the sample sizes for both advantageous and high-risk subgroups are small and the results here should be interpreted with caution due to increased potential for bias and may not be representative of the larger population.

Exhibit 15. Emergency Outcomes as a Function of Residential Setting Among Telecare Clients



Health Care Utilization

Overview

This section describes (a) overall health care utilization across all clients from the beginning of an FSP program, (b) health care utilization by age group from the beginning of an FSP program, and (c) health care utilization for clients by year (2006–2023).

Using the County's EHR data, we present four hospitalization outcomes for 932 total FSP clients including 214 child, 229 TAY, 404 adult, and 85 older adult FSP clients:

1. **Clients with any hospitalizations:** measured by any hospital admission in the past 12 months
2. **Clients with any PES:** measured by any PES event in the past 12 months
3. **Average length of hospitalization (in days):** the number of days associated with a hospital stay in the past 12 months
4. **Average number of PES events:** the number of PES events in the past 12 months

Overall Health Care Utilization Outcomes Across All Clients

We detected statistically significant changes in outcomes from the year before FSP compared with the first year in FSP for all hospitalization outcomes (Exhibit 16). The percentage of clients with any hospitalization decreased by half from 20% before FSP to 10% during FSP. The average number of days spent in the hospital decreased from 6.94 days before FSP to 2.50 days during FSP. The percentage of clients with any PES decreased from 42% before FSP to 27% during FSP. The average number of PES events decreased from 1.16 events before FSP to 0.71 events during FSP.

Exhibit 16. Hospitalization Outcomes Among FSP Clients (*N* = 932)

	Percentage/Mean (95% Confidence Interval)
Percentage of clients with any hospitalization*	
1 year before	20% (17%–22%)
Year 1 during	10% (8%–12%)
Mean number of hospital days*	
1 year before	6.9 (5.6–8.3)
Year 1 during	2.5 (1.7–3.3)

	Percentage/Mean (95% Confidence Interval)
Percentage of clients with any PES event*	
1 year before	42% (39%–45%)
Year 1 during	27% (24%–30%)
Mean PES events, per client*	
1 year before	1.2 (1.0–1.3)
Year 1 during	0.7 (0.6–0.8)

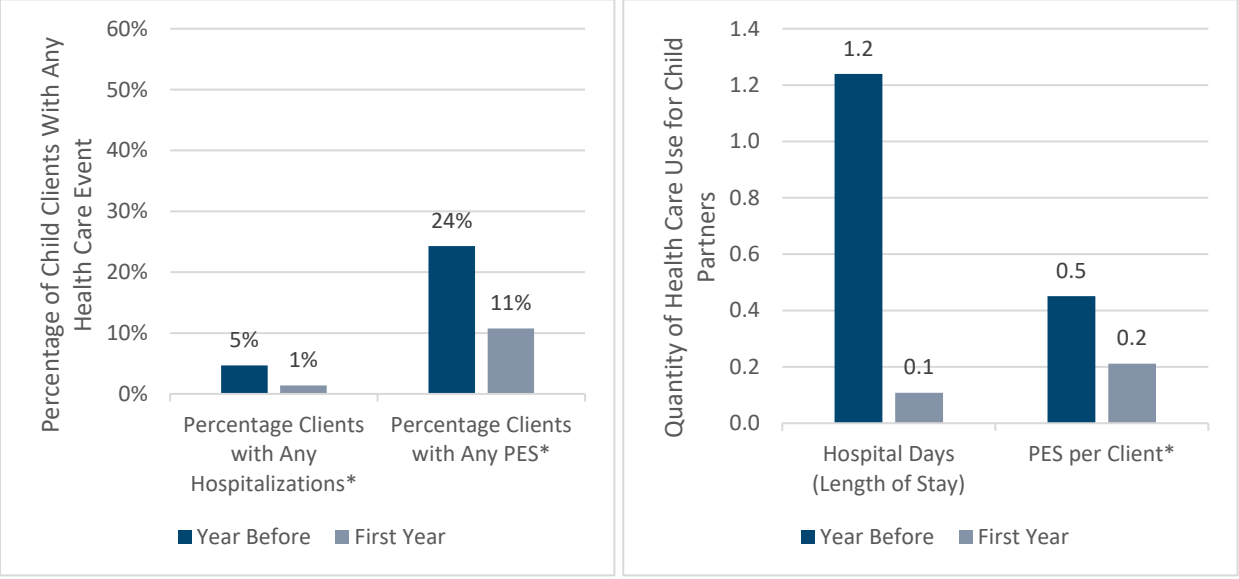
Note. Significance testing was conducted using chi-square tests for percentages and *t* tests for means. * indicates result is statistically significant at the .05 level.

Health Care Utilization for FSP Clients by Age Group

Hospitalization outcomes are presented in Exhibits 17–20 by age group. For all four age groups, the percentage of FSP clients with any hospitalization or PES event showed a statistically significant decrease after joining an FSP. The mean number of hospital days experienced by FSP clients and average number of PES events also had a statistically significant decrease after FSP enrollment for all age groups.

As shown in Exhibit 17, all outcomes but the change in outcome for mean hospital stays are statistically significant for children.

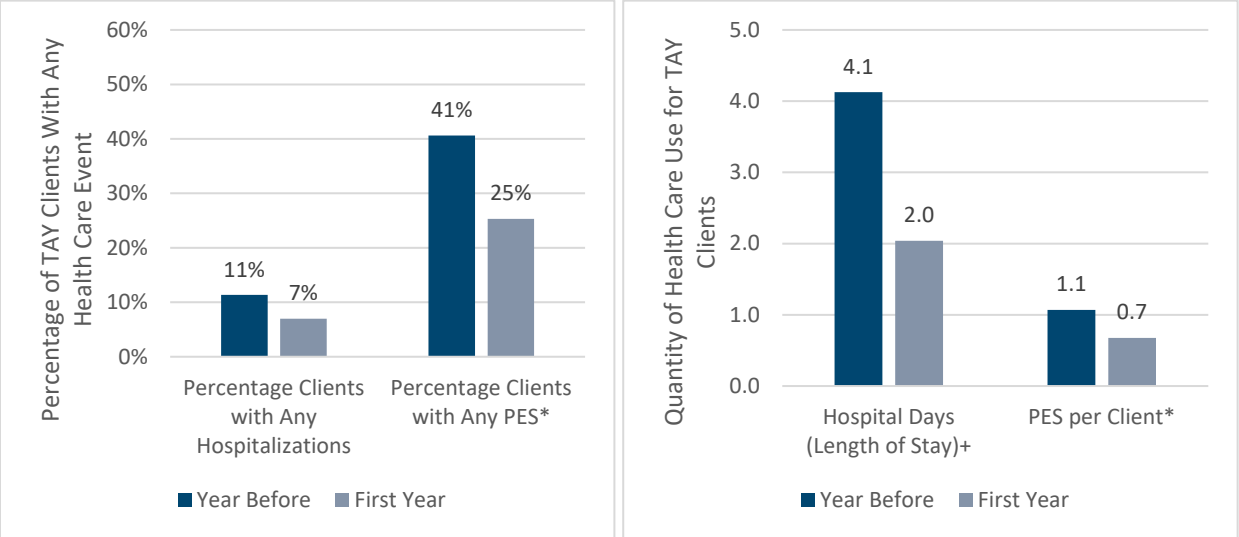
Exhibit 17. Hospitalization and PES Outcomes for Child Clients Completing 1 Year With FSP (*N* = 214)



Note. An outcome with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

For TAY, the change in percentage of clients with PES and the change in mean number of PES events are statistically significant; the change in mean number of hospital days is marginally significant.

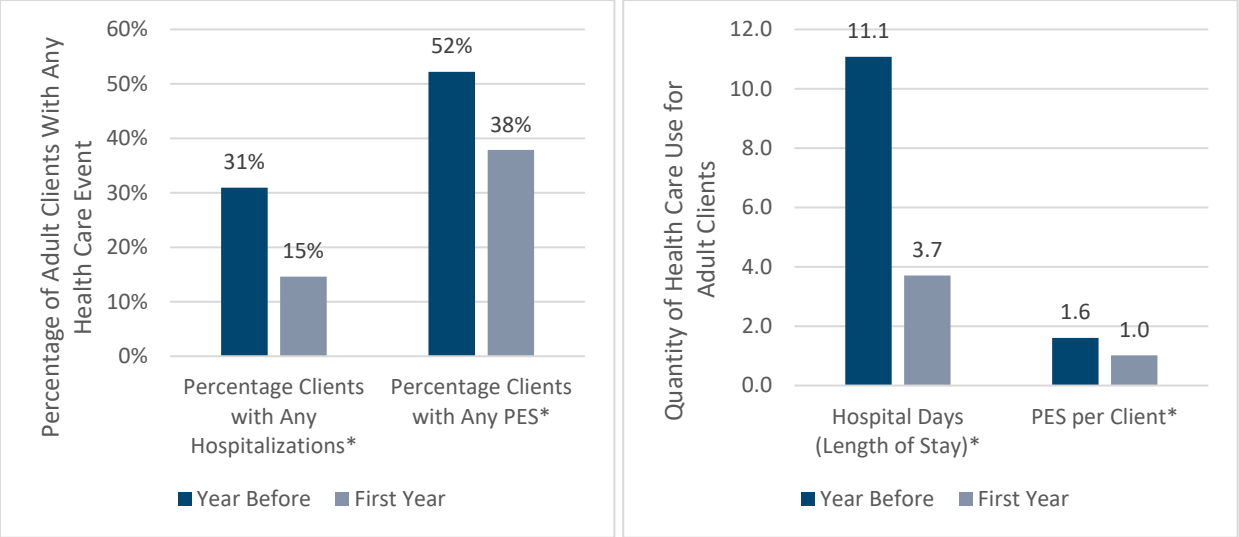
Exhibit 18. Hospitalization and PES Outcomes for TAY Clients Completing 1 Year With FSP (*N* = 229)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level. + indicates a change significantly different from 0 at 0.08 significance level.

In Exhibit 19 below, all four outcomes are statistically significant for adults.

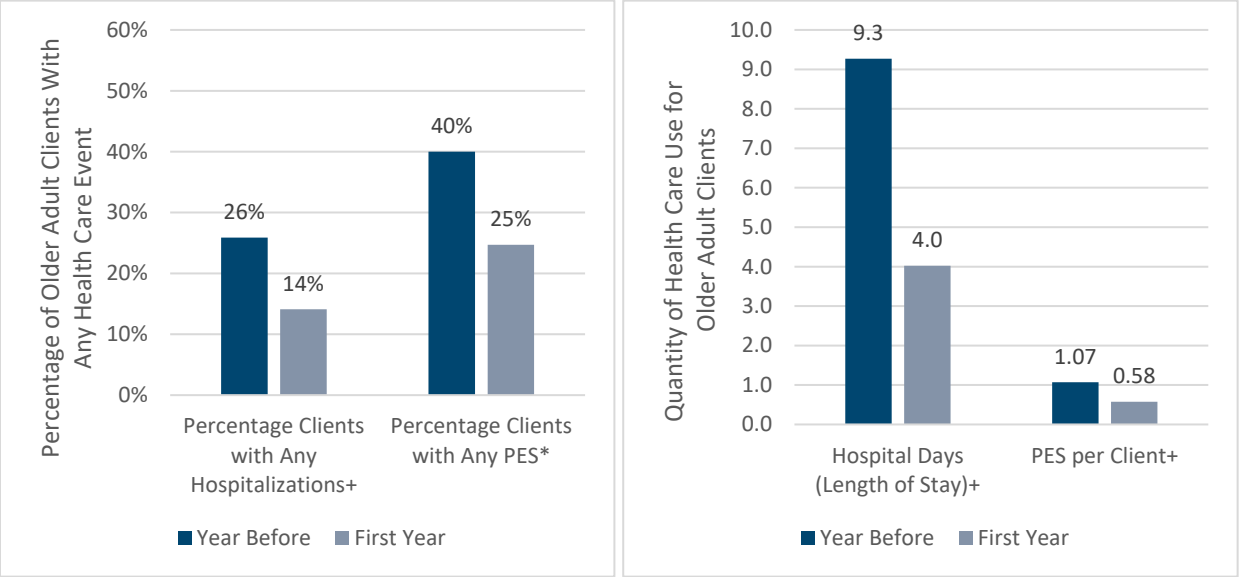
Exhibit 19. Hospitalization and PES Outcomes for Adult Clients Completing 1 Year With FSP (*N* = 404)



Note. An outcome with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

As shown in Exhibit 20, for older adults only the change in percentage of clients receiving PES is statistically significant, and mean number of hospital days and number of PES per client are marginally significant.

Exhibit 20. Hospitalization and PES Outcomes for Older Adult Clients Completing 1 Year With FSP (*N* = 85)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level. + indicates a change significantly different from 0 at 0.08 significance level.

Health Care Utilization for FSP Clients Over Time

Exhibits 21–24 show the four health care utilization outcomes, including the percentage of clients with any hospitalization, mean hospital days per client, percentage of clients using any PES, and mean PES event per client, stratified by year of enrollment. As Exhibit 21 shows, every year the percentage of clients with any hospitalization decreased after joining an FSP program, with the exception of 2022 where percentage remained the same.

Exhibit 21. Percentage of Clients With Any Hospitalization by FSP Enrollment Year

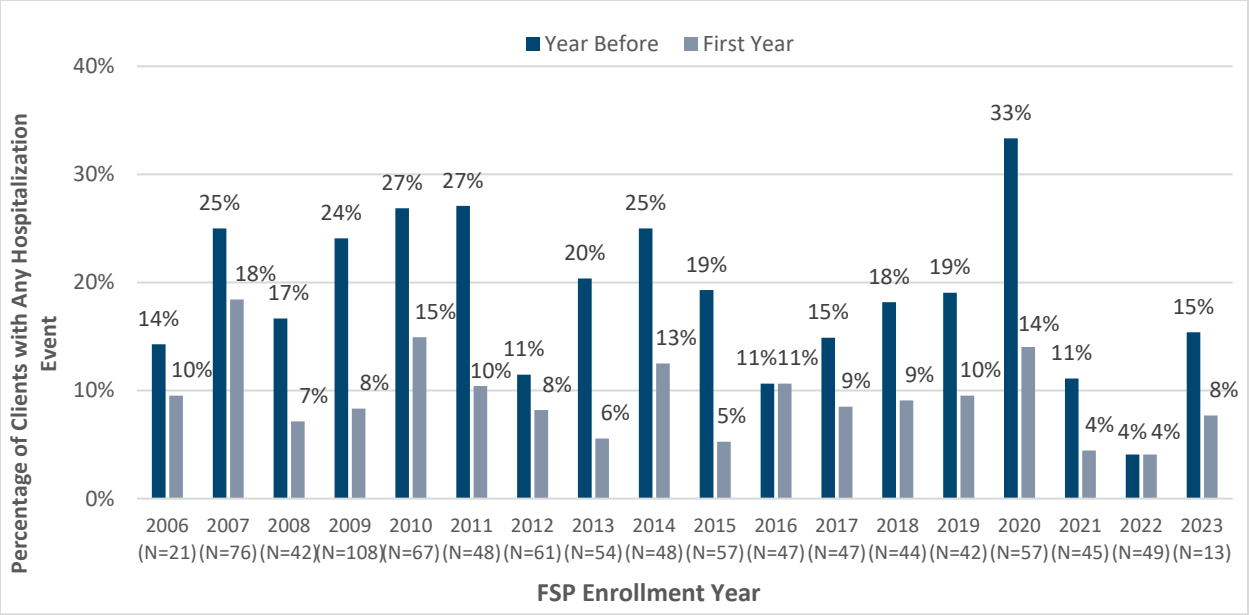


Exhibit 22 displays the mean hospital days per client by enrollment year. Apart from the 2006 and 2007 cohorts, all other years show a decrease in the average hospital days from the year before FSP to the first year of FSP enrollment. Hospital days decreased by an average of over 7 days from the prior year for the 2023 enrollment cohort.

Exhibit 22. Mean Number of Hospital Days by FSP Enrollment Year

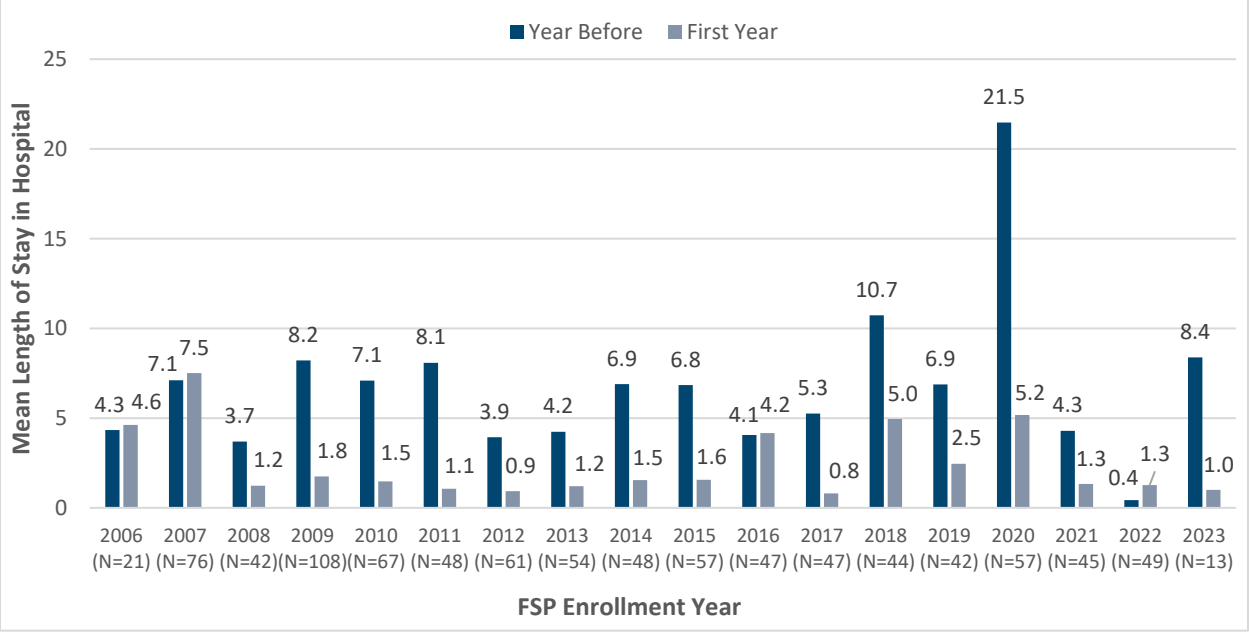


Exhibit 23 below displays the percentage of clients with any PES event by the year they began FSP. All cohorts experienced a decline in the likelihood of a PES event from the year before FSP to the first year of FSP enrollment.

Exhibit 23. Percentage of Clients With Any PES Event by FSP Enrollment Year

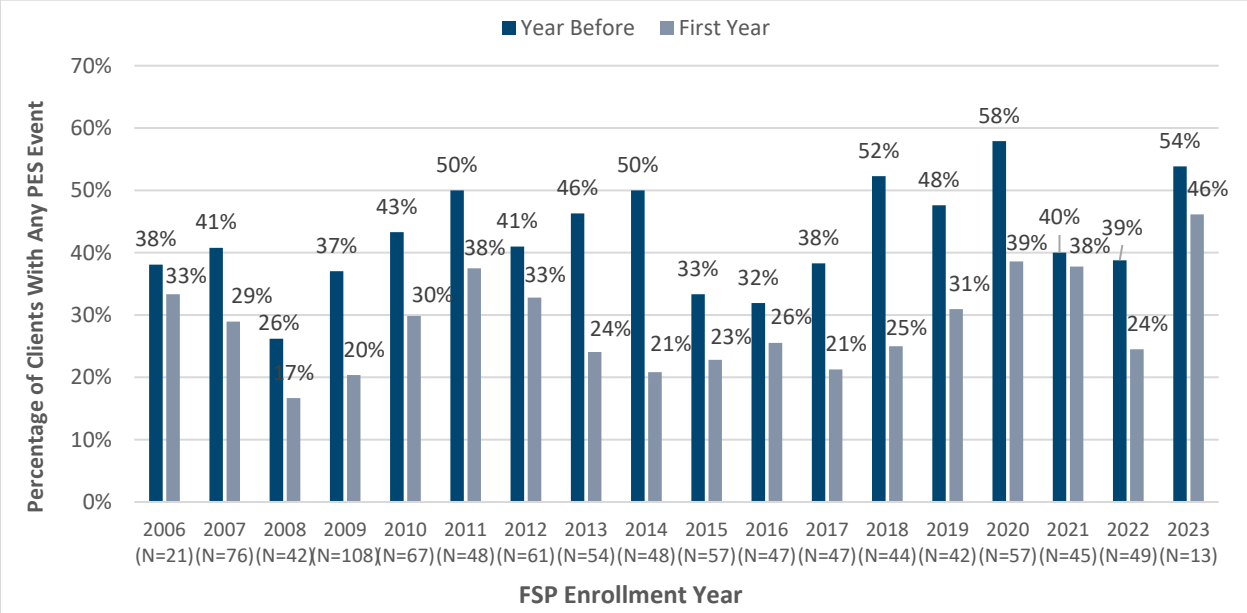
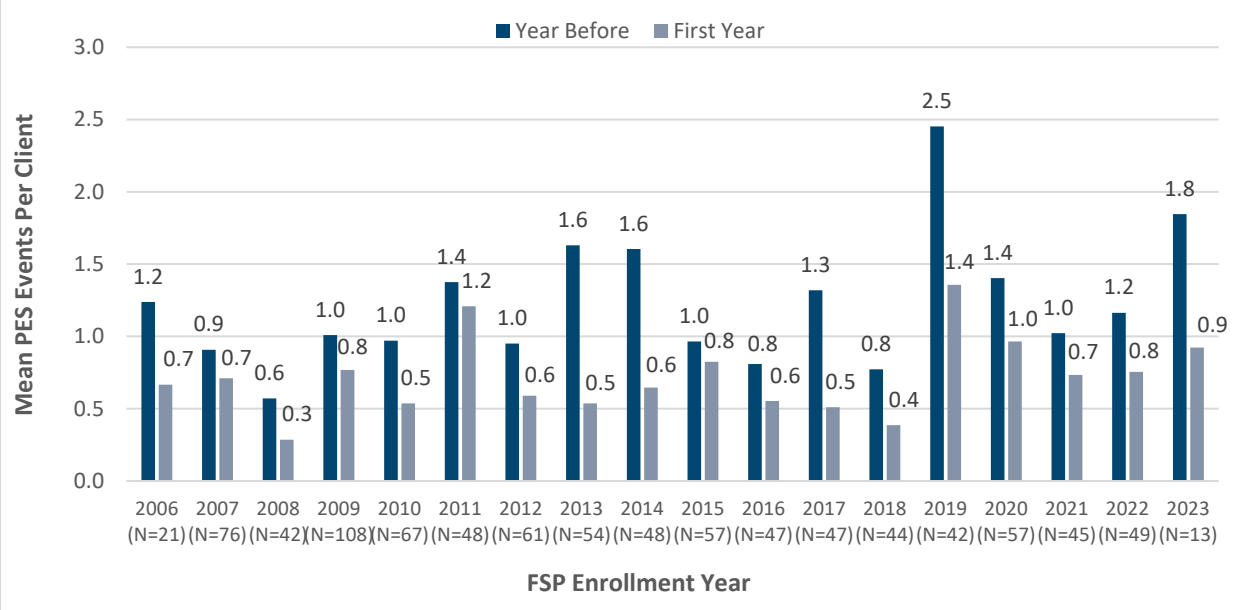


Exhibit 24 displays the mean PES events per client by FSP enrollment year. All cohorts experienced a reduction in PES events from the year before FSP to the first year of FSP enrollment.

Exhibit 24. Mean PES Events by FSP Enrollment Year



The quantitative analysis of the FSP programs reveals significant improvements across multiple client outcomes. The self-reported data show notable reductions in homelessness, arrests, and mental and physical health emergencies, particularly among TAY and adult clients. Employment rates for adults also improved, while youth clients' school-related outcomes, such as attendance and grades, declined slightly. The EHR data results further indicate substantial decreases in hospitalization rates, average hospital days, and psychiatric emergency service (PES) utilization across all age groups. These trends are consistent over time, with marked declines from the year prior to FSP enrollment to the first year of participation. Despite these overall positive outcomes, Telecare clients reported an increase in mental health emergencies, potentially reflecting heightened engagement with health services and improved diagnosis. Overall, the data underscore the effectiveness of FSPs in enhancing client well-being and reducing reliance on emergency care, though areas like academic outcomes for youth clients and early mental health crises may warrant further attention.

Qualitative Analysis

In this year's evaluation report, in addition to the quantitative assessment using self-reported and EHR data, AIR conducted qualitative data collection and analysis to complement the final evaluation for FY 2023–2024. AIR conducted key informant interviews (KIIs) with FSP clients and members of the wraparound treatment team to understand their experiences with the FSP program, perceptions of impact, and factors affecting the implementation of the FSPs in San Mateo County. Below we present the analysis results for the completed KIIs.

Qualitative Evaluation Questions

The qualitative data collection and analysis aimed to answer the following Evaluation questions.

Clients

1. Client experiences—how do clients perceive their experience with FSPs?
2. Interaction with wraparound treatment team—how is the wraparound treatment team helping clients achieve their goals?
3. Improving the FSP experience—what changes do clients recommend for improving their FSP experience?

Treatment Team Members

1. Wraparound treatment team (integrated and comprehensive) experiences—how does the wraparound treatment team perceive their experience with FSP?
2. Providing client services and outcomes—what strategies and resources are wraparound treatment team members using to address the behavioral health needs of clients they serve?
3. Improving the FSP experience—what changes do wraparound treatment team members recommend for improving the FSP program?

FSP Treatment Team and Client Interview Findings

This section presents findings from interviews conducted with the 12 FSP clients and 23 FSP treatment team members across the four service providers as described in Exhibit D2 in Appendix D. Findings describe client and treatment team member:

- Overall experience and satisfaction with the FSP program

- Experience with FSP services and care, including strengths and areas for improvement
- Clients' greatest needs and goals for FSP participation
- Opinions about FSP services provided in response to needs
- Perspectives on health and quality-of-life impact
- Recommendations for the FSP program

We refer to the FSP clients we interviewed, including parents of youth program clients, as "clients," FSP treatment team members as "treatment team members," and FSP service providers, i.e., Fred Finch, Edgewood, Telecare, and Caminar, as "service providers."

Overall Experience and Satisfaction With the FSP Program

Exhibit 25. Summary of Overall Experience and Satisfaction With FSP Program

Clients	Treatment Team
• Clients had overall satisfactory and supportive experiences with the FSP program. • Clients referenced positive interactions with case managers as a reason for their high satisfaction with the program. • The **average satisfaction rating** across clients was **8.9 out of 10.**	• Treatment team members had overall satisfactory and rewarding experiences as staff members in the FSP program. • Treatment team members shared that the productive and efficient work environment contributed to their high satisfaction with the FSP program. • The **average satisfaction rating** across treatment team members was **8.3 out of 10.**

Clients' Overall Experience

Adult clients, **older adult** clients, and **parents of youth** clients reported that they had supportive and satisfactory experiences with the FSP program and were appreciative of its positive impact on their or their child's mental health. An **adult** client expressed gratitude to program staff for being supportive and responsive, and said,

> *"I can't ask for better team members for me to recover from being homeless and everything else. And they've been very helpful. And I know some are young, but everything they say has really been really helpful and it seems like they know what they're doing and I can reach out to them anytime."* (An **adult** client)

Similarly, an **older adult** client appreciated program staff's support, and said,

> *"They've helped me so much, and I mean, I don't know what else to say. I'm grateful to have them."* (An **older adult** client)

A **parent** of a youth client shared that their child's participation in the FSP program has improved their communication and relationship, and stated,

> *"It's made changes with my family, with my daughters in this case, we have had better communication. The change has been that we have a better relationship, more interaction."* (A **parent** of a youth client)

Client Satisfaction

Clients were asked to rate their satisfaction with the FSP program on a scale from 0 to 10, where 0 indicated the client is not at all satisfied, and 10 indicated that the client felt extremely satisfied. More than half of clients gave the program a score of 9 or higher, while the remaining rated the program between 6 and 8. Across all 12 clients we interviewed, the average client rating for the FSP program was **8.9 out of 10.**

Clients who gave the FSP program a rating between 8 and 10 indicated that they have seen positive outcomes after joining the FSP program, such as reconnecting with their families or pursuing an educational degree. Clients also shared that they appreciated FSP staff members' willingness to meet their needs and provide support when needed. An **older adult** client, who gave the program a score of 9.5, appreciated the support Caminar staff provided them with and said,

> *"I'd just like to give credit to Caminar for helping me so much and being there for me. I don't know what I would do if I was by myself . . . because my mom's older now, so I don't know how much longer I have with her. So, once she's gone, I'm going to be all alone in this world. So, at least I have Caminar as some support network to help me a little bit."* (An **older adult** client)

An **older adult** client, who gave the program a rating of 7.5, said that the FSP program should hire more case managers because *"the present case managers have huge caseloads, and they have a hard time getting around to all their clients."*

An **adult** client, who gave a score of 6, shared similar sentiments about hiring more staff and noted a cumbersome program structure, stating that

> *"If [Telecare] had more staff, there would be more programs available . . . I perceive certain inefficiencies in the running of the program . . . you have to go through one person to get to another person."* (An **adult** client)

Overall Treatment Team Experience

Treatment team members from adult, older adult, and youth FSP programs reported that they were satisfied with their experience in their roles and felt that working with FSP clients is

rewarding. Additionally, they showed appreciation for the effective collaboration and productive environment across the treatment team.

A treatment team member from an **adult** program shared that they appreciate how dynamic the environment of the FSP program is, and reported,

> *". . . What I probably enjoy the most is how dynamic the environment is, and every day brings new challenges and opportunities for growth, for myself, for my clients."* (Treatment team member from an **adult** program)

Two other treatment team members expressed similar sentiments, and said,

> *"I genuinely feel that I have a wonderful supervisor and the overall environment of the team*." (Treatment team member from an **adult** program)
>
> *"It's just a very trusting, open, but also efficient environment because we just have such great people."* (Treatment team member from a **youth** program)

Several treatment team members expressed that providing support to clients has been one of the most rewarding aspects of their experience with the FSP program, stating that, *". . . Knowing that I've been given opportunity and the training to help this population in becoming functional members of society and not just survive, but thrive, is just amazing."*

Team Member Satisfaction

Treatment team members were asked to rate their satisfaction with the FSP program from 0 to 10, where 0 suggested they were not satisfied, and 10 indicated they felt extremely satisfied. More than 70% of treatment team members gave their satisfaction with the program a rating of 8 or higher. Across 23 treatment team members, [8] the average rating for the FSP program was **8.3.**

A treatment team member from an **adult** program, who gave their satisfaction with the program a score of 10, expressed that they were extremely satisfied with their experience, and said,

> *"I am very satisfied with what I do, and I put my heart in it."* (Treatment team member from an **adult** program)

One treatment team member from a **youth** program, who gave a satisfaction score of 9, reported that seeing improvements in clients' quality of life felt rewarding, and said,

[8] One treatment team member did not provide a numerical rating, but they indicated they were satisfied with their experience working for the FSP program.

> *"I got to tell you, I love it. Not because I want to be recognized. It's because I hear success, when the parents [say], I was able to do it and my son was so happy, or my son even later on reflected and said, 'Mama, I noticed you were not yelling as usual.' That is very rewarding to me because I was there." (Treatment team member from a **youth** program)*

A treatment team member from a **youth** program, who provided a satisfaction score of 8, shared that they would like to see more diversity across FSP staff and cultural humility trainings,[9] and said,

> *"I would also say maybe discussing more cultural awareness or cultural trainings that would also relate to our clients. . . . We have a group that's supposed to be about diversity, but it's mostly run by the higher ups, but all the higher ups are Caucasian. So, then it doesn't really transfer to the employees who are diverse."* (Treatment team member from a **youth** program)

Greatest Needs and Program Goals of FSP Clients

Exhibit 26. Summary of Clients' Greatest Needs and Program Goals

- **Clients** shared that their goals for participating in the FSP program include **improving their mental and physical health, maintaining sobriety, and continuing education.**
- **Treatment team members** stated that greatest needs among FSP clients include **access to counseling and psychiatric services**, **managing substance use**, and **assistance with finding stable housing**.

Clients' Goals: Client and Parent Views

- **Improving mental health and overall health:** Nearly all clients shared a goal of improving their or their child's mental health and overall health. One parent of a youth client aimed to improve the mental health of their entire family, and said,

  > *"The goal was to improve the mental health of everyone in the family . . . we were in a declining situation with my daughter in a quite severe situation mentally, and my intention was to get help—to be able to help ourselves, everyone, and get out of this mess that we were in." (**Parent** of a youth client)*

  In addition to improving mental health, clients referenced goals related to physical health. An **older adult** client mentioned that they aimed to exercise more and improve their nutrition intake:

[9] Cultural humility trainings are designed to promote ongoing self-reflection, awareness of personal biases, and respectful interactions across cultural differences, emphasizing lifelong learning and mutual respect. Description from the Georgetown University National Center for Cultural Competence.

"Just stay healthier and stay well, work on my mental health, exercise, eat right, lose weight" (An **older adult** client)

Substance use recovery: Two clients, one adult and one older adult, mentioned that they aimed to minimize substance use and maintain sobriety after being referred to the FSP program from the court justice system:

"I'm in recovery now for marijuana, some drug use. But I'm in recovery . . . I haven't been using any kind of drugs at all." (An **adult** client)

"My goals were to maintain my mental health and stay sober, and not drink and use drugs." (An **older adult** client)

- **Continuing education:** Four clients, two adults, and two older adults, shared a goal of going back to school and pursuing higher education or counseling licenses. Three of the four clients said that continuing education was important to them and are actively working toward this goal:

  "Well, back then when I joined, my goals were to get a college degree, which I did get. . . . It was very important to me that I get that degree." (An **older adult** client)

  ". . . But now I'm back and going to school. I just did my readmission application for school, and also to complete my mental health diversion program that I'm in with the court. . . . I'm finally going back to school, and that's something I wanted." (An **adult** client)

  An **older adult** reflected that they appreciated the emotional and tangible support from the treatment team to renew their counseling license and resume employment:

  "So [a treatment team member] thinks I'm ready to renew my license and start working again, so that's kind of nice. . . . When I'm ready to take classes to renew my license, I'm going to ask them to help me with that. For example, they would know how to do that. You know, call the Board of Behavioral Sciences . . . get a laptop. It's a lot to get my license back. It's a big deal to take [continuing education] units. They will help me with that too." (An **older adult** client)

Clients' Needs: Treatment Team Member Views

The FSP program provides services not only with the goal of improving mental health and substance use recovery, but also to build independent living skills and resiliency to help clients transition into the larger community. When asked about clients' greatest needs, treatment team members commonly referenced assistance with accessing stable housing, access to psychiatric services, and substance use. Team members also noted that clients' needs are individualized: *"there's not a one-size-fits-all answer; it just really depends on the client and what their current situation is."*

- **Mental Health:** Access to Counseling and Psychiatric Services
  Treatment team members emphasized the importance of clients having access to counseling or psychiatric services and referenced the FSP program's focus on mental health and supporting clients in living independently. A team member from an **adult** program and a team member from a **youth** program said,

  > *"I'd also just say having that access to psychiatric and therapeutic services or therapy services is extremely important because you're getting to work with the individual."* (Treatment team member from an **adult** program)

  > *"I think for our population, again, in our FSP, it's a lot of focus on mental health, but also a lot of focus on building independent living skills for our clients."* (Treatment team member from a **youth** program)

  A treatment team member from a **youth** program mentioned that there is a need for FSP services among youth clients, given the lingering impacts of the COVID-19 pandemic on their mental health. They stated,

  > *"There's a lot of isolation from the clients across different diagnoses that they come in with. I think we anecdotally attribute a lot of this to the pandemic and how it's impacted people. . . . I think the underlying need there is that being able to have our services available as long as it takes to actually build a relationship and engage a client."* (Treatment team member from a **youth** program)

- **Substance Use Recovery:** Treatment team members cited managing substance use as one of clients' greatest needs. One treatment team member from a youth program shared that they have seen an increase in substance use among youth clients, and there may be difficulty engaging affected youth in FSP services. They shared,

  > *"And then more frequently, I would say after COVID, I've seen an increase in substance use with the youth that we are working with. And that's been, I think, a resource that sometimes can be difficult to find for our youth and get their buy-in because I think when they hear [Alcohol or Drug Abuse] programs or resources, it sounds really scary and intense, and it can be sometimes."* (Treatment team member from a **youth** program)

  A treatment team member from an **adult** and **older adult** program discussed prioritizing clients' greatest needs when they are referred to the FSP program, and shared that *"if there's substance use involved, then that would take a high priority."*

- **Housing Assistance:** Several treatment team members described the extensive challenges of not only finding affordable housing for their clients, but ensuring they remain housed. Team members shared that being able to stay in a home for an extended period is a challenge they regularly encounter in their work, given the struggles that many clients have with substance

use or independently carrying out activities of daily living. One team member expressed the need for specific housing for clients with co-occurring mental health and substance use disorder as these clients have unique needs that may not be addressed by current housing resources:

> *"I'll say the greatest need that doesn't exist is co-occurring specific housing. It doesn't exist in our county. It's like you either are in mental health-focused housing or you are in substance focused housing. And a lot of the substance-focused housing folks are not equipped to manage clients with severe mental illness."* (Treatment team member for **adult** and **older adult** clients)

Treatment team members also shared that connecting clients to the appropriate housing resources depends on their situation. One team member from a youth program stated,

> *"Well, if our clients are homeless, then it's like connecting them to a shelter. Or, if possible, using the [Mental Health Association] funds or the apartment complex we have, or this also applies to if they're living with family, but getting them into a social rehab where they can learn independent living skills and also have housing that's temporary. So, kind of just finding the right fit of housing depending on their situation*." (Treatment team member from a **youth** program)

FSP Program Services Provided in Response to Clients' Needs

Exhibit 27. Summary of Program Services Provided in Response to Clients' Needs

Services received by most clients:

- *Case management*: rehabilitative activities, motivational interviewing, crisis prevention and management, connection to community resources, and health care advocacy
- *Mental health*: psychiatry, psychoeducation, and therapy that is often community-focused

Additional supports available to clients:

- *Peer support*: group activities, workshops, and socializing with mentors who share similar lived experiences as clients
- *Parental and family support*: family therapists and counselors who provide psychoeducation and techniques for crisis avoidance and recovery to clients' family members
- *Transportation*: for attending medical or legal appointments
- *Housing*: housing specialists/coordinators or case managers provide education, funding, or program-affiliated housing

The following section describes information about client services, based on insights drawn from both client and team member interviews. We also identify the types of team member roles that provide each of these services. The majority of treatment team members interviewed described a highly collaborative environment amongst all team member roles. Although specialist team members provide a specific type of service, such as a housing specialist, they regularly

communicate with the larger team to ensure that the client is maintaining appointments with all members of their treatment team.

- **Case Management:** Clients meet with their case manager, or a rotational team of case managers, more often than with any other treatment team member. These meetings are held in-person (or over the phone when necessary) and usually occur weekly, if not multiple times per week. During these sessions, case managers utilize rehabilitative activities including skill building, behavior modelling, and mindfulness and grounding techniques with the goal of increasing the client's independence. They will often engage in motivational interviewing, reflective and empathic listening, and other therapeutic interventions as needed to prevent and handle crisis situations. In addition, case managers will provide targeted case management to connect clients to resources which may include food, clothing, housing, education, employment, or substance use programs. They also connect clients to medical providers for medication and symptom management.

  > *"I think that it's very important to have fun and depending on, again, whatever they're struggling with in the moment, normally it's just a matter of getting to know the client's likes, dislikes, hobbies, interests, what kind of brings a passion, a spark into their life, and then trying to tie it into what are they currently struggling with."* (A dual diagnosis case manager from an **adult/older adult** program)

  > *"I've asked [the case manager] for help with food assistance and I've also asked her for help with my primary healthcare provider. I asked her about some of my anxieties I was experiencing and she helped me advocate for myself."* (An **adult** client)

- **Mental Health Services:** Clients typically meet with a therapist once or twice per month in person. In addition to individual sessions, therapists also hold monthly family conferences and offer group sessions for multiple clients. During these sessions, therapists will utilize the therapeutic and rehabilitative techniques employed by case managers, as well as provide psychoeducation to inform clients about their symptoms, help clients heal from trauma, and reduce harm for clients with substance use disorders. They incorporate spiritual and religious preferences into their treatment approach and involve clients' families in the treatment program as much as the client desires and is possible. Many therapists enjoy using a community-based approach during their sessions, and listed hiking, painting, or grocery shopping as common activities they use to build their clients' independent living skills.

  > *"Also, I think in this role, especially because we are community-based, I found myself not just sitting in a room with clients just providing therapy. I think that's the bulk, but there have been times where I've taken a client grocery shopping to help them with building social skills and building the skills to run their own errands and things like that."* (A clinician from a **youth** program)

- Psychiatry Services: Generally, clients will attend monthly remote sessions with their psychiatrist. During these sessions, psychiatrists will perform assessments, provide interventions, and prescribe medications for symptom management.

  "[My psychiatrist] practices mindfulness with me . . . And I do think that really helps a lot. I would say that I'm using psychiatry the most." (An **older adult** client)

- **Peer Support Services:** Many clients choose to use peer support services, which are more focused on socializing and building interpersonal skills in a relaxed environment. Peer support staff serve as mentors to clients and build relationships with them through activities such as cooking, playing video games, and taking walks. Clients are more likely to connect with and relate to peer support staff because they share similar lived experiences, which is evident in the sentiments shared by clients who regularly engage in peer support services. In addition to individualized activities, peer support services include weekly group activities and monthly workshops.

  "Being in the program provides me with a sense of community. The other peers that are part of FSP, I talk to them, and I see them, and I go to groups." (An **adult** client)

  "Even though we're providers, we keep it chill and casual and get to know them a little bit more. So, we've had really great conversations, and then it's led to workshops. My team puts on workshops with the clients. We just did a harm reduction workshop, résumé building. We take the relationships that we've gained with them, consider their treatment goals, and then invite the entire community to come to our monthly workshops and activities." (An associate director of peer services from a **youth** program)

- **Parental and Family Support:** Family therapists may meet with any number of family members in addition to the client, and often hold sessions in the client's home. Some therapists find it helpful to meet with the client and one parent initially with the aim of gradually including more family members. They work to reinforce boundaries amongst family members, teach crisis avoidance and recovery-centered techniques, and provide psychoeducation to family members to help them understand the client's situation. Sometimes, child clients are unwilling to discuss their needs with providers, so family therapists will coach parents on how to communicate with their child. Clients and their families may also choose to meet with family counselors.

  *"I hold fast to the idea that families are systems, and if one member is sick, then the system is sick. And so, I try very hard to involve family members as much as I can, and as much as seems clinically appropriate." (A licensed marriage and family therapist from an **adult/older adult** program)*

  "Unfortunately, my daughter's mental health struggles are not something that you can say, oh, it's gone. It's something that she will always have, but with the help of knowing

how to handle it, well, I know how to handle it. Also, as a family, we have been able to work on it and we have kept it under control." (**A parent** of a youth client)

- **Transportation Assistance:** Transportation assistance is available to some clients who may use this service to attend medical appointments or legal appointments in court. Case managers and therapists may collaborate to provide transportation assistance to clients.

Housing Assistance

Clients may utilize housing assistance to find or maintain current housing. Some programs have dedicated housing specialists or housing coordinators that collaborate with case managers. Their involvement is correlated with clients' level of need, and the frequency of their client meetings may range from multiple visits per week to once or twice per month. Services provided may include education, funding, and building independent living skills with the goal of maintaining a clean unit and preventing fires caused by space heaters. Housing staff will involve client family members at the client's discretion and may also provide direct client care if the client is residing in an apartment complex affiliated with the FSP program.

> *"I have a client that he just lost a roommate, so I constantly like calling him just to make sure. . . . I wanted him to be comfortable and understand that we are here to support him and refer him to see his psychiatrist and make sure that he's taking his medication and he has other network support like his parents."* (A housing specialist from an **adult/older adult** program)

Perspectives on FSP Program Referrals and Initiation of Care

Exhibit 28. Summary of Perspectives on FSP Program Referrals and Initiation of Care

Clients	Treatment Team
• Clients had overall positive feedback about referral and initiation of care processes. • Suggested expanding awareness of the program to make it more accessible to potential clients. • Satisfied with comprehensive assistance provided by multidisciplinary treatment team during initial meetings.	• Treatment team members said the referral and intake processes run smoothly. • Identified lack of supplemental documentation from referring providers (e.g., health and ID records) as a challenge. • Warm handoff from the referring provider is essential and could create a service gap if not executed properly.

Exhibit 28 above summarizes the feedback received from clients and treatment team members about FSP referrals and initiation of care. Most of the clients interviewed have been receiving services from the FSP program for 5 years or more, while the remainder of clients joined the program within the past 3 years. One client reported they had been with the same FSP provider for over 10 years, when the provider's FSP program first started.

FSP Referral Process

- **Client Experiences:** Referral sources varied for clients interviewed as part of this year's FSP study. Sources of referral seem to vary between youth and adults. All parents of **youth** clients stated that clinicians, including therapists and psychiatrists, referred their children to the FSP program. Meanwhile, three **adult** clients were referred by SMC's Correctional Health Services staff after their release from prison or jail. Other clients were referred to FSP services by an external provider or therapist, either during a medical appointment, therapy appointment, or hospitalization. One **adult** client was referred during their discharge from a facility as they were transitioning out of a conservatorship. Another **older adult** client was referred during their exit from an assisted living facility. Two **adult** clients reported being referred from other SMC BHRS programs, including the Assisted Outpatient Treatment (AOT) program.

  > *"I heard about [FSP program] from AOT, this outpatient assistance program. When I got out of jail, my case manager from jail signed me up with Caminar. I was on a mental health diversion program, and I was on that for two years. So, I had to be part of taking medication and stuff in order to be out of jail."* (An **older adult** client)

  Many clients shared positive sentiments about their referral and transition to the program, including describing the staff as kind, welcoming, helpful, and knowledgeable. Both adult and youth clients expressed how they viewed referral into the FSP program as an opportunity for them to transition from a hospital or the prison system into a lower level of care facility, and

eventually into the larger community. Overall, clients did not identify any issues or concerns with the current referral process, although one parent of a youth client mentioned that they wish there were greater awareness about the program to make referrals easier:

> *"There needs to be more information about where to find this kind of help for mental health. Making it a bit more accessible, easier to find, I think all of that would help . . . because when I talk about the program, everyone asks, 'where did you find it, who told you about it?' I know other parents who are also going through similar situations to mine, and they ask me how I found it, and there's no easy way to find it. . . . "* (**Parent** of a youth program client)

- **Treatment Team Experiences:** Treatment team members elaborated on the most common reasons for client referrals to FSP. Many clients have received mental health diagnoses such as posttraumatic stress disorder (PTSD), depression, anxiety, schizophrenia, or bipolar disorder. These clients may be exhibiting intense suicidal ideation or self-harm, are unable to attend school, or unable to maintain a job or housing. Youth clients may be referred from their school for truancy or from the court system due to probation or arrest. Often, clients are referred to adult programs as they are aging out of youth services.

  > *"We work with clients that have SMIs [severe mental illness] . . . helping clients that have cycled in and out of inpatient hospitalizations or have been evicted from their homes and are just really getting their footing in society. Especially in the Bay Area, it's not the easiest place to live."* (A treatment team member from an **adult** program)

  Several treatment team members cited the BHRS access line as a main source of referrals to the FSP program. Specifically, county clients, therapists, psychiatrists, social workers, potential clients themselves, or other parties may call the access line to initiate a referral. Clients in jail or under probation may also be referred directly to the FSP program from the county court system. An intake coordinator is responsible for gathering information about the potential client. Multiple treatment team members also mentioned recurring weekly or monthly meetings amongst the county, FSP programs, and community clients to discuss placement of potential clients. Once an FSP program receives a referral, they continue with their intake process to assign a treatment team, gather additional details about the client, and work with the client to develop a treatment plan.

  Like clients, most team members had positive feedback about the FSP program referral process, particularly related to identifying treatment teams, navigating program capacity, and determining client service needs and program placement. Many described the referral form as extensive and providing comprehensive documentation about clients. Although team members' feedback suggests overall that the referral process runs smoothly, some team members described challenges or areas for improvement. A common issue noted across team

members was a lack of supplemental documentation included with the referral form, such as health records and identification records, which can delay the intake process for new clients:

> *"As the client's being referred to us, if all the places were able to provide us proper copies of important documents that are relevant to the client, that would be helpful. For example, copies of their Medi-Cal cards or Medicare cards or IDs, driver's licenses, or other insurance material, things of that sort, so that we don't have to run around looking for them."* (A treatment team member from an **adult** program)

FSP Intake Process

- **Client Experiences:** Clients who joined the FSP program within the past 1–2 years reported they had their first appointments conducted through Zoom—some from inpatient hospitals or from jail—while clients who started the program earlier had in-person appointments. Despite differences in modality and context, clients reported positive experiences with their first interaction with the FSP program, highlighting several factors that contributed to their satisfaction. A common theme is a strong sense of support and positive engagement with team members during the initial appointment. A **parent** of a youth program client appreciated the introduction to and presence of multiple FSP team members at the first virtual appointment, noting how the collective support across members with diverse expertise instilled a sense of confidence in the care provided.

  > *"I was impressed to see everyone. The truth is that when I started, I saw in the first appointment that there were many people involved. For me, it was impactful . . . to see, wow, there are quite a few people who are going to help us. Personally, as a father, I felt quite supported."* (**Parent** of youth program client)

  Other clients reported they initially met with a lead case manager or therapist who then connected them with other team members, such as additional case managers, and psychiatrists.

  These clients similarly echoed their satisfaction with the comprehensive assistance provided in the first appointment, including addressing immediate needs related to housing, counseling, and psychiatric support. Another **parent** of a youth program client recounted from the first appointment:

  > *"It went very well. It was an experience I honestly did not expect, but it cleared up any doubts I had. . . . I was provided with a psychiatrist, a behavioral worker . . . there were about four or five services."* (**Parent** of youth program client)

  However, two **older adult** clients did not feel comfortable with their first assigned case managers and eventually transitioned to different team members, with whom they are satisfied. The initial client experiences with the FSP program emphasize the importance of the

first impression made during the intake process, which can set the tone for long-term engagement and satisfaction with the FSP program. Using a collaborative and multidisciplinary team approach appears to help build trust and create a sense of a supportive environment for clients.

- **Treatment Team Experiences:** A few treatment team members mentioned that warm handoffs are an important part of the intake process and can be especially helpful when working with clients who are difficult to engage. Edgewood team members specified their success by incorporating a clinical coordinator into the warm handoff and intake process, which has reduced intake delays and workload of case managers. In addition, team members across programs identified strong relationships and frequent communication with county and community clients as particular strengths of the process.

  > *"When we have a barrier, or a challenge that is impacting our ability to open a client case, or to process a referral, we have that flexibility to be able to collaborate between both programs to determine how we'll be able to best support the client, and the referral."* (A program director from an **adult** program)

  > *"I think what's worked well is we work very closely with the county in terms of who they were referring us, you know, the county really takes our feedback in terms of the clients and they're very willing to meet us more than halfway in terms of how to best support the clients."* (A behavioral health clinician from an **adult** program)

  Another team member noted difficulty with scheduling the initial client meeting within the required limit of days, either due to current hospitalization or trouble connecting with a working parent. In addition, one team member from a **youth** program identified a service gap in coordinating care that occurs when referring providers (e.g., primacy care providers) discharge clients out of their current services to behavioral health services too quickly. They described multiple instances where clients were excluded from behavioral health services because they had not yet agreed to FSP services, but they had already been discharged from their referring provider's services.

  > *"The bare minimum is to have that warm handoff meeting because a lot of times, the client has a trusting relationship with their provider, but they need a higher level of service so they get referred to us. And then a lot of times, [for] clients, it's difficult to start a whole new relationship with a treatment team. So, if we can coordinate and cross over more, we can build our relationship faster by working close with the current provider."* (A behavioral health director from a **youth** program)

Clients' Experience With FSP Wraparound Services and Care

Exhibit 29. Summary of Clients' Experiences With FSP Services

- Clients gave positive feedback about their experience with FSP case managers, particularly highlighting case manager **availability, responsiveness, guidance, and resources.**
  - Clients were satisfied with how frequently they meet with their case managers and appreciated the ability to communicate in multiple ways (e.g., in-person, phone, Zoom).
  - Clients reported that case managers provide valuable guidance, connect clients with helpful external resources and services, and are attentive to client needs.
- Some clients mentioned issues with **interruptions in care** and **lack of shared lived experiences** with their case managers.
  - Some clients experienced disruptions due to turnover in case managers and expressed a desire for more consistent case manager assignments to avoid frequent changes.
  - An older client felt uncomfortable with younger case managers from different racial backgrounds, citing difficulties in relating due to differences in age and life experience.
- Clients reported strong **interpersonal connections** with other treatment team members and expressed gratitude for how their treatment team interactions have led to **positive impacts on health and well-being.**
  - Clients said they felt supported and highlighted close relationships with psychiatrists, therapists, and other specialists.
  - Clients expressed that treatment teams help them achieve their program goals, such as abstaining from drug use and improving family dynamics.
- Some clients faced **difficulties in scheduling sessions** and **desired greater personal agency** in treatment decisions.
  - Frustrations included repeated cancellations by psychiatrists and challenges in balancing busy schedules with multiple team member appointments.

Experience With Case Managers

- **Case Manager Availability and Responsiveness:** Nearly all clients report meeting with their case managers in-person weekly, and some meet with their case managers multiple times a week. Most clients reported being satisfied with the frequency of communication and appreciated the ability to contact case managers by phone outside of meeting times. An **older adult** client expressed appreciation for the support they receive during weekly meetings with their case manager, and shared,

  > *"I like meeting with my case manager every Tuesday. It's going to have coffee with her and going for a walk along the beach, and then just hanging out with her talking. We talk about recovery and talk about what's going on with me, having a friend that I could talk with and stuff. Having the support from her, I really like that every week."*
  > (**Older adult** client)

An **adult** client shared that several case managers have gone the extra mile to help them with immigration paperwork, and stated,

> *"They've been helping me with the immigration [paperwork] and all that stuff, and they went out of their way to help me, and I appreciate everything that they've done."* (An **adult** client)

- **Providing Guidance and Resources:** Clients shared that case managers provide valuable guidance and resources and expressed that they understood their needs. Case managers also connected clients to external services if they needed additional support.

  A **parent** of a youth client voiced appreciation for their child's case manager, who was attentive to their child's needs and connected them to external resources and services. They said,

  > *"[The case manager] was very good. It's been a very good experience with her. She's a good person who supported me a lot. Very attentive. We started making a list of what things I considered needs. . . . She actually gave me places where I could go, gave me a phone number where I could call, and she was always, always there. She always said, 'give me an update. I want to know if you need anything else.' She was always trying to check in to see if we needed anything."* (**Parent** of a youth client)

  An **older adult** client reported that their case manager connected them with food assistance, employment resources, and any other services they need to become independent.

  > *"They've been very good with getting food donations or referring me to maybe job interviews or what I can do to become more independent and more comfortable with myself and more well-adjusted."* (**Older adult** client)

- **Interruptions in Care:** Three clients mentioned turnover in case managers or therapists interrupted their care or said they would like the same treatment team members supporting them for a longer time.

  Regarding turnover in case managers, **adult** clients expressed that "you get tired of being bounced around" and suggested improvements in continuity of care, "so that you're not switched around and moved around different case managers and doctors."

  A **parent** of a youth client also shared that their child's previous therapist resigned. They shared that the waiting period was longer than expected and their child did not receive services for some time. They said,

  > *"Unfortunately, the therapist who was providing her therapy resigned and she was in limbo. I'm waiting, I have to wait two months to see if she finds someone else. So, when I started looking for help, it also took a long time, but it's because of the therapist's offices,*

so we're in another kind of pandemic situation, because this is urgent."
(**Parent** of a youth client)

- **Case Manager Attributes and Lack of Shared Lived Experiences:** The personality and skills of case managers were factors in clients' satisfaction with FSP services. Many clients reported their ability to create a strong interpersonal connection with their case manager. For example, clients spoke highly of case managers who they felt were attentive, empathetic, supportive, and efficient.

  "[My case manager] he's awesome. He talks to me like a person, not like he's above me."
  (An **older adult** client)

  However, an **older adult** client did not feel comfortable with case managers who were younger and from a different racial background and felt that their difference in age and life experiences made it difficult for case managers to relate to them.

  "I am in my 60s, so you can't go on and give me a 20 or 30 or 40-year-old person to put on me as a caseworker and think that I'm going to be comfortable. . . " (An **older adult** client)

- **Experiences With Other Treatment Team Staff**: Nearly all clients reported positive experiences with their additional treatment team staff, including psychiatrists, therapists, and other specialists. Emerging themes from the interactions described include deep interpersonal connections between clients and their treatment teams and clients' gratitude for positive impacts to their health and well-being resulting from high-quality care. However, a few clients also identified ways to improve their experience with the treatment team, including greater ease of scheduling sessions with treatment team members and more personal agency in making treatment decisions.

- **Personal connection and comfort:** Multiple **adult and older adult** clients reported having a close relationship with their treatment team, and one client even views their team as friends. One **adult** client appreciated extensive conversations with their psychiatrist and feels that they effectively monitor their symptoms and well-being. Most clients feel well supported and cared for by their treatment team and are comfortable with asking for assistance on a variety of topics. However, one client explained that their comfort in asking for assistance depends on the connection they have with their provider.

  "I've never had such a caring team, and I've been in the mental health system ever since I was 18 years old, and I'm going to be 53 in August. I've never had such a caring experience compared to this Caminar yet." (An **older adult**)

- **Positive impact on client care and well-being:** Multiple clients described positive effects from interacting with their treatment team and expressed gratitude for their care. They perceived effective collaboration and a strong sense of commitment amongst treatment team members.

Some explained how their treatment team assists with achieving their goals, such as abstaining from drug use for the sake of their children, maintaining upcoming doctors' appointments, and gaining independence.

> *"I've been trying to maintain my independence and stability of my mental health. And I think that would only have been doable with the help of my treatment team and the aid of the medications that my psychiatrist prescribes me."* (An **adult** client)

In addition, the **parent** of a youth client explained how they learned to care for their daughter's mental health through educational videos, courses, and guidance provided by the treatment team. The **parent** described improved family life and confidence in parenting skills because of the treatment team's support and guidance.

> *"I am very grateful to [the treatment team]. My daughter had episodes. She was hospitalized five times for suicide attempts. We clashed at first because of her condition. I was unaware at that time. I was also unaware of the way to work with her condition and the way to work with depression. . . [FSP] is helping me by giving me tools to start. They give me tools for me to use for my family and for parenting."*
> (A **parent** of a youth program client)

- **Challenges with scheduling and coordinating care:** Two client participants mentioned difficulty in scheduling sessions with treatment team staff, due to limitations posed either by the psychiatrist or the client's family. One **older adult** client exhibited frustration about their psychiatrist repeatedly cancelling their upcoming session, without providing justification.

  > *"I am upset with Caminar, young lady, because I have not seen my psychiatrist. . . . I'm very disappointed because they canceled on me again for no reason. . . . I just need somebody to talk to me and hear me."* (An **older adult**)

  The other participant, a single **parent** of a youth program client, described how their busy schedule creates a barrier to scheduling sessions with their family therapist. However, they mentioned that the flexibility of remote and in-home appointments has helped mitigate scheduling issues.

  > *"It's a bit difficult to schedule appointments and meet in person, you know, not because of her, but because of me. I'm a single parent, you know, and my time is really tight, so the way we do it with her is over the phone."* (A **parent** of a youth program client)

- **Limited agency in treatment decisions:** One **adult** client has been taking medication as prescribed by their treatment team, however, it is the client's preference to lower the dose or discontinue the medication. They explained that although it has helped them to achieve stability, it negatively affects their ability to study and exercise. Despite the client's sentiments, they are still taking the medication as prescribed by their treatment team. The

client wishes their treatment team would be more receptive to their preferences when making treatment decisions:

> *"A big thing in psychiatry is medication, and I've always tried to stay clear of these medications even when I've been forced them in certain situations. . . . I still would prefer to be off medication and try to lead my life that way, but oftentimes people on my team, because I'm still on the injection medication, some of them think that the medication helps and things like that."* (An **adult** client)

Team Members' Experience Providing FSP Wraparound Services and Care

Exhibit 30. Summary of Treatment Team Members' Experiences

Key FSP strengths

- FSP team members highlighted **strong collaboration and communication within their teams**. Frequent and varied communication methods foster a supportive and cohesive environment, enhancing both client care and team member satisfaction.
- Team members emphasized the importance of **meeting clients where they are and providing consistent support**, which contributes to positive client outcomes and satisfaction in their roles.

Challenges to providing services

- Reported challenges include high client caseloads, frequent staff changes, and emotional demands of the work, which can **limit staff capacity and continuity of care**.
- Team members cited that **gaps in resources and funding** impact client engagement and staff well-being.
- Some team members had **challenges engaging clients with high needs and their families** because some clients and families are reluctant to participate in services.

Impact of COVID-19

- Residual effects of the pandemic include challenges in conducting in-person visits and significant staff turnover. However, the pandemic also highlighted gaps in service accessibility, leading to improved flexibility in FSP service delivery and enhanced communication.

Perceived Program Strengths

Almost all FSP team members interviewed have been working at their respective FSP providers for at least 2 years, and several members reported working with the same providers for more than 10 years. The longest tenured treatment team member has been providing care through the FSP program for roughly 20 years. This level of retention underscores the positive experiences and fulfillment that staff derive from their work, contributing to the stability and consistency of care provided to clients. Treatment team members shared various insights into strengths of the FSP program and elements that contribute to their effectiveness.

- **Team Collaboration and Communication:** The most consistent strength mentioned across treatment team interviews was strong collaboration and communication within FSP teams.

Nearly all providers emphasized the importance of frequent and varied communication methods, including texting, phone calls, Zoom meetings, and in-person interactions, to ensure comprehensive and cohesive client care. Team members mentioned that the collaborative environment fosters a robust network of mutual support among team members, contributing to a positive and productive work atmosphere. One treatment team member of an **adult** program noted,

> *"The collaboration is very strong. Our staff are great. We're always getting continuing education, to better our services. . . I work with people that really truly passionate about what they do and the population that we serve."* (A treatment team member of an **adult** program)

This supportive dynamic is mirrored among treatment teams working with both **adult and youth** clients, where team members provide emotional and social support that contributes to better outcomes for team members and their clients:

> *"There's a sense of camaraderie, a sense of taking care of one another if somebody is going through a tough time. . . it makes a difference for both the case managers and the clients."* (A treatment team member of an **adult** program)

A treatment team member of a **youth** program highlighted the importance of this collaborative and supporting team:

> *"When things are going really tough, we tend to lean on one another for support, whether it be on the job or sometimes some of us can be dealing with our own personal situations, and then we got to go to work. We have to do the work for our families that we serve and help us get back to focus. We tend to lean on each other in a very positive way."*

This robust teamwork not only enhances client care but also creates a nurturing and empathetic work environment that helps retain staff, as reflected by another treatment team member's experience:

> *"I think that's definitely what's kept me here this long is just the way in which we work together, so I feel like harmoniously and just the culture we've built here, so I've really enjoyed my experience working with my colleagues."*

- **Strong Rapport and Relationship With Clients:** A major strength of FSP programs highlighted by more than half of treatment team members is the strong rapport and relationships built with clients. Team members emphasized a "whatever it takes" attitude, demonstrating flexibility and commitment to meet clients where they are, regardless of the circumstances.

  > *"The 'whatever it takes' attitude that supports our clients is one of the biggest strengths. . . we'll meet clients wherever they're at, however they're presenting. We're willing to work*

with people. You know, we offer second third chances." (Treatment team member of an **adult** program)

Several treatment team members from **adult** and **youth** programs also expressed profound satisfaction in creating strong connections with clients who help support their recovery journeys. A treatment team member of an **adult** program said,

"I love just seeing and tracking their growth from literally right out of hospitalization to gaining housing and getting employment and managing their symptoms . . . just to see them grow and prosper as individuals."

Similarly, a treatment team member of a **youth** program emphasized the successful approach of the FSP program:

"There's different ways to reach clients and be able to help them on their journey. Just showing up and being there makes a world of a difference. I think that is the biggest intervention that has been successful and showing our members that we believe in them and accept them as they are. Anyone can grow when they feel accepted."

Additionally, treatment members mentioned how flexible and accessible services, such as drop-in centers for youth clients, play a crucial role in building rapport. This approach allows for more meaningful and sustained interactions, contributing to the overall effectiveness of the program in fostering strong, supportive relationships with clients. One treatment team member of a **youth** program explained:

"Those one-on-one conversations mean a lot to me. Having that direct client care, but in a space that is not time-sensitive . . . that's when I think you really get to build rapport with people."

- **Large Interdisciplinary Treatment Teams:** Treatment team members regularly identified the large interdisciplinary teams as a key strength of the FSP program. These teams consist of members from various professional backgrounds, bringing diverse expertise to the table. This variety enhances the ability to address complex client needs and fosters a learning environment among staff. Treatment team members valued the drive and commitment to the work exhibited by their coworkers. They also voiced appreciation for the ability to focus on their specific roles while benefiting from the collective expertise of their colleagues. One treatment team member said the varied expertise allowed staff to learn from each other and problem solve more creatively. A treatment team member of an **adult** program described the positive experience of feeling heard and learning from diverse perspectives:

  "It's really great when we are collaborating and we're all putting in our different opinion and come into a common ground, and just the fact that everybody has a voice."

Another member appreciated the internal supervision among team members, which contributes to professional development and improved service delivery. This structure is particularly effective in maintaining staff engagement and satisfaction, as evidenced by the long tenure of several team members, some of whom have worked at their respective FSP providers for over a decade.

Perceived Challenges to Providing Services

- **Staff Capacity and Staff Turnover:** Almost half of the treatment team members interviewed reported challenges related to staff capacity and turnover, which can overburden existing team members and disrupt continuity of care for clients. Team members cited high caseloads, frequent leadership changes, and the job's emotional demands as main contributors to burnout and compassion fatigue among team members. One treatment team member of a **youth** program noted the nature of the work that can be challenging to team member wellbeing:

  > *"Sometimes the acuity of the clients, it takes its toll. A lot of containment, a lot of emotions from the families and stuff. . . . I'd say our biggest challenges are just the bandwidth sometimes that you have at the end of the day of just talking to so many people and storing so much inside."*

  Apart from reduced team member bandwidth, high caseloads, and staffing issues impact team members' ability to provide consistent and effective care to FSP clients:

  > *"The biggest challenge is just having more clients on your caseload than you can handle. . . Some stuff just doesn't get done or fast enough because it is so much. . . . I think it can be frustrating for [clients]. And sometimes it causes them to split because they do have so many case managers. It's definitely challenging to them when we don't have time to get certain things done and when they have to wait on things, or when they start something with one case manager and then have to finish it with another case manager."*
  > (A treatment team member of an **adult** program)

  A treatment team member of a **youth** program echoed this sentiment and recounted the toll on clients when staff leave unexpectedly: "*A staff member leaves and sometimes we don't know about it. One time, there was a client who we haven't heard from for a while and . . . the clinician left, and we didn't know that the clinician left. It wasn't our fault, but it seems that we kind of triggered an emotion with the client because she was so close to this clinician*."

  Treatment team members from adult programs identified recommendations that would help mitigate the challenges related to staff retention and burn out. These include the need for more competitive compensation, additional training and resources, mental health support,

and improved collaboration with community and schools. One treatment team member from an **adult** program suggested programs build in rest and recovery time into schedules:

> *"This job is really hard, very stressful and fast-paced, and there's no self-care. It would be pretty great if the county or the agency contracted a Self-Care Day or Week."*

- **Resource Limitations and Service Gaps:** Multiple treatment team members from **adult and youth** programs mentioned gaps in resources and funding as an important challenge faced by FSP programs. Treatment team members noted the need for funding to get essential items for clients, provide adequate staff compensation, and pay for staff transportation or other needs when going into the field. Team members also stressed how resource limitations and funding challenges create barriers to service provision, impacting both client engagement and staff well-being. For example, a treatment team member of a **youth** program said fewer program resources impacts operational aspects of the FSP programs, such as food budgets for youth drop-in centers, which can influence client participation:

  > *"Because the prices of goods have gone up in the world, we spend more money, and if they want our numbers to go up, but if we don't have enough food on site, people don't come in."* (Treatment team member of a **youth** program)

  Another treatment team member of a **youth** program described how funding is directly linked to staff retention and turnover, which is another major challenge:

  > *"Sometimes it takes a little longer to hire someone or not, but that really helps so you just don't get people with too high a case load. And I think that a lot of times, that all comes down to economics . . . that means for people to be able to be paid enough at their job so they can live in the Bay Area when doing their job. So, when it comes to the county, I would really hope if they're weighing the idea of saving, it's like, if you save a little money now, does it end up costing more in the long run? We could have one less therapist and move people's cases up a little bit, save that one salary. But if the other three therapists all burn out and you end up with constant turnover, then you have to invest way more money in all the whole hiring process and training and all that stuff."* (Treatment team member of a **youth** program)

- **Engaging Reluctant Clients and Families:** While most team members reported good engagement with clients, four treatment team members from **youth** programs and one treatment team member of **adult** programs described persistent challenges engaging clients, particularly those with high needs, and their families in therapeutic services. A treatment team member from an **adult** program underscored the difficulty in supporting clients effectively when they are not fully engaged in treatment*: "Until a client is willing to engage in that treatment, sometimes we experience a challenge in being able to support them to the best of our ability."* This sentiment reflects the delicate balance between addressing client

needs and managing potential risks associated with lack of engagement. Similarly, a team member from a **youth** program emphasized the struggle with engaging clients with high needs in long-term therapeutic interventions: "*A lot of the clients who have the most need, it's hard to get them to see the value in engaging in some of these longer term things like doing therapy and stuff when they're surviving day to day.*"

One treatment team member of **youth** programs also noted difficulties in engaging with parents and family members who may have initial distrust or are hesitant to participate in treatment: "*usually by the time a family gets to our program, they've probably been struggling for years and they might be discouraged or just not have a lot of motivation to engage or work on changes*." Another treatment team member described unique challenges in cases involving nonbiological caregivers, such as foster parents or relatives, who may feel less inclined to participate fully in treatment because they do not want or feel they are responsible for participating in treatment.

Continual Impact of the COVID-19 Pandemic

- Client and treatment team interviews from this year suggest a minimal influence of the COVID-19 pandemic on FSP programs and most team members noted program services have since returned to prepandemic levels. None of the clients interviewed reported feeling that the COVID-19 pandemic currently affects their FSP services. Four clients joined the FSP program within the last 2 years after COVID-19 emergency measures were lifted and thus experienced fewer direct impacts from the restrictions. Despite diminished impacts, treatment team members noted residual influence of the pandemic on service delivery and program staffing. One **older adult** client expressed gratitude for the postpandemic return of weekly in-person sessions with his psychiatrist. However, other clients accustomed to virtual communication during the pandemic still prefer phone or Zoom interactions and are reluctant to meet for face-to-face sessions. This reluctance can present challenges in providing case management and treatment that requires frequent contact or is more effective in-person, such as assessing clients' mental and physical states and conducting therapy.

  > *"What I am seeing is sometimes clients have gotten used to limited contact but FSP levels of care are intensive case management, with three points of contact per client, per week. . . So sometimes we're still working with clients to explain to them, 'I can't conduct just a phone session with you. We're face-based. I need to see you."* (Program director of an **adult** program)

  In some cases, COVID-19 continues to affect other logistical aspects of care delivery. One treatment team member of a **youth** program explained that conducting in-home visits can be complicated when COVID-19 spreads within families, leading to extended periods before in-person visits can resume. Organizationally, the pandemic created considerable staff turnover,

particularly among case managers and other leadership roles. One treatment team member of an **adult** program described how this turnover reshaped the management structure of their FSP program by reducing the number of case managers:

> *"During the pandemic, all managers one after another had departed . . . they also minimized the job role so there's not as many managers now*." (A treatment team member of an **adult** program)

On the other hand, interviews highlighted how treatment teams learned to quickly adapt service delivery during the pandemic and developed more robust infrastructure to provide more flexible service delivery. For example, one treatment team member of a **youth** program explained the pandemic exposed gaps in service accessibility, particularly for young parents and caregivers who struggled to attend in-person sessions prior to pandemic shutdowns. With this information, the program is now able to provide services to clients more effectively.

> *"We learned through the pandemic, by having to shift everything, that there were folks that cannot physically come to the center. Also, just accessibility is a thing. And for folks who are caregivers, it was impossible to come. So, we were able to give services to them."* (A treatment team member of a **youth** program)

While most FSP services have returned to pre-pandemic norms, the residual lingering effects and challenges of the COVID-19 pandemic emphasize the need for ongoing adaptability and enhanced communication to ensure effective client engagement and support.

Perceived Impact of FSP Program on Quality of Life

Exhibit 31. Impact on Clients' Quality of Life

Clients reported that the FSP program had a positive impact on multiple areas of their lives, including:

- mental and physical health outcomes
- strengthening interpersonal relationships and social networks
- developing independence

Both clients and treatment team members report that the FSP has a substantial positive impact on clients' well-being and quality of life. Clients reported feeling seen and heard and respected in the FSP program compared with other programs they were previously involved in. These sentiments speak to the quality and caliber of the treatment team and demonstrate the strength of having treatment team members who truly care about their clients. Reported client outcomes, such as improved mental health, quality of life, maintaining sobriety, and reduced hospitalizations, demonstrate the beneficial outcomes of this partnership. When reflecting upon

the overall impact of the FSP program, treatment team members felt overwhelmingly proud of the positive impact it has had on their clients' health and lives.

- **Improvements in mental and physical health outcomes:** In terms of health outcomes, clients praised the FSP program for its impact on their mental and physical well-being. Specifically, clients referenced improvements in sleeping habits, a reduction in hospitalizations, and positive interactions with case managers and other treatment team members when discussing improvements in overall health:

  > *"So overall, it's helped me to be back to normal like I did before, with my weight and my sleeping and all that stuff. And my health has been a lot better, I haven't really had any outbursts at all."* (An **adult** client)
  >
  > *"I have stayed out of the hospital, which has been good."* (An **adult** client)
  >
  > *"I think my mental health is doing a little bit better gradually, as long as I go to meetings regularly and meet with my case manager, talk to my psychiatrist, take my medication."* (An **older adult** client)
  >
  > *"Of course, it's not like it's 100% improved, but there's quite a noticeable difference. So that change in quality of life has been very, very, very, very good for us."* (**Parent** of a youth client)

- **Improvements in familial and interpersonal relationships:** Clients shared that there have been positive effects on the quality of interactions with others, particularly family members. A **parent** of a youth client shared that they have a better relationship with their daughter after another provider referred her to the FSP program. They specifically credited an improvement in communication as a contributing factor in their improved relationship:

  > *"It's made changes with my family, with my daughters in this case, we have had better to keep that going. I think I'm in a good place."* (An **adult** client) *communication. The change has been that we have a better relationship, more interaction. I feel a totally different quality of life than I had before. Of course, it's not like it's 100% improved, but there's quite a noticeable difference. So that change in quality of life has been very, very, very, very good for us."* (**Parent** of a youth client)

  An **adult** client expressed similar sentiments about reconnecting with family members and an improvement in familial relationships since joining the FSP program and stated that *"I've been connected with my family since I started [FSP program]. I think our relationship now has gotten better."* Another **adult** client also mentioned reconnecting with friends and the impact of this change on their wellbeing:

  > *". . . I had some difficult circumstances with friends and things like that, but now I talk to some of them and they talk to me, and so that's good."* (An **adult** client)

- **Integration into community and social networks:** Treatment team members commented that the FSP program provides invaluable social support and keeps clients connected to larger community. One team member from a **youth** program shared that clients have made new friends and are more independent after their transition out of the FSP program.

  > *"Usually when clients graduate [from] our program, they're able to be more resourceful or self-independent, they're able to keep an employment or make new friends or connect with a drop-in center to make new friends or attend outings. So, they're more self-sufficient."* (Treatment team member from a **youth** program)

  Clients, particularly **older adult** clients, described an increase in socializing with friends and other people and indicated that these connections improved their well-being:

  > *"It's enriched my life a bit. It's improved my symptoms by socializing a little bit more. By socializing more and stuff, it's increased my mood a little bit."* (An **older adult** client)

  > *"I'm connected to a lot of the people. . . . I went to a reunion, 50th reunion, so we touched base again and we connected. So that was good. That was a scary thing for me and [name of service provider] really helped me with that."* (An **older adult** client)

  Additionally, some clients shared how connections with others made through FSP program services have helped them build their social skills and a sense of community:

  > *"It's good to develop my social skills or use my social skills and meet other peers. . . . I've made some friends in the program as well. It's helpful to meet people who are also peers in the community."* (An **adult** client)

Recommendations

This section presents recommendations for improving implementation of the FSP program based on the quantitative and qualitative findings. This year's recommendations emphasize staff retention through enhanced training, mental health resources, and incentives, similar to last year's recommendations. However, this year there is an added focus on providing opportunities for treatment team members to continue education and specialized training for diverse client needs. Additionally, this year's recommendations introduce the need to ensure consistent team member assignments and to implement a system to communicate team member transitions, as well as increasing awareness and accessibility of FSP services.

Overarching Recommendations

Overall, the combined findings across the self-reported data, EHR data, and client and treatment team member interviews suggest that the FSP program has improved outcomes across all populations served. Furthermore, the key informant interviews illustrate a high level of satisfaction with the program. These findings suggest the program should continue to expand and serve the needs of county residents. While there is consistent evidence of improved client-level outcomes each year, the interviews help illuminate some challenges and possible solutions. Additionally, the data collection process over the past year provided critical insights into existing gaps and methodological strengths, informing targeted recommendations to enhance the rigor and relevance of both qualitative and quantitative analyses moving forward.

Future Program Implementation Recommendations

Improve staff retention through additional staff training, incentives, and mental health resources. The treatment team is the backbone of the FSP program, and continual investment in team members is crucial to creating and maintaining effective relationship-building with clients. Interviews with treatment team members highlighted concerns around staff burnout and a desire for increased collaboration among staff. To address challenges noted above, we recommend a multifaceted approach that focuses on providing enhanced staff training, mental health resources, and team-building initiatives to treatment team members:

- *Implementation of a comprehensive and ongoing staff training program.* Some treatment team members suggested that enhanced staff training programs and opportunities to attend conferences may aid in improving staff retention. One treatment team member noted that attending conferences on wraparound programs would allow team members to learn from other programs and incorporate successful approaches into their own programs. Another treatment team member thought staff would benefit from cultural and age-group specific training to relate more effectively with clients. AIR recommends SMC BHRS to work with

service providers to offer more ongoing staff training and conference opportunities, such as case manager training, with an emphasis on direct engagement and strengthening professional skills. This training should also emphasize cultural awareness and training around supporting diverse clients across different age groups, such as young adults. By broadening the education and skill set of the treatment team members, they will be better equipped to manage their caseloads and provide more personalized support to clients.

- *Provide mental health resources for staff.* In addition to training opportunities, FSP providers should take steps to prioritize the mental health and well-being of FSP staff. Several team members reported feeling burned out due to the challenging situations with clients and extended caseloads. We suggest SMC BHRS work with the service providers to offer their staff mental health or "self-care" workdays and accessible mental health resources, such as counseling and stress management workshops through services, such as an Employee Assistance Program.
- *Incentives to boost longer-term retention.* We suggest the implementation of longer term retention strategies that go beyond immediate staff concerns. These strategies would include offering career development opportunities, pathways for advancement, and incentives for long-term service, such as special recognitions or rewards for staff member dedication on significant career anniversaries or milestones.

By combining these measures, FSP service providers can build more resilient and effective FSP treatment teams. These enhanced teams, in turn, will strengthen client-staff relationships, improve program outcomes, and reduce staff turnover rates, benefiting both the staff and the clients they serve.

Expand workforce and increase diversity to enhance satisfaction and service delivery. While clients are generally satisfied and appreciative of the services they received from treatment team members, especially their case managers, some clients expressed frustration that sometimes their case managers are not available for their needs, and other clients requested more frequent psychiatric services. Given the workload of treatment team members and the varying and greater needs of program clients, it is difficult to accommodate all the requests from clients. Addressing such an issue may require workforce adjustments. In addition to the staff retention measures we recommended above, if resources permit, we recommend the County work with FSP service providers to recruit additional team members, especially case managers, to not only serve FSP clients but also alleviate the burden for current members. Another strategy to consider is redistribution of tasks. If possible, nonessential tasks can be redistributed so that essential team members, like case managers, can focus on core responsibilities. Service providers can implement this strategy by hiring administrative assistants or employing technological tools.

In expanding the workforce, we recommend a focus on increasing workforce diversity. FSP clients come from various cultures and backgrounds and may use a primary language that is different from English. A few treatment team members mentioned the need for more bilingual staff members. Having a workforce that mirrors the diversity of the clientele may improve service delivery and ensure that clients feel understood and represented. Increased linguistic competency can also ensure clear communication and build trust with clients. In addition, it may be beneficial to conduct diversity and inclusion training sessions for all staff members to foster a workplace culture of understanding and respect, ensuring that clients from all backgrounds feel welcome and understood.

Increase awareness and accessibility of FSP services. Clients and treatment team members highlighted a gap in awareness and referrals to FSP programs, leaving many potential beneficiaries unaware of available resources. A **parent** of a youth client expressed gratitude for the services their child receives but emphasized that other families could benefit if they knew about FSP programs. This feedback suggests the need for increased outreach and visibility, such as distributing information through schools and community channels. Schools serve as a central point for community interaction, making them an ideal venue for distributing information about youth and family mental health resources. Additionally, a **youth** program team member noted underutilization due to low referrals despite available capacity. Strengthening connections with school counseling and health services could improve referrals and prevent resource underuse. Another **parent** also mentioned that frequent, multiple appointments overwhelmed their family, leading to session refusals. To enhance accessibility, the County should encourage FSP providers to coordinate schedules with families, ensuring services remain both supportive and manageable.

Ensure consistent team member assignments and implement notifications of team member transitions. A key issue raised in interviews was inconsistent case manager assignments and poor communication during staff transitions. Clients expressed frustration, with one adult client reporting a 3-month gap in care after their therapist resigned. These disruptions can hinder trust-building and trigger feelings of abandonment, making future engagement harder. To address this, AIR recommends the County collaborate with FSP providers to establish clear guidelines for consistent case manager assignments and implement a notification system to promptly inform clients of any changes. These guidelines might involve a provider-level survey before new cases are assigned to assess individual strengths and workload capacities. Caseload distribution should only be done if providers are overwhelmed with too many cases or crises to manage simultaneously. In addition, FSP programs should develop a notification system so that both clients and team members are promptly informed of any transitions within the treatment team, including temporary coverage arrangements, and ensure sustained quality of care. Assigning the same case manager when possible and ensuring timely communication of staff changes can foster trust, continuity, and better client-team member relationships.

Quantitative Data Collection

Integrate Telecare data into the existing self-reported data from Edgewood/Fred Finch and Caminar providers for analysis in future program evaluations. Currently, Telecare cannot provide FSP clients' data prior to December 2018. Therefore, the sample size for Telecare does not reflect the actual enrollment and impact of the FSP program for those enrolled with Telecare. Integrating Telecare data will allow the County to report consolidated results for all providers since FSP inception in 2006 and enhance data completeness and quality. AIR is in ongoing conversations with Telecare to develop a process to upload their historical and current data to the state data reporting system. AIR is continuing to work with the County and Telecare to convert Telecare's self-reported data into the accepted format by the state reporting system that can be merged with data from the other FSP providers.

Qualitative Data Collection

This year, the AIR team conducted qualitative data collection to better understand the current implementation and impact of the FSP program, following the qualitative evaluation last year. We planned to complete 35 interviews with FSP clients and treatment team members, with the goal of recruiting roughly equal numbers of participants from the two adult and older adult service providers (i.e., Caminar, Telecare). Between the youth and TAY service providers (Edgewood, Fred Finch), we expected to recruit more participants from Edgewood given the small number of current Fred Finch clients. Despite conducting 12 of 15 planned client interviews, we reached the goal of completing 35 total interviews by over-recruiting team member interviews and extending the data collection period. To improve client recruitment for future FSP qualitative data collection, we propose the following recommendations:

Increase participation incentives to improve client participation. Despite efforts to balance client participant recruitment across various service providers, we faced challenges, particularly with recruitment from Fred Finch who was unable to identify any available clients. To strengthen interest in participating in future evaluations, we recommend increasing the financial incentive for client interviews. Currently, clients and parents of clients (in the case of youth and TAY clients) receive a $30 stipend for their participation, which may be considered as insufficient compensation for their time when accounting for the high cost of living and inflation in San Mateo County.[10] Further, most individuals and families served by SMC BHRS have lower incomes and are eligible for Medi-Cal, suggesting FSP clients may be facing economic difficulties. Our experience, combined with feedback from the County and insights from similar qualitative data collection efforts, suggests that enhancing incentives to a minimum of $50 may make participation more

[10] Bureau of Labor Statistics. "San Francisco Area Economic Summary." *Bureau of Labor Statistics*. Last modified April 28, 2023. https://www.bls.gov/eag/eag.ca_sanfrancisco_md.htm.

appealing to clients, thereby boosting recruitment and participation rates for future data collection.

Leverage FSP service providers in the recruitment outreach process. To increase client participation in interviews, particularly among Fred Finch FSP clients, we recommend involving FSP treatment team members, such as child welfare workers, in the recruitment process. These professionals have established trust and rapport with clients because they regularly engage with them in a supportive capacity. By providing FSP providers with information about the project's aim and significance, confidentiality measures, and the potential benefits of participation, they can introduce the project face-to-face and in a manner that addresses client concerns and encourages participation. Additionally, FSP providers may have a better understanding of the unique challenges of their clients and can provide insight into recruitment strategies that suit their contexts. They may also be able to directly assist clients in scheduling interviews and navigating technological challenges.

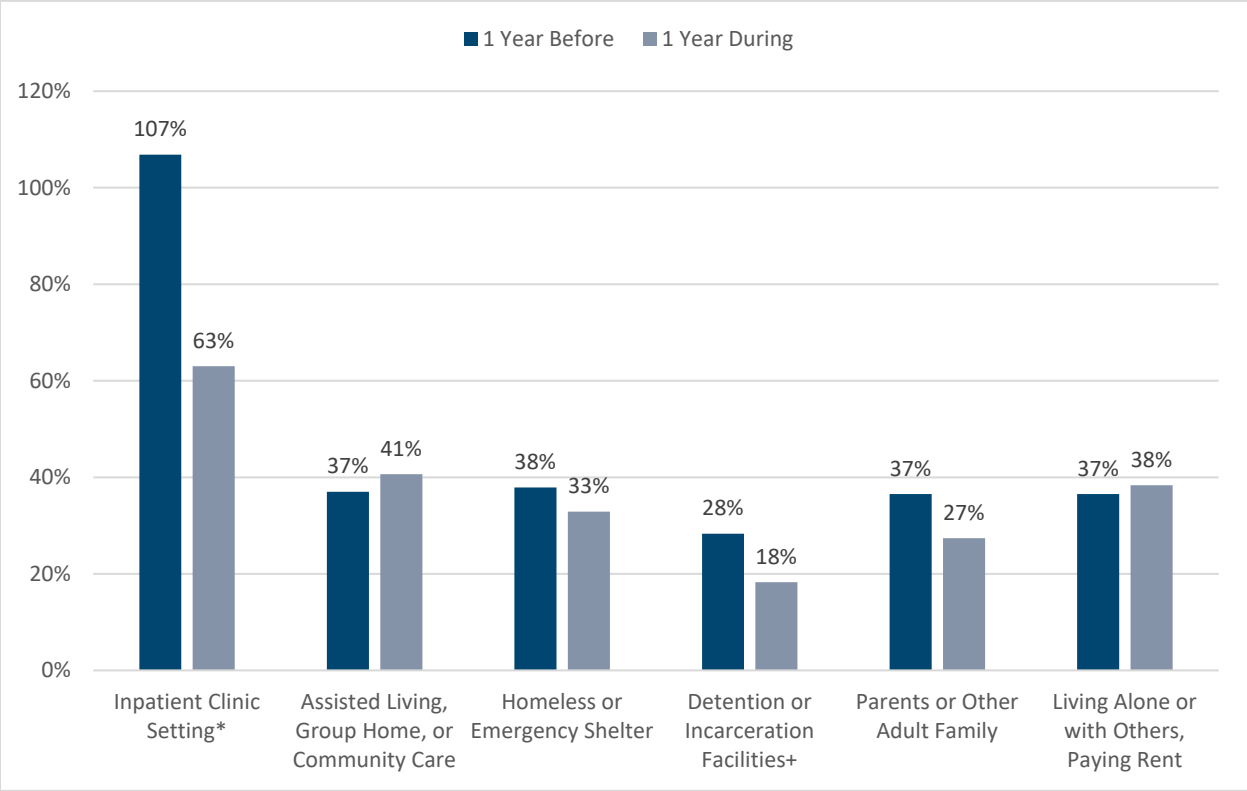
Appendix A. Additional Detail on Residential Outcomes

For residential setting outcomes by full service partnership (FSP) provider, we present all the categories of living situations and compare the percentages of any clients spending any time in various residential settings the year prior to FSP and in the first year of FSP participation. There are currently four comprehensive FSP providers in San Mateo County (the County): Edgewood Center and Fred Finch Youth Center (hereafter, Edgewood/Fred Finch), serving children, youth, and transitional age youth, and Caminar and Telecare, serving adults and older adults. A list of all residential settings and categories is presented in Appendix C with the methodological approach.

We used self-reported data from Caminar for Exhibit A1, data from Edgewood/Fred Finch for Exhibit A2, and data from Telecare for Exhibit A3. As shown in Exhibits A1–A3, the percentage of clients reporting any time in an inpatient clinic or living with parents decreased. Further, the percentage of clients who were homeless or living in a shelter decreased for Caminar and Telecare and remained the same for Edgewood/Fred Finch clients. In contrast, the percentage of clients who reported any time living alone or with others and paying rent increased. In general, there appears to be a shift in living situations from institutional settings (clinics, shelters, detention centers) toward living alone or with others in group homes, signaling improvement in independence after FSP enrollment. The emphasis on housing assistance in the FSP programs may help clients establish more stable living situations, which in turn can reduce stress, support recovery efforts, and deter behaviors that might otherwise lead to arrests or homelessness.

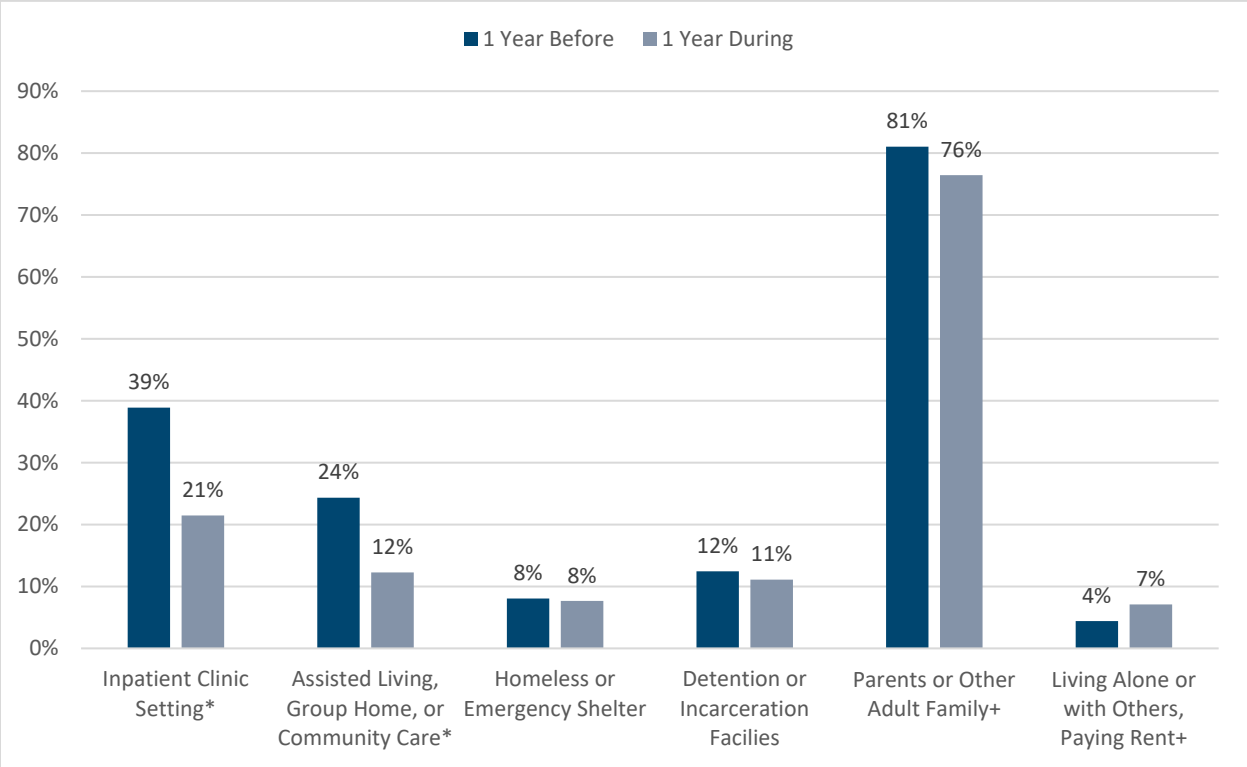
Inconsistency across providers is observed for clients reporting any time in assisted living, group home, or community care environment: the percentage for Caminar and Telecare clients increased between the 2 consecutive years, while the percentage for Edgewood/Fred Finch clients decreased. For Caminar and Edgewood/Fred Finch, there were reductions in the percentage of clients reporting any time in detention or incarceration facilities, whereas the percentage increased among Telecare clients. Asterisks in the exhibits denote outcomes that are statistically significant.

Exhibit A1. Percentage of Caminar Clients Completing 1 Year in the FSP Program Who Lived in a Residential Setting for Any Time During the Study Period (*N* = 219)



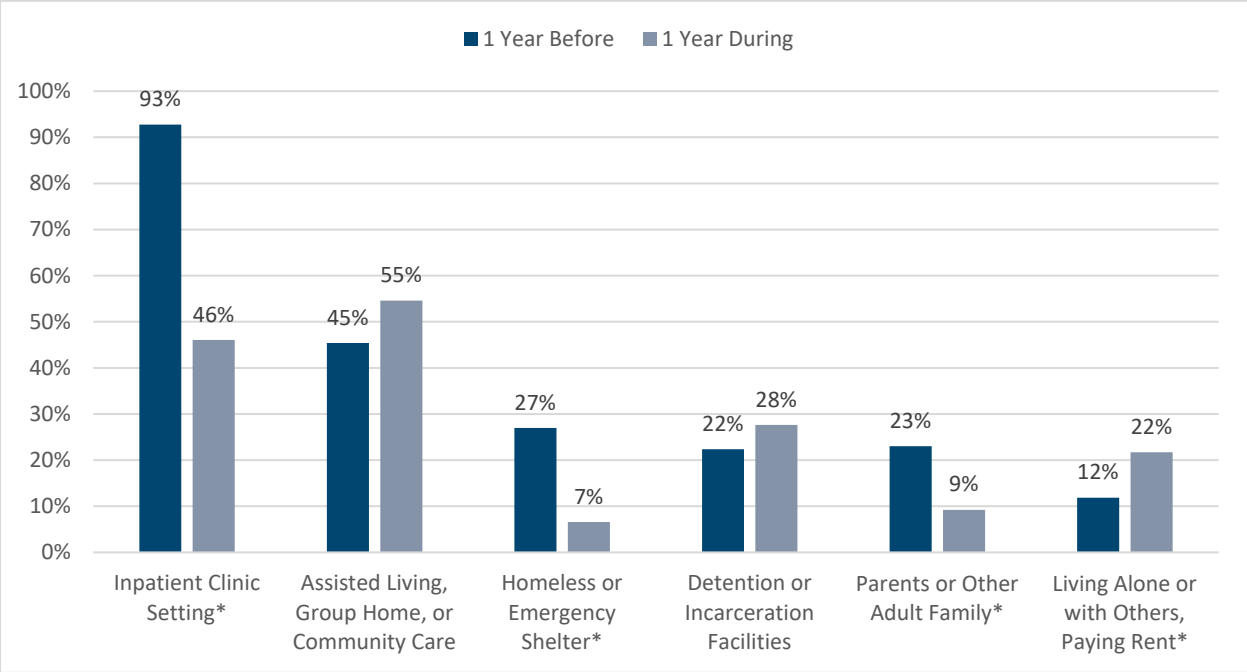
Note. Residential settings are not mutually exclusive, so percentages may exceed 100. An outcome with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level. An outcome with + indicates that the change in that outcome is marginally significantly different from 0 at 0.08 significance level.

Exhibit A2. Percentage of Edgewood/Fred Finch Clients Completing 1 Year in the FSP Program Who Lived in a Residential Setting for Any Time During the Study Period (*N* = 522)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level. An outcome with + indicates that the change in that outcome is marginally significantly different from 0 at 0.08 significance level.

Exhibit A3. Percentage of Telecare Clients Completing 1 Year in the FSP Program Who Lived in a Residential Setting for Any Time During the Study Period (*N* = 152)



Note. An outcome with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Appendix B. Additional Detail on Outcomes by FSP Providers

This section provides outcomes by each FSP service provider. Exhibits B1–B3 present the percentage of clients with any events the year just prior to full service partnership (FSP) enrollment and the first year in an FSP, as well as the percentage of improvement for each FSP provider. Percentage improvement is the change in percentage of clients who experienced the named event in the first year of FSP participation compared to the percentage of clients experiencing the event in the year prior to participating in an FSP.

As shown in Exhibit B1, there are improvements comparing the year prior to FSP to the first year during FSP for Caminar on all the available self-reported outcomes. Among these, outcomes on detention or incarceration, employment, arrests, mental, and physical health emergencies are statistically significant.

Exhibit B1. Percentage of Caminar Clients With Outcome Events by Year and Percentage Change in Prevalence of Outcome Events (Year Before FSP vs. the First Year of FSP Participation) (*N* = 219)

Survey outcomes, Caminar	1 year before	Year 1 during	Change (%)
Homelessness	38%	33%	-13%
Detention or incarceration	28%	18%	-36%*
Employment	1%	3%	600%
Arrests	22%	7%	-69%*
Mental health emergencies	70%	28%	-60%*
Physical health emergencies	37%	12%	-67%*
Active substance use disorder	49%	48%	-4%
Substance use disorder treatment	19%	22%	15%

Notes. Blue font indicates outcomes that improved. Black font indicates outcomes did not change or changed but the change was not statistically significant. * indicates a change significantly different from 0 at 0.05 significance level.

Exhibit B2 shows improvement for Edgewood Center and Fred Finch Youth Center (hereafter, Edgewood/Fred Finch) clients in all outcomes except for self-rated academic grade and school attendance. All but the outcomes on homelessness and detention or incarceration are statistically significant.

Exhibit B2. Percentage of Edgewood/Fred Finch Clients With Outcome Events by Year and Percentage Change in Prevalence of Outcome Events (Year Before FSP vs. the First Year of FSP Participation) (*N* = 522)

Survey outcomes, Edgewood/Fred Finch	1 year before	Year 1 during	Change (%)
Homelessness	8%	8%	-5%
Detention or incarceration	13%	11%	-11%
Arrests	18%	6%	-68%*
Mental health emergencies	43%	8%	-81%*
Physical health emergencies	15%	1%	-92%*
Suspension	14%	5%	-64%*
Academic grade	3.28	3.02	-8%*
School attendance rating	2.31	2.15	-7%*

Notes. Blue font indicates outcomes that improved. Red font indicates outcomes that worsened. Black font indicates outcomes did not change or changed but the change was not statistically significant. * indicates a change significantly different from 0 at 0.05 significance level.

As shown below in Exhibit B3, there are improvements when comparing the year prior to FSP to the first year during FSP for Telecare on four out of eight available self-reported outcomes. Of these, outcomes on homelessness, arrests, and active substance use disorder are statistically significant. There are worse outcomes for detention and incarceration, and mental and physical health emergencies, though only the outcome for mental health emergencies is statistically significant. Additionally, fewer clients reported receiving treatment for substance use disorder. However, we also see a decrease in reported active substance use, which may help explain the decrease in reported treatment. The percentage difference with employment is reported as N/A because the percentage of clients with employment did not change (from 0% to 0%). Therefore, the denominator is 0.

Exhibit B3. Percentage of Telecare Clients With Outcome Events by Year and Percentage Change in Prevalence of Outcome Events (Year before FSP vs. the First Year of FSP Participation) (*N* = 152)

Survey outcomes, Telecare	1 year before	Year 1 during	Change (%)
Homelessness	27%	7%	-76%*
Detention or incarceration	22%	28%	24%
Employment	0%	0%	N/A
Arrests	30%	11%	-62%*
Mental health emergencies	12%	36%	200%*
Physical health emergencies	10%	16%	60%
Active substance use disorder	63%	31%	-51%*
Substance use disorder treatment	7%	5%	-20%

Note. Blue font indicates outcomes that improved. Red font indicates outcomes that worsened. Black font indicates outcomes did not change or changed but the change was not statistically significant. * indicates a change significantly different from 0 at 0.05 significance level.

Appendix C. Quantitative Methods

Methodology for Full Service Partnership Survey Data Analysis

The full service partnership (FSP) survey data are collected by providers through discussions with clients and should thus be viewed as self-reported outcomes. Among the service providers included in these analyses (Edgewood Center and Fred Finch Youth Center [hereafter, Edgewood/Fred Finch], Caminar, and Telecare), 893 clients completed a Partner Assessment Form (PAF) at intake and completed a full year with FSP since program inception.

In general, three data sets were used for this report: one from Caminar, one from Telecare, and one from Edgewood/Fred Finch. All providers provide their data sets in a Microsoft Excel format. In 2018, Telecare changed their data system for the FSP survey in which the data structure and variable names were different from before. Because of data reliability issues, Telecare only provided the data after its data system change, with data from December 2018 onward. Therefore, the main analysis of this report includes all Caminar and Edgewood/Fred Finch clients, and a separate analysis is included for Telecare data since December 2018.

Edgewood/Fred Finch serve child and transitional age youth (TAY) clients. Caminar and Telecare serve primarily adult and older adult clients, and a small number of older TAY clients. Caminar's older TAY clients (*N* = 77) are excluded from the TAY-specific self-reported outcomes because Caminar does not reliably complete the ongoing program surveys for this age group (i.e., KET, 3M). Exhibit C1 describes the age group of clients completing at least 1 full year of FSP from 2006 to 2024 by provider. For Telecare, these data include December 2018 through June 2024.

Exhibit C1. Age Distribution of Clients With a Minimum of One Full Year of FSP Participation, by Provider

Age group	Edgewood/ Fred Finch	Caminar	Telecare	Total[a]
Child (ages 16 and younger)	238	—	—	238
TAY (ages 17–25)	284	77	15	376
Adult (ages 26–59)	—	118	103	221
Older Adult (ages 60+)	—	24	34	58
Total	522	219	152	893

[a] Telecare clients in the analysis include only those who joined the FSP after December 1, 2018, due to data availability. Telecare clients were not reported in the survey outcomes by age group. A separate analysis was conducted for Telecare clients; it combines all age groups because of the small sample size.

A comprehensive assessment file with FSP start and end dates and length of FSP tenure was created at the client level. Note that for clients who stopped and then reestablished their FSPs, we only kept the record corresponding with their most recent participation in an FSP (using Global ID), as indicated in the state's documentation.

Client type (child, TAY, adult, and older adult) is determined by the Partnership Assessment Form (PAF) data.

- For Caminar and Edgewood/Fred Finch, records with the following specific Age Group codes were selected:
  - Caminar: Selected records with Age Group codes of "7" (TAY client, ages 17 to 25), "4" (adult client, ages 25 to 59), and "10" (older adult client, ages 60 and older).
  - Edgewood/Fred Finch: Selected records with Age Group codes of "1" (child client, ages 16 and younger) and "4" (TAY client, ages 17 to 25).
  - In both cases, Age Group codes were confirmed using the data file's continuous *Age* variable.
- For Telecare data, clients were given an age-appropriate PAF. Records with specific *Form Type* codes were retained in the analysis (i.e., Form Types "TAY_PAF," "Adult_PAF," and "OA_PAF").

Partnership date and *end date* were determined as follows: Partnership date was determined using enrollment start date. End date was determined by the reported date of the partnership status change in the Key Event Tracking (KET) form to "discontinued." For clients still enrolled at the time of data acquisition, we assigned an end date of June 30, 2024.

All data management and analysis were conducted in Stata. Code is available upon request.

Additional details on the methodology for each outcome are presented below.

Residential Setting

1. Residential settings were grouped into categories as described in Exhibit C2.
2. The baseline data were populated using the variable PastTwelveDays (Caminar and Edgewood/Fred Finch) or res_past12m_days_int (Telecare) collected by the PAF. Individuals without any reported locations were assigned to the "Don't Know" category.
3. The client's first residential status after they joined FSP is determined by the Current (Caminar and Edgewood/Fred Finch) or res_curr_dsr (Telecare) collected by the PAF. Individuals without any reported current residence were assigned to the "Don't Know" category. Some individuals had more than one first residence location. In this case, if there

was one residence with a later date (as indicated by the variable DateResidentialChange [Caminar and Edgewood/Fred Finch] or main_resident_date [Telecare]), this residence was the first residential setting. If the residences were marked with the same date, both were considered part of the client's first year in an FSP.

4. Additional residential settings for the first year were found using the KET data, inclusive of all residence types listed with a corresponding date of residential change (DateResidentialChange [Caminar and Edgewood/Fred Finch] or main_resident_date [Telecare]) occurring within 1 year of the FSP partnership start date. If no residential data were captured after the PAF by a KET, it was assumed that the individual remained in their original residential setting.

Exhibit C2. Residential Setting Categories and Corresponding Classification Values Used to Derive Them

Category	Telecare, Caminar, Edgewood/Fred Finch setting value[a]
With family or parents	
With parents	1
With other family	2
Alone	
Apartment alone or with spouse	3
Single occupancy (must hold lease)	19
Foster home	
Foster home with relative	4
Foster home with nonrelative	5
Homeless or emergency shelter	
Emergency shelter	6
Homeless	7
Assisted living, group home, or community care	
Individual placement	20
Assisted living facility	28
Congregate placement	21
Community care	22
Group home (Levels 0–11)	11

Category	Telecare, Caminar, Edgewood/Fred Finch setting value[a]
Group home (Levels 12–14)	12
Community treatment	13
Residential treatment	14
Inpatient facility	
Acute medical	8
Psychiatric hospital (other than state)	9
Psychiatric hospital (state)	10
Nursing facility, physical	23
Nursing facility, psychiatric	24
Long-term care	25
Incarcerated	
Juvenile hall	15
Division of Juvenile Justice	16
Jail	27
Prison	26
Other / Don't know	
Don't know	18
Other	17

[a] Setting names determined by the following guide: http://www.dmh.ca.gov/POQI/docs/FSP_Data_Dictionary_October_2011.pdf

Employment

Employment outcomes were generated for adults only. Therefore, Edgewood/Fred Finch data were excluded.

1. The baseline data were populated using the PAF data. An individual was considered as having had any employment if there was a nonzero, nonblank value for one of the following variables (note that variable names differ slightly by data set):
    a. Any competitive employment in the past 12 months (any competitive employment; any competitive employment for any average number of hours per week; any average wage for competitive employment)

b. Any other employment in the past 12 months (any other employment; any other employment for any average number of hours per week; any average wage for any other employment)

2. Ongoing employment was populated using any dates of employment change (variable names vary slightly by file) noted in the KET file within the first year of membership in an FSP (as determined by the partnership start date). An employment change was coded if the new employment status code corresponding to the employment change date indicated competitive employment or other employment. If the KET contained no information on employment, the original employment was presumed to sustain throughout FSP membership.

Arrests

1. The baseline arrest data were populated using the variable *ArrestsPast12* (Caminar and Edgewood/Fred Finch) or *lgl_arrest_p12_times* (Telecare) collected by the PAF. If the variable was blank, the client was assumed to have zero arrests in the year prior to FSP.
2. Ongoing arrests were populated using any dates of arrest (variable names vary slightly by file) noted in the KET file within the first year of membership in FSP (as determined by the partnership date). If the KET file contained no information on arrests, the client was assumed to have had no arrests in the first year in an FSP.

Mental and Physical Health Emergencies

1. The baseline utilization of emergency services was populated using the PAF's variables for mental health emergencies (*MenRelated* [Caminar and Edgewood/Fred Finch] or *emr_mental_p12* [Telecare]) and physical health emergencies (*PhysRelated* [Caminar and Edgewood/Fred Finch] or *emr_physical_p12* [Telecare]), respectively. If either of these fields were blank, the client was assumed to have had zero emergencies of that type in the year prior to FSP.
2. Ongoing emergencies were populated using the variable indicating the date of emergency (variable names vary slightly by file) in the KET file, if the date is within the first year with an FSP as determined by the partnership date. The type of emergency was indicated by *EmergencyType* (Caminar and Edgewood/Fred Finch) or *main_emergency_int_dsr* (Telecare) ("1" = physical; "2" = mental). We assumed that no information on emergencies in the KET indicated that no emergencies had occurred in the first year of an FSP.

Substance Use Disorder

1. Baseline data on substance use disorder were populated using variables in the PAF for active substance use disorder (*ActiveProblem* [Caminar and Edgewood/Fred Finch] or *sub_co_mh_sa_probl_past* [Telecare]) and participation in substance use disorder treatment and recovery services (*AbuseServices* [Caminar and Edgewood/Fred Finch] or *sub_sa_services_now* [Telecare]). If these fields were blank, the client was assumed to have had no substance use disorder nor received substance use disorder treatment and recovery services in the year prior to FSP.
2. Ongoing substance use disorder data were populated using the 3-month data variables of the same name. Any record of an active substance use disorder or participation in a substance use disorder treatment during the first year of FSP was recorded. If there were no observations in the variables of interest, clients were assumed to have no ongoing substance use disorder or participation in substance use disorder treatment.

Methodology for County EHR Data Analysis

Hospitalization outcomes were derived from electronic health records (EHR) data obtained through the Avatar system. Using EHR data avoids some of the reliability shortcomings of self-reported information but presents several challenges as well. The Avatar system is limited to individuals who obtain emergency care in the San Mateo County (the County) hospital system. Hospitalizations outside of the County, or in private hospitals, are not captured. The hospitalization outcomes include 932 clients who were both (a) included in the County's EHR system and (b) completed 1 full year or more in an FSP program by the June 2024 data acquisition date. Thus, individuals included in the EHR analysis had to have started with the FSP between July 2006 (the program's inception) and June 2024.

All data management and analysis were conducted in Stata. Code is available upon request.

To count instances of psychiatric hospitalizations and psychiatric emergency services (PES) admissions, we relied on the Avatar *view_episode_summary_admit* table. Exhibit C3 shows the corresponding program codes. In addition, FSP episodes were identified through the Avatar *episode_history* table.

Exhibit C3. Program Codes Among Clients Ever in an FSP

Program code	Program value
Psychiatric hospitalizations	
410200	ZZ410200 PENINSULA HOSPITAL INPT-MSO I/A
410205	410205 PENINSULA HOSPITAL INPATIENT
410700	410700 SMMC INPATIENT
921005	921005 NONCONTRACT INPATIENT
926605	926605 JOHN MUIR MED. CTR INPT MAN CARE
Psychiatric emergency services	
410702	Z410702 SMMC PES-termed 10/31/14
410703	410703 PRE CONV SMMC PES~INACTIVE
41CZ00	41CZ00 SAN MATEO MEDICAL CENTER - PES

Note. Data represent all utilization from FSP clients for these codes, as pulled from Avatar on September 17, 2024.

Client type (child, TAY, adult, and older adult) was determined by the client'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 clients by age group is different between the County's EHR data and the FSP survey data. This disparity is likely due to the different ways age group was determined. For the survey data, AIR determined age group by whether the client was evaluated using the child, TAY, adult, or older adult FSP survey forms. For the County's EHR data, AIR assigned individuals to an age group based upon the date they joined FSP and their reported date of birth.

Appendix D. Qualitative Methods

Methodology for Full Service Partnership Interviews

Participants

This analysis included 35 interviews with 12 clients and 23 treatment team members. AIR worked with San Mateo County (SMC) Behavioral Health and Recovery Services (BHRS) staff and the four FSP service providers (Exhibit D1) to recruit clients and treatment team members. Exhibit D2 presents the number and types of clients and wraparound treatment team members whom we have interviewed and included in this analysis across the FSP service providers. Note that we were not able to recruit client participants from Fred Finch.

Exhibit D1. FSP Service Providers

Service Provider	Description	Population served
Edgewood Center	Edgewood's FSP provides services to help clients stabilize and maintain current placements, while offering comprehensive mental health services.	Children, youth, and transitional age youth (TAY)
Fred Finch Youth Center	Fred Finch Youth & Family Services FSP serves foster youth and provides an array of services to promote wellness, resilience, and stability in the youth's home. Services include safety planning and behavioral interventions, as well as family and individual support.	
Caminar	Caminar FSP provides services to individuals who are among those in most need in San Mateo County and integrates streamlined, holistic health care utilizing the best-practice model of assertive community treatment. The team includes the added benefit of medical clinic services and a 24-hour on-call emergency response service.	Adults and older adults
Telecare	Telecare FSP provides "Integrated Service Delivery" to San Mateo County residents who have symptoms commonly associated with a profound psychiatric disability (or disabilities) and who may also have co-occurring disorders (such as substance use or medical conditions), and serious life stressors such as problems obtaining or maintaining housing or involvement with the legal system.	

Exhibit D2. Summary of Interviewees

FSP Service Provider(s)	Clients	Wraparound Treatment Team
Edgewood Center	**2 parents** whose children have accessed services through FSP in the last year or are currently accessing services through FSP	**13 team members including:** • Program manager (3) • Case managers (2) • Behavior coach (2) • BH Clinician/Substance Use Specialist (2) • Parent client (1) • Emerging adult client or peer ambassador (1) • Crisis response worker (1) • Housing specialist (1)
Fred Finch Youth Center*		**1 team member** including: • Program manager (1)
Caminar	**6 clients** who accessed FSP in the last year or are currently accessing services through FSP	**5 team members** including: • Case manager (1) • BH Clinician/Substance Use Specialist (1) • Crisis response worker (1) • Program manager (1) • Housing specialist (1)
Telecare	**4 clients** who accessed FSP in the last year or are currently accessing services through FSP	**4 team members** including: • BH Clinician/Substance Use Specialist (3) • Case manager (1)
Total Interviewees (35)	**12 clients**	**23 team members**

*Fred Finch Youth Center was not able to identify any client participants at the time data collection ended.

Interview Format and Length

Each interview lasted about 30 minutes in length and was conducted virtually using Zoom software. When participants had technical difficulties with the Zoom software, the AIR team conducted interviews by directly calling clients or treatment team members. A trained, bilingual interviewer with Spanish as their primary language conducted the interviews with Spanish-speaking participants. Interviewers obtained consent and permission from all participants before starting the recording. There was one participant who requested not to be recorded, for which a note-taker joined the interview and took notes.

Analysis

All interviews except one were recorded and transcribed. For the interview that was not recorded, we used the notes from the interview for the analysis. A deductive method was used to code the transcripts. We then conducted a thematic analysis of the concepts, exploring similarities and differences between participants.

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26706_12/24

APPENDIX 5. CONTRACTORS' ASSOCIATION REPORT, FY 2023–24

Caminar
for Mental Health

NEEDS ADDRESSED BY FUNDING FY 23-24

CONTRACTOR	Amount Granted	Amount Spent	Improved capacity to provide integrated models for addressing trauma and co-occurring disorders	Improved capacity to incorporate evidence-based practices into day-to-day resources	Improved cultural competency	Improved capability to collaborate, partner and share resources and information with other Association Members
California Clubhouse	$ 4,000.00	$ 4,000.00	No	Yes	No	No
	$ 5,555.55	$ 5,555.55				
Caminar	$ 4,000.00	$ 4,000.00	Yes	Yes	No	No
	$ 5,555.55	$ 5,555.55				
Children's Health Council	$ 4,000.00	$ 4,000.00	Yes	Yes	Yes	No
	$ 5,555.55	$ 5,555.55				

Daly City Youth Health Center	$ 4,000.00	$ 4,000.00	Yes	Yes	Yes	No
	$ 5,555.55	$ 5,555.55				
Edgewood	$ 4,000.00	$ 4,000.00	Yes	No	Yes	No
	$ 5,555.55	$ 5,555.55				

El Centro de Libertad	$ 4,000.00	$ 4,000.00	No	Yes	No	No
	$ 5,555.55	$ 5,555.55				
Felton	$ 4,000.00	$ 4,000.00	Yes	Yes	Yes	Yes
	$ 5,555.55	$ 5,555.55				

Fred Finch Youth Center	$ 4,000.00	$ 4,000.00	Yes	No	Yes	Yes
	$ 5,555.55	$ 5,555.55				
Free at Last	$ 4,000.00	$ 4,000.00	No	No	Yes	No
	$ 5,555.55	$ 5,555.55				

Heart & Soul, Inc	$ 4,000.00	$ 4,000.00	No	Yes	Yes	No
	$ 5,555.55	$ 5,555.55				
Horizon Services, Inc.	$ 4,000.00	$ 4,000.00	Yes	No	Yes	No
	$ 5,555.55	$ 5,555.55				
Mental Health Association	$ 4,000.00	$ 4,000.00	Yes	No	No	No

	$ 5,555.55	$ 5,555.55				
Puente	$ 4,000.00	$ 4,000.00	Yes	Yes	Yes	No
	$ 5,555.55	$ 5,555.55				
Sitike	$ 4,000.00	$ 4,000.00	Yes	Yes	Yes	Yes
	$ 5,555.55	$ 5,555.55				
	$ 4,000.00	$ 4,000.00				

Star Vista	$ 5,555.55	$ 5,555.55	No	No	No	Yes
	$ 4,000.00	$ 4,000.00				

The Latino Commission	$ 5,555.55	$ 5,555.55	Yes	Yes	Yes	No
Voices of Recovery	$ 4,000.00	$ 4,000.00	Yes	Yes	Yes	No
	$ 5,555.55	$ 5,555.55				
Youth Service Bureau	$ 4,000.00	$ 4,000.00	No	No	Yes	No
	$ 5,555.55	$ 5,555.55				
Mental Health Association (Fiscal Sponsor for the BHRS Contractors' Association, the Contractor)	$ 32,857.10	$ 32,857.10				

	$204,857.00	**$204,857.00**

TOTALS	Amount Granted	Amount Spent

% of Funding Recipients' staff who provide direct services participated in training that developed new skills in the areas of trauma, co-occurring disorders and/or cultural awareness	Comments
100%	$4,000.00 - MHSA Grant $7,000.00 - Training Fees $3,000.00 - Total (the additional $3,000 cost was used towards the $5,555,55 workforce grant below)
	$5,555.55 - Workforce Grant $2,900.00 - Training Fees $3,000.00 - Add'l training fees (from above) -$ 344.45 - (in kind) - Total
75%	$3,325.00 - TRAINER FEE $ 675.00 - FOOD FOR ALL DAY TRAINING $ 4,000.00 - TOTAL
	$5,555,55 - WORKFORCE BUDGET
75%	$4,031.20 on Cultural Competency Trainings (DBT trainings, supplies, manuals in Spanish/English) $4,000.00 - funded through MHSA $ 31.20 - in-kind from CHC
	$5,562.96 - Workforce Development Activities (stipends, team training/retreat, conferences, other staff engagement) $5,555.55 - funded through MHSA $ 7.41 - in-kind from CHC

100%	EMDR Training and consultation for 2 clinicians and 1 supervisor x $1050 = $3,150 DEI resources and refreshments for 9 months = $200 Building Transformational School Health Conference and Understanding Childhood Defenses Training for Behavioral Health Leadership = $650
	11 Workforce Retention Stipends x $506.12 = $5,567.32 We used individual donations to cover the remainder of $1,311.77
79%	Cultural Competency - RECEIVED: $4000.00 SPENT: $4000.00 - Power, Privilege, and Interrupting the Cycle of Oppression with Kelsey Pacha - $950.00 - Cultural Humility with Liberation Consulting - $2100.00 - Engaging in Necessary Conversations about Race, and related topics - $975.00 ($25.00) TOTAL= $4000.00
	Workforce Retention Grant - RECEIVED: $5555.55 SPENT: $5555.55 - LG-Counter-DepthFrench Door Smart Refrigerator with Internal Water - Stainless Steel - $1783.98 - CitiZ&Milk Nespresso - $361.75 - Marshall Stanmore III Speaker - $416.56 - Pods & Parcel - $339.70 - Our Place Wonder Oven & Hot Grips - $217.08 - Target Staff Beverages & Food - $870.16 - Staff Incentive Lounge Furniture - $1800.00 ($233.68) TOTAL = $5555.55

75%'	$1,100.00 Co-occurring Training Expense Sarah Solis, LCSW Motivational Interviewing Live Training $ 187.90 - Arguello Catering Lunch for staff / Live Training day $2,712.10 - Relias, LLC , Online Training Platform Configuration, setup and licensing
	$5,555.00 - Relias, LLC , Online Training Platform Configuration, setup and licensing
75%	**Cultural Competency Funding:** Professional fees for evidence-based practices training and technical assistance (contractors and training organizations) Evidence-Based Approaches to Bipolar and Other Mood Disorders - Monthly sessions between 7/1/23 - 6/27/24 by UCSF - $3,000.00 SOGIE trainings (sessions provided between 5/1/24 and 6/15/24) - $320.00 Purchase of books, journals, videos, and manuals - $784.01 In-kind agency contribution ($104.01) **Total Expenses $4,000.00**
	Workforce Funding: Workforce recruitment and retention activities: job advertising (including developing materials for social media), employee bonus (language capacity), employee wellness resource subscription and management skills development materials. **Total Expenses $5,555.55**

83%	**For Cultural Competence:** $350 - Neurodivergence, Play, and Behavioral Interventions training $765 - Working with Resistant Youth and Families from a Trauma Informed Perspective - $767 - Facility Fee for training - $450 - Self Care in Working with Multi-stressed Youth and Families training - $200 - Cultura y Bienestar: Mental Health for Latinx Folks training $342.61 - Books and Materials $1,139.96 - Food for above trainings **$4,014.57 - Total Cultural Competence**
	$5,555.55 - 12 Fred Finch Staff
88%	**MHSA CULTURAL COMPETENCY TRAINING GRANT** Trainer Fees: $3,000 Wages for part-time staff to attend training outside of regualr working hours: 11 part time staff @ $20/hr x 8 hours = $1,760 In Kind from FAL for remainder wages for part time staff to attend training - $760 **TOTAL: $4,000**
	MHSA WORKFORCE GRANT 1 Staff x 805.55 = $805.55 1 Staff x 500 = $500.00 1 Staff x 400 = $400.00 3 Staff x 300 = $900.00 11 Staff x 250 = $2750.00 1 Staff x 200 = $200.00 **TOTAL: $5,555.55**

100%	Cultural Competency Grant - $4,000 BHRS Cultural Humility 101: Building Bridges to Diversity and Inclusion - $468 Language Cultural Competency Lessons - $3,600 Psychological Safety Training to integrate Racial Equity, Diversity and Inclusion - $125 Overage (In-Kind) - ($193) Total: - $4,000
	Workforce Development Grant $5,555.55 WRAP Training Total Costs - $9,213.55 Overage (In-Kind) - ($3.658.00) Total: - $5,555.55
75%	**Line Item For the Cultural Competency:** CADTP Spring Conference - $1,529 RELIAS Training System - $4,086 In-Kind from Horizon Services - ($1,615) **Total $4,000**
	Line Item For the WORKFORCE: WORKFORCE SCIENCE- Employee Engagement Survey Services - $3,150 - Additional Manager Coaching - $350.00 Job fair & advertising - $779.83 Recruitment - $5,150.15 In-Kind from Horizon Services - ($3,874.43) **Total $5,555.55**
80%	Honorium: $1,200 Lunches $1,200 Pay for staff attending on days/times they do not work: $1,450 Purchase of printed materials: $250 **Total $4,100** MHSA funds utilized: $4,000 In-kind MHA funds utilized $ 100

	Retention Bonuses for Nurses: $4,556 Retention Bonus for Occupational Therapist: $1,000 Total: $5,556
100%	**Cultural Competency Funding:** Frontier of Social Justice: Cross Cultural Compassion training for 2 people - $994 Start Up! Therapy training for 2 people - $2,994 Development books - $12.00 **Total: $4,000**
	Workforce Funding: Job recruiter professional services fee (hiring of a bilingual/bicultural mental health clinician) - $382.50 Videographer job advertisement fees to increase engagement with candidates - $5,000.00 Staff appreciation - San Francisco Mural Tour Fee - $72.85 Interpretation services for our clinical staff language skills development to connect with Spanish speaking clients - $100.20 **Total $5,555.55**
100%	Anil Awasti Consulting - $2,065.00 John Hamel and Associates - $2,000.00 Total: $4,065.00
	$5,555.55 grant was spent entirely on staff retention bonuses.
	Training Preparation & Sessions (1 contractor x $1,000.00/session x 4 sessions) - $4,000.00

75%	Facility Rental Twin Pines Park Lodge & Cottage - $1,650.00 Catering “Nick the Greek” - $1,925.00 Chair Massage Therapists (2 massage therapists x $213.60/hour x 5 hours) - $1,068.00 Yoga & Sound Bath Therapist (1 therapist x $300.00/session x 2 sessions) - $600.00 Stretch Therapy (1 stretch therapist x $40/hour x 5 hours) - $200.00 Arts and Crafts Materials (Paints, canvases, flowerpots, watercolors, water cups) - $112.55 Internal, in-kind donation from StarVista (Covering extra expenses) - $287.45 TOTAL - $5,843.00 (including in-kind) Total from MHSA Grant - $5,555.55 Workforce Staff Retention
	Cultural Competency Funding Latino Conference Fee (10 staff x $200 each) $2,000.00 Includes 7 teaching sessions Includes lunch for 2 days Includes training materials Includes AOD Continuing Education units Hotel (2 nights @$160/nt x 5 rooms shared) $1,600.00 Travel Personal Cars (2 roundtrips x 308 miles x $.65) $ 400.00 Agency Vans (8 people) $ 0 Total $ 4,000.00

83%	Workforce Development Funding Purchase ads for recruiting staff at Recovery Homes Counselor ads at Indeed Casa Maria - San Bruno $50 5 weeks $1,850.00 Counselor ads at Indeed Casa Aztlan - Belmont $50 5 weeks $1,850.00 Attendant Ads at Indeed Casa Maria - San Bruno $30 4 weeks $ 960.55 Attendant Ads at Indeed Casa Maria - San Bruno $30 4 weeks $ 960.00 subtotal $5,620.55 Inkind discount ($ 65.55) Total $5,555.55
83%	consultant from AHP provided Voices Staff with a three-day Advanced Level WRAP Facilitator Workshop. - $4,000.00
	consultant from AHP provided Voices Staff with a three-day Advanced Level WRAP Facilitator Workshop. - $5,555.55 In-Kind from VOR - $2,136.00
82%	4,000.00 Cultural Competency - RRC Phase 4 trauma-informed anti-racist work, skill building
	5,555.55 Workforce - RRC staff personal/professional development for staff retention and inclusivity
	FY 23-24 MHSA funding to the Contractor for two grant cycles for The Cultural Competency Grant and The Workforce Grant for technical assistance and grant support.

APPENDIX 6. PEI DATA COLLECTION AND REPORTING FRAMEWORK

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

Mental Health Service Act (MHSA)

Prevention and Early Intervention (PEI)
Data Collection and Reporting Framework

Originally Prepared by RDA Consulting, June 2022
Updated by San Mateo County BHRS, November, 2024
RDACONSULTING.COM |

RDA CONSULTING

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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Project Background

In June 2018, the California Mental Health Services Oversight and Accountability Commission updated the reporting requirements for the Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA). Programs funded through the PEI component of MHSA, which is intended to prevent mental illness from becoming severe and disabling, can focus on prevention, early intervention, or a combination of both. The new reporting requirements focus on individual demographics, referrals and access to treatment, and individual outcomes.

San Mateo Behavioral Health & Recovery Services (BHRS) contracted with RDA Consulting (RDA) to provide outcome data planning and technical assistance for San Mateo County's PEI programs that provide some component of individual-level services.[1] The project aimed to identify a reporting framework in which PEI data and individual outcomes could be analyzed across all PEI-funded programs. The framework that was developed uses a set of 9 Outcome Domains that were identified in alignment with MHSA requirements, our local BHRS Office of Diversity and Equity's (ODE) strategic planning, and through this project's exploration with contracted providers and BHRS staff of the expected outcomes across the current PEI-funded programs.

The framework initially focused on programs that collect individual-level data, or unduplicated individuals served. Starting in May 2023, non-individual level programs- those that primarily collect population-level data, or duplicated individuals served, were incorporated to allow for a broader assessment of the impact of PEI programs. These programs focus on community awareness campaigns, education, and trainings and include The Parent Project®, Health Equity Initiatives, Mental Health First Aid, Suicide Prevention, and Photovoice/Storytelling. Standardized questions based on the Outcome Indicators were identified and were embedded into each program's respective evaluation surveys beginning in FY 2023-24. Additional PEI programs such as the Outreach Collaboratives and newly launched programs such as PEARLS (Program to Encourage Active, Rewarding Lives) for older adults and allcove® youth drop-in centers are being incorporated in FY 2024-25.

This version of the PEI framework also refined some of the crosswalks, narrowing and honing them based on clarified written domain definitions for the nine domain areas, which are outlined in a subsequent section of this document. Notably, there was a language shift in two of the domain categories: "general mental health" was switched to "general behavioral health" to include both mental health and substance use, and the "cultural identity" category was changed to "cultural responsiveness" to encompass both cultural humility and cultural identity concepts.

Programs focused exclusively on systems development, such as Trauma- and Resiliency-Informed Systems Initiative (TRISI), are not included in this framework, as the evaluation focus of these programs is on measuring organizational capacity building and not individual or population level impacts.

[1] PEI programs that primarily provide awareness, referrals and system-change services are unable to collect unduplicated individual-level data and were not included in the original PEI data collection and reporting framework.

This document outlines a PEI Data Collection and Reporting Framework, highlighting the key decisions points that were made to inform the framework, and provides visual summaries of how the currently funded PEI programs will be reporting data and outcomes based on this framework.

PEI Program Reporting

MHSA legislation requires counties to fund specific types of programs under the following program areas: prevention, early intervention, outreach for increasing recognition of early signs of mental illness, access and linkage to treatment, stigma and discrimination reduction, and suicide prevention. Funding will continue to be allocated in these program areas. Additionally, PEI programs must address three strategies and collect specified data in each of these strategies: 1) Access & Linkage to Treatment, 2) Timely Access to Services for Underserved Populations, and 3) Stigma & Discrimination Reduction.

Key Decision Point

How PEI programs were categorized for data reporting purposes:

1. **Prevention Programs:** focus on *outreach and education*.
2. **Prevention and Early Intervention Programs:** include both an *outreach/education* component as well as early intervention *clinical services*.
3. **Early Intervention Programs:** primarily provide one-on-one early intervention *clinical services*.

The programs provide services across the spectrum of prevention and early intervention, from awareness and education initiatives to outreach and programs that create entry ways into clinical short-term treatment services. For the purposes of this reporting framework and data collection activities, programs were categorized to reflect this spectrum of prevention and early intervention: (1) Prevention Programs, (2) combined Prevention and Early Intervention Programs, and (3) Early Intervention Programs. The San Mateo County MHSA PEI funded programs included in this framework are listed in Table 1 by these three reporting categories and the required MHSA strategies.

Table 1. Programs by PEI Component and Strategies

PEI Component	PEI Program	Agency	PEI Strategies		
			Access & Linkage to Treatment	Timely Access to Services for Underserved	Stigma & Discrimination Reduction
Prevention	Health Ambassador Program (HAP)	BHRS			✓
	Youth Health Ambassador Program (Y-HAP)	StarVista			✓
	Health Equity Initiatives (HEI's)	BHRS			✓
	Mental Health First Aid	BHRS			✓
	Mindfulness-Based Substance Abuse Treatment (MBSAT)	Puente de la Costa Sur, YMCA, and StarVista	✓		
	Panche/GiraSol	The Latino Commission	✓		
	Parent Project®	BHRS			✓
	Photovoice	BHRS			✓
	Suicide Prevention	BHRS			✓
Prevention & Early Intervention	allcove® YOUTH CENTER		✓		
	Early Childhood Community Team (ECCT)	StarVista		✓	✓
	Project SUCCESS	Puente de la Costa Sur		✓	
	The Cariño Project	ALAS		✓	✓
	PEARLS	Daly City Partnership	✓		
	Peer Counseling	Peninsula Family Service		✓	✓
	Youth S.O.S.	StarVista	✓		
Early Intervention	Primary Care Interface	BHRS	✓	✓	
	re(MIND)® Early Psychosis Program	Felton Institute	✓	✓	
	The Pride Center	StarVista	✓	✓	

PEI Data Collection and Reporting Framework

This framework utilizes standardized reporting templates through which all PEI programs report their data. It also includes individualized PEI Program Crosswalks that outline the specific reporting expectations for each program (see Appendix A for each program's crosswalk). This approach allows programs to clearly identify how their specific program data aligns with the framework.

The standard reporting templates are: 1) the MHSA Annual Reporting Template, which includes preset sections for narrative and tables to report aggregate data, and 2) a PEI Data Template which includes preset spreadsheets for programs to report individual-level and population-level data. Each program's individualized crosswalk outlines specific MHSA reporting requirements, including:

1. Individuals served (unduplicated)
2. Individuals reached (duplicated)
3. Demographics
4. Referrals
5. Individual-level outcomes

Unduplicated Individuals Served, Individuals "Reached" and Demographics

Key Decision Points

How PEI programs will report unduplicated vs. duplicated data:

- **Unduplicated Individuals Served:** During the initial phase of the rollout of this framework that focused on individual-level programs, all programs identified at least one primary program component for which they would report the required unduplicated number of individuals served. A program could select more than one primary component but will be required to report an unduplicated count for their program. For example, if a program's primary components are short-term clinical therapy and case management, an individual receiving both services would only be captured once in the unduplicated number of individuals served.
- **Individuals "Reached":** Programs also identified components through which they may have a broader reach, such as outreach or educational activities. The number reported under this "reach" category does not need to be an unduplicated count. For example, if a program offers workshops as another program component, they can report on the number of workshops attendees over the course of the reporting period, which may include some duplicate individuals who attended multiple activities. Newer programs added to this framework will report under this category.
- **Demographics:** Programs will collect full demographic data on unduplicated individuals served through their primary program components. Full demographics will be reported in the standardized San Mateo County format, which addresses the MHSA PEI requirements and local community input received regarding how we ask sensitive questions regarding race, ethnicity, and language (REAL) and sexual orientation, gender identity, and expression (SOGIE). For individuals "reached", the program may collect a standardized shortened list of demographic data. For example, in group settings, such as workshops or classes, or at large events. Demographic information is not required for light-touch outreach activities.

Table 2. PEI Program Components for Individuals Served and Individuals "Reached"

PEI Component	PEI Program	Unduplicated individuals served through primary program component(s)	Individuals reached through other program components, may be duplicated
Prevention	Health Ambassador Program	Health ambassadors	Individuals reached through outreach and presentations
	Youth HAP	Cohort	Individuals reached through outreach and presentations
	Health Equity Initiatives (HEIs)	NA	Individuals reached through outreach, presentations, and other events
	Mental Health First Aid	Training Participants	Individuals reached through outreach, presentations, and other events
	Mindfulness-Based Substance Abuse Treatment	Youth cohort	Individuals reached through outreach/presentations, family members of youth, providers
	Panche/GiraSol	Youth	Family members
	Parent Project®	Cohort	Individuals reached through outreach and presentations
	Photovoice	Cohort	Individuals reached through outreach and presentations
	Suicide Prevention	NA	Individuals reached through presentations, trainings, and other events
Prevention & Early Intervention	allcove®	Group services and one-on-one counseling	Individuals reached through outreach, presentations, and other events
	Early Childhood Community Team	Children receiving one-on-one services and participating in groups	Parents/caregivers in groups, teachers who receive consultations, children reached by consultations
	Project SUCCESS	Group services and one-on-one counseling	N/A
	The Cariño Project	Clinical services	Case management services and individuals reached through workshops, events
	PEARLS	One-on-one peer counseling and groups	N/A
	Peer Counseling	One-on-one peer counseling and groups	N/A
	Youth S.O.S.	Mobile crisis response	Family members of youth served, individuals reached through outreach/education

Early Intervention	Primary Care Interface	Counseling, case management, psychiatry	N/A
	re(MIND)® Early Psychosis Program*	Early psychosis treatment and re(MIND) Alumni	Family members/caregivers
	The Pride Center	Therapy and case management	Peer groups, trainings, consultations

Referrals

Key Decision Points

How PEI programs will report on referrals:

- **Referrals into Early Intervention Programs:** Collecting extensive data on referrals into the PEI programs is not possible for prevention-focused programs. Therefore, referral to and enrollment into a PEI program will only be collected from Early Intervention Programs. Individuals enrolling into an Early Intervention Program will likely have a period of untreated mental illness to report as part of a formal intake process. These Early Intervention Programs will also collect referral data into their programs and report on the MHSA requirements for the average duration of untreated mental illness and the interval between a referral and participation in early intervention treatment.
- **Referrals to SMI, SUD, and other MH Services:** Prevention-focused programs often make referrals to a higher level of care for SMI, SUD, and other mental health needs. As these referrals are made to different programs within an agency or to outside agencies that generally use different electronic health record systems or other data systems, collecting additional data on the duration of untreated mental illness or interval between referral and actual enrollment is not feasible. Therefore, Prevention Programs that make referrals to SMI, SUD, or other mental health services will only report on the number of referrals made for each category of referrals and indicate whether those referrals were made within the PEI-program's agency, or to a County* service or other outside agency.
- **Referral Data Reporting:** Programs will be asked to provide unduplicated individual-level data, from their primary program component, on any referrals made to SMI/SUD/Other MH, social services, and other services. If collected, referrals made for individuals reached through other program components will also be reported. These referral data will be reported on separate tabs of the PEI data template spreadsheet. If programs do not have a process to collect individual-level data on referrals made through other (non-primary) program components, they may choose to only report aggregate totals for those referrals.

** Treatment services/programs provided, funded, administered, or overseen by the County can report sources of referrals and data related to average duration of untreated mental illness and the interval between a referral and participation in treatment. This will not be reported by the PEI Programs.*

Individual/Program Outcomes

The MHSA Annual Reporting Template's individual/program outcomes section comprises three key subsections:

1. **Increased protective factors/decreased risk factors and/or increased recovery indicators/decreased symptoms:** All programs will report under this section.
    - Prevention Programs will primarily report on increased protective factors/decreased risk factors, and
    - Early Intervention Programs will primarily report on increased recovery indicators/decreased symptoms.
2. **Stigma reduction:** Only programs with a stigma reduction strategy will report outcomes in this subsection. Programs not included in the stigma reduction strategy category may report outcomes related to stigma reduction in the other two outcome sections.
3. **Additional program and/or individual outcomes:** All programs can report additional outcomes under this section.

To facilitate BHRS' assessment of impact across all PEI-funded programs, this data collection and reporting framework uses a set of Outcome Domains under which programs can report their specific data. The subsections listed above requires that PEI programs identify a corresponding Outcome Domain for each data point. See Appendix B for a complete visual overview of the domains that will be reported on for each program and see Appendix C for a full inventory of the specific data indicators that will be reported.

The framework utilizes nine **PEI Outcome Domains**, defined as follows:

1. **Access to services:** This domain focus on reducing barriers to accessing services due to financial, administrative, social, and cultural challenges. Improving access to services may include:
    - **Increasing understanding of existing services and systems:** Programs help participants understand the landscape of mental health treatment options and resources available in their community. Programs implement interventions that lead to better understanding of how to navigate various systems of care.
    - **Connecting to services:** Programs help participants navigate resources and/or directly connect individuals with local community and county services and resources that address their specific needs.
2. **Community Advocacy:** This domain is focused on empowering individuals with lived experience[2] to become active participants in their communities, influencing decisions about policies and programs that impact their lives. This may include:

[2] Lived Experience: having first-hand experience of living as a member of a marginalized group. Individuals with behavioral health challenges, and their families, hold unique insights into how services can best respond to needs and promote recovery.

- **Developing advocacy and leaderships skills:** Programs equip participants with communication strategies and techniques to effectively engage with policy and decision makers. Programs help participants to build confidence in their ability to impact change by offering opportunities to actively participate in or lead change initiatives.
- **Fostering a sense of collective support**: Programs create a supportive community where participants can share experiences, collaborate to develop and implement change strategies, and support one another in community advocacy efforts.

3. **Connection and Support:** This domain focuses on an individual's ability to connect with and receive support from their community and family. Programs that focus on building connection and support will help participants strengthen these relationships and community ties, leading to a greater sense of belonging. Key aspects of building connection and support may include:

    - **Developing social connections:** Programs offer opportunities for participants to interact in positive and meaningful ways with others through social events, mentorship programs, group activities, etc.
    - **Strengthening relationships:** Programs help participants to improve communication and build stronger bonds with family members, friends and others in their lives.
    - **Building a sense of belonging:** Programs create a welcoming and inclusive environment where participants feel supported and more connected to others.

4. **Cultural Responsiveness:** This domain focuses on programs that help participants develop a stronger sense of their cultural identity and foster a greater understanding of how mental health and substance use challenges impact different cultures. To better define the type of cultural responsiveness impact, the cultural responsiveness outcome section is broken into two concepts. Programs may choose to report on indicators aligned with either of the two cultural responsiveness concepts including:

    A. Cultural Humility:
    - Programs emphasize affirmation of diverse cultures and backgrounds and encourage self-reflection and awareness of biases and assumptions about culture.

    B. Cultural Identity Formation:
    - Programs integrate various cultural practices and traditions into the core services provided and foster a stronger connection and sense of pride in participants' identity and culture.

5. **General Behavioral Health:** This domain focuses on individuals' clinical outcomes. Programs will typically provide short term mental health and/or substance use treatment and are considered early intervention strategies. Programs emphasize interventions that contribute to improved overall mental health outcomes including:

    - **Reduced** symptoms of anxiety, depression, and stress.
    - **Improved** coping tools to deal with stressors.
    - **Improved** general behavioral health and functioning.

6. **Improved knowledge, skills, and/or abilities:** Programs focus on building individual and community awareness, understanding of and developing capacity to improve overall mental well-being. Examples include:
    - **Improving skills, abilities and confidence** to respond to and/or support mental health and substance use needs through psychoeducation, workshops, courses, etc.
    - **Raising awareness and educating the community** about mental health and substance use through communication campaigns, community events, outreach, sharing information, etc.

7. **Self-empowerment:** Programs help equip individuals with the skills and confidence to advocate for their own and/or their family's mental health and substance use needs, while simultaneously fostering a sense of self-worth and self-belief and encouraging participants to take an active role in their health. Aspects of self-empowerment domain may include:
    - **Communication skills development:** Programs teach communication techniques to effectively advocate for and express needs and concerns to health care providers and others.
    - **Building confidence:** Program activities help participants develop a positive self-image and a strong sense of self-efficacy in managing and advocating for their and/or their family's mental health and substance use needs.

8. **Stigma reduction**: To better define the type of stigma reduction impact and to align this reporting framework with other program impacts, the stigma reduction outcome section is broken into three concepts of stigma reduction. Programs may choose to report on indicators aligned with any of the stigma reduction concepts including:
    A. **Self/internalized:** Programs focus on building participants' self-acceptance and comfort with talking about their mental health and substance use and/or identity. Programs encourage participants to reframe their experiences and view their own mental health challenges as opportunities for growth, self-discovery, and self-compassion.
    B. **Seeking help/treatment:** Programs focus on promoting help seeking as a strength and normalizing seeking treatment when needed. As a result of participation, individuals are more comfortable asking for help for themselves and their families and/or sharing their stories of recovery.
    C. **Public/external:** Programs implement interventions and activities that lead to increased knowledge, understanding, and compassion towards those with mental health and substance use conditions.

9. **Utilization of emergency services:** Programs implement strategies and interventions that help individuals identify and manage health challenges before a crisis arises, ultimately reducing the need for emergency services or reducing the length of stay in emergency facilities.

Key Decision Points

How PEI Programs will report on the following PEI Domain Outcomes

- **Increased Protective Factors/Decreased Risk Factors or Increased Recovery Indicators/Decreased Symptoms:** The outcomes that programs select for this subsection must demonstrate the impact on individuals served through the program's primary component(s). For example, if a program's primary component is short-term clinical therapy for youth, but it also offers workshops to family members through other program components, the outcomes reported under this subsection should focus on the youth receiving clinical therapy.

- **Stigma Reduction**: To better define the type of stigma reduction impact and to align this reporting framework with other program impacts, the stigma reduction outcome section is broken into three concepts of stigma reduction: (1) Self/internalized, (2) Seeking help/treatment, and (3) Public/external. Programs may choose to report on indicators aligned with any of the stigma reduction concepts. See Table 4 for each program's stigma reduction concepts.

- **Other Individual/Program Outcomes:** The outcomes that programs select for this subsection may demonstrate either additional impact of the program on individuals served through the program's primary component(s) or the impact on individuals reached through the program's other components. For example, if a program's primary component is short-term clinical therapy for youth, but it also offers workshops to family members through other program components, the program may choose to report on additional outcomes for the youth receiving clinical therapy and/or family members attending workshops.

Table 3. Primary Program Component Individual Outcomes (7A)

PEI Component	PEI Program	Access to services	Community advocacy	Connection and support	Cultural responsiveness	General Behavioral health	Improved knowledge, skills, and/or abilities	Self-empowerment	Stigma reduction	Utilization of emergency services	Other
Prevention	Health Ambassador Program			✓	✓			✓	✓		
	Youth Health Ambassador Program		✓						✓		
	Health Equity Initiatives	✓			✓			✓	✓		
	Mental Health First Aid	✓			✓						
	Mindfulness-Based Substance Abuse Treatment						✓				
	Panche/GiraSol	✓			✓			✓	✓		
	The Parent Project®	✓							✓		
	Photovoice		✓						✓		
	Suicide Prevention	✓		✓					✓		
Prevention & Early Intervention	allcove®					✓					
	Early Childhood Community Team			✓			✓				
	Project SUCCESS							✓	✓		
	The Cariño Project					✓					
	PEARLS			✓		✓					
	Peer Counseling			✓		✓					
	Youth S.O.S.			✓		✓					
	re(MIND)® Early Psychosis Program					✓				✓	
	The Pride Center			✓		✓	✓				

Table 4. Stigma Reduction Outcomes

PEI Component	PEI Program	Self/ Internalized	Seeking Help/Treatment	Public/External	Not Required to Report on Stigma Reduction
Prevention	Health Ambassador Program	✓	✓		
	Youth Health Ambassador Program	✓	✓		
	Health Equity Initiatives	✓		✓	
	Mental Health First Aid				✓
	Mindfulness-Based Substance Abuse Treatment				✓
	GiraSol	✓			
	The Parent Project®	✓			
	Photovoice	✓	✓	✓	
	Suicide Prevention	✓			
Prevention & Early Intervention	allcove®				✓
	Early Childhood Community Team				✓
	Project SUCCESS				✓
	The Cariño Project	✓			
	PEARLS	✓			
	Peer Counseling	✓	✓		
	Youth S.O.S.				✓
Early Intervention	Primary Care Interface				✓
	re(MIND)® Early Psychosis Program				✓
	Pride Center				✓

Table 5. Additional Program/Individual Outcomes (7C)

PEI Component	PEI Program	Access to services	Community advocacy	Connection and	Cultural responsiveness	General behavioral health	Improved knowledge, skills, and/or abilities	Self-empowerment	Stigma reduction	Utilization of emergency services	Other
Prevention	Health Ambassador Program	✓	✓								
	Youth Health Ambassador Program										✓
	Health Equity Initiatives		✓								
	Mental Health First Aid										
	Mindfulness-Based Substance Abuse Treatment										
	Panche/GiraSol			✓			✓				
	The Parent Project®				✓						
	Photovoice	✓			✓						
	Suicide Prevention				✓						
Prevention & Early Intervention	allcove®						✓				
	Early Childhood Community Team										✓
	Project SUCCESS					✓					
	The Cariño Project			✓	✓		✓				
	PEARLS							✓			
	Peer Counseling	✓					✓				
	Youth S.O.S.	✓								✓	
Early Intervention	Primary Care Interface							✓			
	re(MIND)® Early Psychosis Program							✓	✓		✓
	The Pride Center			✓		✓	✓	✓	✓		

Appendix A: Program Crosswalks

This appendix includes the crosswalks for the following programs (linked):

- Allcove® San Mateo
- The Cariño Project
- Early Childhood Community Team
- Health Ambassador Program
- Health Equity Initiatives
- Mental Health First Aid
- Mindfulness-Based Substance Abuse Treatment
- GiraSol
- The Parent Project®
- Peer Counseling
- PEARLS
- Photovoice
- The Pride Center
- Primary Care Interface
- Project SUCCESS
- re(MIND)® Early Psychosis Program
- Suicide Prevention
- Youth Health Ambassador Program
- Youth S.O.S.

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured	Data collection tool used
Client information and demographics	5	Unduplicated number of individuals served in primary program components (clinical)	Clinical spreadsheet
	PEI Data Template, Client Demographics (long) tab	Demographics of unduplicated individuals served in clinical component	Demographics collected from clinical participants, QR code, survey monkey
	5	Duplicated number of individuals served through other program components (events, workshops, groups, and outreach activities)	Attendance and outreach tracking
	PEI Data Template, Client Demographics (short) tab	Demographics of individuals reached through other program components (case management, events, workshops, groups, and outreach activities), may be duplicated	Demographics of duplicated attendees collected from the participant QR code/survey monkey provided to attendees or events, groups, workshops, and any outreach activities
Referrals to your PEI program	6A	Number of referrals into allcove ETO	Jot Form, data tracking spreadsheet
		Number of referrals that resulted in enrollment (number engaged) ETO	Jot Form, data tracking spreadsheet
	PEI Data Template	Client-level data on referrals into allcove ETO	Jot Form, data tracking spreadsheet
Mental health and substance use referrals to other agencies	6B	Number of referrals by type of treatment referred to (SMI, SUD, or other MH)	Data tracking Spreadsheets, social determinants of health (SDOH) referral tracking tab
		Programs or treatment referred to	

and within your agency	PEI Data Template, Referrals Out tab	Client-level data on mental health and substance use referrals to other agencies and within allcove		Same as above
Referrals to other services	6C	Number of referrals to other services by type		Clinicians' spreadsheet, social determinants of health (SDOH) referral tracking tab
	PEI Data, Referrals Out tab	Client-level data on referrals to other services		Same as above
Client Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: General behavioral health	Due to the services I received at allcove San Mateo, I feel fewer or less intense symptoms of depression.	#/% of clinical participants who improved rating for question from intake clinical self-assessment to ongoing/discharge clinical self-assessment
			Due to the services I received at allcove San Mateo, I have decreased urges for self-harm and/or suicide.	#/% of clinical participants who improved rating for question from intake clinical self-assessment to ongoing/discharge clinical self-assessment
Additional Client/Program Outcomes	7C	Domain: Knowledge, skills and/or abilities	Due to this workshop/event at allcove San Mateo, I have more or better skills to cope with difficult things in my life.	#/% of event/workshop participant survey respondents who selected somewhat agree or agree.
			Due to this workshop/event at allcove San Mateo, I have more knowledge of how to best manage my behavioral health symptoms.	#/% of event/workshop participant survey respondents who selected somewhat agree or agree.

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured	Data collection tool used
Individual information and demographics	5	Unduplicated number of individuals served in primary program components (clinical)	Clinical spreadsheet
	PEI Data Template, Individual Demographics (long) tab	Demographics of unduplicated individuals served in clinical component	Demographics collected from clinical participants
	5	Duplicated number of individuals served through other program components (case management, events, workshops, groups, and outreach activities)	Attendance and outreach tracking logs, case management spreadsheet
	PEI Data Template, Individual Demographics (short) tab	Demographics of individuals reached through other program components (case management, events, workshops, groups, and outreach activities), may be duplicated *Note: You may submit additional demographic data for case management participants on this tab since you are using the long demographic form for case management.*	Demographics of duplicated attendees collected from the participant survey provided to attendees or events, groups, workshops, and any outreach activities and demographics of case management participants.
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or other MH)	SMI referrals from the Clinical spreadsheet, SMI referral log (If you start making referrals for substance use treatment, you can add a column to the referral log tab to capture whether the referral is SMI or SUD. Also, non-SMI mental health referrals to organizations outside ALAS will be captured in the Case Management spreadsheet, Mental health referral tracking tab and noted as Other in Column F.
		Programs or treatment referred to	

	PEI Data Template, Referrals Out tab	Individual-level data on mental health and substance use referrals to other agencies and within ALAS		Same as above
Referrals to other services	6C	Number of referrals to other services by type		Case management spreadsheet, social referral tracking tab
	PEI Data, Referrals Out tab	Individual-level data on referrals to other services		Same as above
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: General behavioral health	Number who experience an overall improvement in their mental health (clinical population)	#/% of clinical participants who improved rating for question #1 from intake clinical self-assessment to ongoing/discharge clinical self-assessment (taken every 6 months)
		Domain: General behavioral health	Number who reported an improved ability to manage mental health symptoms (clinical population)	#/% of clinical participants who improved rating for question #2 from intake clinical self-assessment to ongoing/discharge clinical self-assessment
		Domain: General behavioral health	Number who reported an improved ability to cope with stressors (clinical population)	#/% of clinical participants who improved rating for question #3 from intake clinical self-assessment to ongoing/discharge clinical self-assessment
		Domain: General behavioral health	Number who reported that the services they are receiving are helping them to function better in daily life (clinical population)	#/% of clinical participants who improved rating for question #7 from intake clinical self-assessment to ongoing/discharge clinical self-assessment
Individual Outcomes – Stigma Reduction	7B	Stigma (Self/Internalized)	Number of participants who reported feeling more comfortable talking about mental health since they began attending sessions (clinical population)	#/% of participants who selected somewhat agree or agree on question #8 on the ongoing/discharge clinical self-assessment (use the latest assessment per individual)

Additional Individual/ Program Outcomes	7C	Domain: Cultural responsiveness (identity)	Number who felt more connected to their culture (participant population)	#/% of event/workshop participant survey respondents who selected somewhat agree or agree on question #4.
		Domain: Connection and Support	Number who reported being better able to support themselves and/or their family after receiving services (case management population)	#/% of case management survey respondents who selected somewhat agree or agree on question #8.
		Domain: Improved knowledge, skills, and/or abilities	Number who learned how to recognize and support their community/family (participant population)	#/% of event/workshop participant survey respondents who selected somewhat agree or agree on question #6.

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Individual information and demographics	5	Number of unduplicated individuals served in primary program components (children who are receiving one-on-one services, including direct therapy, and participating in groups)		ETO
	PEI Data Template	Demographics of unduplicated individuals served in primary program components (children who are receiving one-on-one services, including direct therapy, and participating in groups)		ETO
	5	Number of individuals reached in all other program components (parents and caregivers in groups, teachers who receive consultations, children reached by consultations), may be duplicated		ETO
	PEI Data Template	Demographics of individuals reached in all other program components, (parents and caregivers in groups, teachers who receive consultations, children reached by consultations), may be duplicated		ETO
Referrals to your PEI program	6A	Number of referrals into ECCT		ETO
		Number of referrals that resulted in enrollment (number engaged)		ETO
	PEI Data Template	Individual-level data on referrals into ECCT		ETO
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or other MH) *Note: SMI referrals should include referrals to any services for beyond mild to moderate needs.*		ETO
		Programs or treatment referred to		ETO
	PEI Data Template	Individual-level data on mental health and substance use referrals to other agencies and within your agency		ETO
Referrals to other services	6C	Number of referrals by type		ETO
	PEI Data Template	Individual-level data on referrals to other services		ETO
Individual Outcomes – Increased Protective Factors/Improved	7A	Domain: Improved knowledge, skills, and/or abilities	As a result of participation in this program, the number of parents/caregivers who improved their parenting knowledge, skills, and abilities as measured by an	Parent Stress Index, Protective Factors Survey, ETO

Recovery Indicators; Decreased Risk Factors/Symptoms			improvement in their Parent Stress Index score (population = one-on-one services)	
			Due to my engagement in this program, I feel more confident in my parenting. (population = group services)	End of year/group survey, ETO
		Domain: Connection and support	Due to my engagement in this program, I feel more connected to other parents in my community. (population = group services)	End of year/group survey, ETO
			As a result of participation in this program, the number of parents/caregivers who improved their familial connection and support as measured by an improvement in their Protective Factors Survey score (population = one-on-one services)	Protective Factors Survey, ETO
Additional Individual/Program Outcomes	7C	Domain: Other/Client Satisfaction	I am satisfied with the services I received (population= one-one-one and group services)	End of Year/Group Survey, Satisfaction Surveys, ETO

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Participant (individual) information and demographics	5	Number of unduplicated individuals served in primary program component (ambassadors)		Existing intake log
	PEI Data Template	Demographics of unduplicated individuals served in primary program component (long form on ambassador intake)		Existing intake log
	5	Number of individuals reached in all other program components (those impacted by community outreach/presentations), may be duplicated		Existing intake log
	PEI Data Template	Demographics of individuals reached in all other program components, (those impacted by community outreach/presentations) may be duplicated (short)		Existing intake log
	PEI Data Template	Individual-level data on SDOH responses		Referral/SDOH tracking log
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or MH) *Note: You can report on referrals provided to both ambassadors and audience members.*		Referral/SDOH tracking log
		Programs or treatment referred to		Referral/SDOH tracking log
	PEI Data Template	Individual-level data on mental health and substance use referrals *Note: Please provide a individual ID with referrals made for ambassadors. You do not need to report a individual ID for referrals made for audience members.*		Referral/SDOH tracking log
Referrals to other services	6C	Number of referrals by type *Note: You can report on referrals provided to both ambassadors and audience members.*		Referral/SDOH tracking log
	PEI Data Template	Individual-level data on referrals to other services *Note: Please provide a individual ID with referrals made for ambassadors. You do not need to report a individual ID for referrals made for audience members.*		Referral/SDOH tracking log
Individual/Participant Outcomes – Increased	7A	Domain:	Due to my participation in HAP courses and/or activities, I feel more connected to my family. (population = HAP ambassadors)	HAP Ambassador Annual Survey

Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms		Connection and support	Due to my participation in HAP courses and/or activities, I feel more connected to my community. (population = HAP ambassadors)	HAP Ambassador Annual Survey
			Due to my participation in HAP courses and/or activities, I feel more connected to the service providers in my and my family's life. (population = HAP ambassadors)	HAP Ambassador Annual Survey
		Domain: Cultural Responsiveness (humility)	I feel like my identity, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion, etc.) were affirmed by this program/training/event (population = HEI event participant).	HAP Ambassador Annual Survey
		Domain: Self-empowerment	Due to my participation in HAP courses and/or activities, I am more confident in my ability to advocate for myself and/or advocate for my child/children. (population = HAP ambassadors)	HAP Ambassador Annual Survey
Individual Outcomes – Stigma Reduction	7B	Stigma (Seeking Help/Treatment)	Due to my participation in this course, I feel more comfortable seeking mental health and/or substance use services for myself and/or my family. (population = course audience members including both community members and ambassadors, may be duplicated)	HAP course survey addendum (collected from each HAP course)
		Stigma (Self/internal)	Due to my participation in this program, I feel more comfortable talking about *my* mental health and/or substance use. (population = course audience members including both community members and ambassadors, may be duplicated)	HAP course survey addendum (collected from each HAP course)
Additional Individual/Program Outcomes	7C	Domain: Community advocacy	Due to my participation in HAP courses and/or activities, I am more confident in my ability to create change in my community. (population = HAP ambassadors)	HAP Ambassador Annual Survey
		Domain: Access to services	Through my participation this program, I have learned knowledge and skills that I can use to *access* mental health and/or substance use health services. (population = course audience members including	HAP course survey addendum (collected from

			both community members and ambassadors, may be duplicated)	each HAP course)
			Through my participation in this course, I and/or my family have been connected to mental health services/resources that have been helpful. (population = course audience members including both community members and ambassadors, may be duplicated)	HAP course survey addendum (collected from each HAP course)

Health Equity Initiatives

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Client information and demographics	5	~~Number of unduplicated individuals served in primary program component (HEI Participants)~~		~~Existing intake log~~
	PEI Data Template	~~Demographics of unduplicated individuals served in primary program component (HEI Participants)~~		~~Existing intake log~~
	PEI Data Template	Number of individuals reached in all other program components (those impacted by community outreach/presentations), may be duplicated		Existing intake log
	5	Demographics of individuals reached in all other program components, (those impacted by community outreach/presentations/events) may be duplicated (short)		Audience survey
	PEI Data Template	Individual-level data on SDOH responses		Survey, Excel Document
~~Mental health and substance use referrals to other agencies and within your agency~~	~~6B~~	~~Number of referrals by type of treatment referred to (SMI, SUD, or other MH)~~		~~Referral/SDOH tracking log~~
		~~Programs or treatment referred to~~		~~Referral/SDOH tracking log~~
	~~PEI Data Template~~	~~Individual-level data on mental health and substance use referrals to other agencies and within your agency~~		~~Referral/SDOH tracking log~~
~~Referrals to other services~~	~~6C~~	~~Number of referrals by type~~		~~Program Data~~
	~~PEI Data Template~~	~~Individual-level data on referrals to other services~~		~~Referral/SDOH tracking log~~
Client Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: Self-Empowerment	Due to this program/training/event, I am more confident in my ability to advocate for the behavioral health needs of myself and/or my child/ren and/or another family member (population = HEI event participant).	Participant Survey
		Domain: Cultural responsiveness (humility)	I feel like my identity, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion, etc.) were affirmed by this	Participant Survey

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
			program/training/event (population = HEI event participant).	
		Domain: Improved knowledge, skills, and/or abilities	Through my participation in this event/program/training, I have learned knowledge and skills that I can use to access mental health and substance use services (population = HEI event participant).	Participant Survey
Stigma Reduction	7B	Stigma (public external)	This program/training/event affirmed that people with mental illness are capable and able to make positive contributions to society (population = HEI event participant).	Participant Survey
		Stigma (Self/Internalized)	Due to this program/training/event, I feel more comfortable talking about *my* mental health or substance use (population = HEI event participant).	Participant Survey
Additional Client/Program Outcomes	7C	Domain: Community advocacy	Due to my participation in this program/training/event, I feel more confident in my ability to create change in my community around mental health or substance use conditions (population = HEI event participant).	Participant Survey

Mental Health First Aid

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Client information and demographics	~~5~~	~~Number of unduplicated individuals served in primary program component (SP Training Participants)~~		~~Existing intake log~~
	~~PEI Data Template~~	~~Demographics of unduplicated individuals served in primary program component (SP Training Participants)~~		~~Existing intake log~~
	PEI Data Template	Number of individuals reached in all other program components (those impacted by community outreach/presentations), may be duplicated		Existing intake log
	5	Demographics of individuals reached in all other program components, (those impacted by community outreach/presentations/events) may be duplicated (short)		Audience survey
	~~PEI Data Template~~	~~Individual-level data on SDOH responses~~		~~Survey, Excel Document~~
Client Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: Cultural responsiveness (humility)	As a result of this course, I have a better understanding of how mental health and substance use challenges affect different cultures (population = MHFA course participant).	Participant Survey
			I feel like my identity, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion, etc.) were affirmed by this program/training/event (population = MHFA course participant).	Participant Survey
		Domain: Access to services	Through my participation in this event/program/training, I have learned knowledge and skills that I can use to *access* behavioral health services (population = MHFA course participant).	Participant Survey

MINDFULNESS-BASED SUBSTANCE ABUSE TREATMENT

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured	Data collection tool used *Note: Each MBSAT agency can complete the sources based on its processes.*
Participant (individual) information and demographics	5	Number of unduplicated individuals served in primary program component (youth cohort)	
	PEI Data Template	Demographics of unduplicated individuals served in primary program component (youth cohort) (long)	
	5	Number of individuals reached in all other program components (those impacted by community outreach/presentations, family members of youth, providers), may be duplicated	
	PEI Data Template	Demographics of individuals reached in all other program components (those impacted by community outreach/presentations, family members of youth, providers), may be duplicated (short)	
	PEI Data Template	Individual-level data on social determinants of health screener responses	
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or MH) *Note: You can report on referrals provided to both youth cohort members and family members.*	
		Programs or treatment referred to	
	PEI Data Template	Individual-level data on mental health and substance use referrals *Note: Please provide a individual ID with referrals made for youth cohort members. You do not need to report a individual ID for referrals made for family members.*	
Referrals to other services	6C	Number of referrals by type *Note: You can report on referrals provided to both youth cohort members and family members.*	

	PEI Data Template	Individual-level data on referrals to other services *Note: Please provide a individual ID with referrals made for cohort members. You do not need to report a individual ID for referrals made for family members.*		
Individual/Participant Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: Improved knowledge, skills, and/or abilities	Because I participated in this program, when I'm worried about something, I make myself think about it in a way that helps me feel better. (population = youth cohort)	Revised ERQ (post program only)
			When I want to feel better about something, I change the way I'm thinking about it. (population = youth cohort)	Revised ERQ (post program only)
			As a result of participating in this program, I learned that trauma affects physical, emotional, and mental well-being. (population = Trauma 101 attendees/family members/providers)	Trauma 101 post survey
			As a result of participating in this program, I believe that recovery from trauma is possible. (population = Trauma 101 attendees/family members/providers)	Trauma 101 post survey
			Due to my participation in this program, I practice self-care (taking care of my own needs and well-being). (population = Trauma 101 attendees/family members/providers)	Trauma 101 post survey
			As a result of participating in this program, I believe in and support the principles of Trauma Informed Practice (TIP). (population = Trauma 101 attendees – providers only)	Trauma 101 post survey

GIRASOL (FORMERLY THE PANCHE BE YOUTH PROJECT)

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Individual information and demographics	5	Number of unduplicated individuals served in primary program component (youth)		Intake Form
	PEI Data Template	Demographics of unduplicated individuals served in primary program component (youth)		Intake Form
	PEI Data Template	Individual-level data on social determinants of health screener responses		Intake form
	5	Number of individuals reached in other program components (family members), may be duplicated		Parent orientation forms
	PEI Data Template	Demographics of individuals reached in other program components (family members), may be duplicated		Parent orientation forms
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or other MH)		Program Data
		Programs or treatment referred to		Program Data
	PEI Data Template	Individual-level data on mental health and substance use referrals to other agencies and within your agency		Program Data
Referrals to other services	6C	Number of referrals by type		Program Data
	PEI Data Template	Individual-level data on referrals to other services		Program Data
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: Self-empowerment	I have "control" of my own narrative, design my own narrative, go for my dreams. (population = youth)	Youth Pre/Post Survey
		Domain: Access to services	I know at least one place I can go for mental health services. (population = youth)	Youth Pre/Post Survey
		Domain:	I feel proud and connected to my cultural roots. (population = youth)	Youth Pre/Post Survey

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
		Cultural Responsiveness (identity)	I can name three positive values from my culture. (population = youth)	Youth Pre/Post Survey
Stigma Reduction	7B	Domain: Stigma reduction (Self/Internal)	I feel more comfortable speaking about *my* mental health challenges. (population = youth)	Youth Pre/Post Survey
Additional Individual/Program Outcomes	7C	Domain: Improved knowledge, skills, and abilities	Parent perception of improved behavior/academics of daughter (population = family members)	Parent Survey
		Domain: Connection and support	Improved relationship between parent/sibling and daughter (population = family members)	Parent Survey

The Parent Project®

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Participant (client) information and demographics	5	Number of unduplicated individuals served in primary program component (Parent Project® participants)		Existing intake log
	PEI Data Template	Demographics of unduplicated individuals served in primary program component (Parent Project® participants)		Existing intake log
	5	Number of individuals reached in all other program components (those impacted by community outreach/presentations), may be duplicated		Existing intake log
	PEI Data Template	Demographics of individuals reached in all other program components, (those impacted by community outreach/presentations) may be duplicated (short)		Existing intake log
	PEI Data Template	Client-level data on SDOH responses		Referral/SDOH tracking log
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or MH) Note: Report on referrals provided to Parent Project® participants.		Referral/SDOH tracking log
		Programs or treatment referred to		Referral/SDOH tracking log
	PEI Data Template	Client-level data on mental health and substance use referrals.		Referral/SDOH tracking log
Referrals to other services	6C	Number of referrals by type		Referral/SDOH tracking log
	PEI Data Template	Client-level data on referrals to other services		Referral/SDOH tracking log
Client/ Participant Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk	7A	Domain: Access to services	Through my participation in this course, I've learned knowledge and skills that I can use to access mental health or substance use services (for myself or my family). (population = Parent Project® course members, unduplicated)	Parent Project® course Survey (collected from each course participant at end of course)

Factors/Symptoms				
Individual Outcomes – Stigma Reduction	7B	Stigma (Self/Internal)	Due to my participation in this course, I feel more comfortable talking about *my* mental health and/or substance use. (population = Parent Project® course members, unduplicated)	Parent Project® course Survey (collected from each course participant at end of course)
Additional Client/Program Outcomes	7C	Domain: Cultural Responsiveness (identity)	I feel like my identity, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion) were affirmed by taking the Parent Project® course. (population = Parent Project® course members, unduplicated)	Parent Project® course Survey (collected from each course participant at end of course)

PEARLS

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Individual/ Participant information and demographics	5	Number of unduplicated individuals served in primary program components (one-on-one coaching) Intake form, Charity Tracker		Charity Tracker
	PEI data template	Demographics of unduplicated individuals served in primary program components (one-on-one coaching)		Charity Tracker
Referrals to your PEI program	6A	Number of referrals to PEARLS		Charity Tracker
		Number of referrals that resulted in enrollment (number engaged)		Charity Tracker
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals and types of treatment referred to (SMI, SUD, or other MH)		Charity Tracker
		Programs or treatment referred to		Charity Tracker
	PEI Data Template	Client-level data on mental health and substance use referrals to other agencies and within agency		Charity Tracker
Referrals to other services	6C	Number of referrals by type		Charity Tracker
	PEI Data Template	Individual-level data on referrals to other services		Charity Tracker
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: Connection and support	As a result of participating in this program, I feel more connected to others.	PEARLS Participant survey
		Domain: General behavioral health	Due to this program, I am better able to participate in daily life	PEARLS Participant survey
Stigma Reduction	7B	Stigma (Self/Internalized)	Due to this program, I feel more comfortable talking about my problems.	PEARLS Participant survey

Additional Individual/Program Outcomes	7C	Domain: Self-Empowerment	Due to this program, I can take control of personal aspects of my life.	PEARLS Participant survey
			Due to this program, I am confident that I can improve my life through decisions that I make.	PEARLS Participant survey

PEER COUNSELING

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Individual/ Participant information and demographics	5	Number of unduplicated individuals served in primary program components (one-on-one peer counseling and group sessions)		ETO
	PEI data template	Demographics of unduplicated individuals served in primary program components (one-on-one peer counseling and group sessions) *Note: Please provide an explanation in section 5 of the annual report template stating the reason why Peer Counseling is not reporting SOGI data for its unduplicated individuals served.*		ETO
Referrals to your PEI program	6A	Number of referrals to Peer Counseling		ETO
		Number of referrals that resulted in enrollment (number engaged)		ETO
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals and types of treatment referred to (SMI, SUD, or other MH)		ETO
		Programs or treatment referred to		ETO
	PEI Data Template	Individual-level data on mental health and substance use referrals to other agencies and within agency		ETO
Referrals to other services	6C	Number of referrals by type		ETO
	PEI Data Template	Individual-level data on referrals to other services		ETO
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: General behavioral health	As a result of participating in this program, I feel less stressed.	Participant survey
		Domain: Connection and support	As a result of participating in this program, I feel supported.	Participant survey
Stigma Reduction	7B	Stigma (Self/Internalized)	Due to this program, I feel more comfortable talking about my problems.	Participant survey

		Stigma (Seeking Help/Treatment)	Due to this program, I feel more comfortable reaching out for emotional support.	Participant survey
Additional Individual/Program Outcomes	7C	Domain: Improved knowledge, skills, and/or abilities	The program improved my knowledge and confidence in seeking support when I need it.	Participant survey
		Domain: Access to services	As a result of participating in this program, I am connected to community resources.	Participant survey

PHOTOVOICE

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Client information and demographics	~~5~~	~~Number of unduplicated individuals served in primary program component (SP Training Participants)~~		~~Existing intake log~~
	~~PEI Data Template~~	~~Demographics of unduplicated individuals served in primary program component (SP Training Participants)~~		~~Existing intake log~~
	PEI Data Template	Number of individuals reached in all other program components (those impacted by community outreach/presentations), may be duplicated		Existing intake log
	5	Demographics of individuals reached in all other program components, (those impacted by community outreach/presentations/events) may be duplicated (short)		Audience survey
	~~PEI Data Template~~	~~Individual-level data on SDOH responses~~		~~Survey, Excel Document~~
Client Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: Community advocacy	Due to my participation in this workshop, I feel more confident in my ability to create change in my community around mental health and substance use conditions by telling my story (population = Photovoice course participant).	Participant Survey
Individual Outcomes – Stigma Reduction		Domain: Stigma (Self/Internal)	Due to this workshop, I feel more comfortable talking about my mental health and/or substance use (population = Photovoice course participant).	Participant Survey

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
	7B	Domain: Stigma (help seeking)	As a result of this program, I am more willing to seek professional support for a mental health and/or substance use condition if I need it (population = Photovoice course participant).	Participant Survey
		Domain: Stigma (public/external)	As a direct result of this program, I am MORE likely to believe that people with mental illness are capable and able to make positive contributions to society (population = Photovoice course participant).	Participant Survey
Additional Individual/ Program Outcomes	7C	Domain: Access to Services	Through my participation in this workshop, I have learned knowledge and skills that I can use to access mental health and substance use health services (population = Photovoice course participant).	Participant Survey
		Domain: Cultural identity/humility	As a result of this course, I have a better understanding of how mental health and substance use challenges affect different cultures (population = MHFA course participant).	Participant Survey
			I feel like my identity, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion, etc.) were affirmed by this program/training/event (population = Photovoice course participant).	Participant Survey

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured	Data collection tool used
Individual information and demographics	5	Number of unduplicated individuals served in primary program component (therapy and case management)	ETO
	PEI Data Template	Demographics of unduplicated individuals served in primary program component (therapy and case management)	ETO / Participant Information Form
	5	Number of individuals reached in all other program components (peer groups, trainings, consultations), may be duplicated	ETO / Spreadsheet (for now)
	PEI Data Template	Demographics of individuals reached in all other program components (peer groups, trainings, consultations), may be duplicated	ETO / Participant Information Form
Referrals to your PEI program	6A	Number of referrals to PEI program *Note: Referral counts should be unduplicated for the "primary program component" - case management or therapy services, but not duplicated even if someone was referred to both. If a family is referred, count each individual separately.*	ETO
		Number of referrals that resulted in enrollment (number engaged)	ETO
		Duration of untreated mental illness *Maybe appropriate for screening or assessment questions.*	ETO
		Average interval between referral and enrollment	ETO
		Minimum length of time from referral to enrollment	ETO
		Maximum length of time from referral to enrollment	ETO
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals and types of treatment referred to (SMI, SUD, or MH) to other agencies and within StarVista	Spreadsheet (for now)
		Programs or treatment referred to	Spreadsheet (for now)
	PEI Data Template	Individual-level data on mental health and substance use referrals to other agencies and within StarVista	

Referrals to other services	6C	Number of referrals by type		Spreadsheet (for now)
	PEI Data Template	Individual-level data on referrals to other services		
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: General behavioral health	Number of individuals who experienced reduced depression symptoms as measured by a reduction in their ANSA/CANS depression subscale score. (population = youth and adult therapy services)	CANS/ANSA
			Number of individuals who experienced reduced anxiety symptoms as measured by a reduction in their ANSA/CANS anxiety subscale score. (population = youth and adult therapy services)	CANS/ANSA
			Number of individuals who reported an improvement in their mental health as measured by the following: "How would you rate your mental health in the last 30 days?" (population = therapy services)	Mental Health Self-Assessment
			Number of individuals who reported an improvement in their ability to cope with stress as measured by the following: "How would you rate your ability to cope with stress in the last 30 days?" (population = therapy services)	Mental Health Self-Assessment
		Domain: Connection and support	Number of individuals who reported feeling more connected as measured by the following: "I feel more socially connected by participating in Pride Center programs and services." (population = individuals reached in other program components)	Individual survey
			Number of individuals who experienced improved support as measured by a reduction in their CANS Natural Supports subscale score (population = youth therapy services) and by a reduction in their ANSA	CANS/ANSA

			Community Connection subscale score. (population = adult therapy services)	
Individual Outcomes – Stigma Reduction	7B	Domain: Stigma Reduction (self/internalized)	Number of individuals who reported reduced self-stigma as measured by the following: "I feel comfortable talking about my sexual orientation and/or gender identity?" (population = therapy services)	Mental Health Assessment
Additional Individual/Program Outcomes	7C	Domain: Self-empowerment	Number of individuals who reported improved self-empowerment as measured by the following: "I am confident I can affect my life through the decisions I make?" (population = therapy services)	Mental Health Assessment
		Domain: Improved knowledge, skills, and/or abilities	Number of individuals who experienced improved social and relationship skills as measured by a reduction in their CANS Interpersonal subscale score (population = youth therapy services) and by a reduction in their ANSA Interpersonal/social connectedness subscale score (population = adult therapy services).	CANS/ANSA
			Number of individuals who reported improved knowledge as measured by the following: "After this training, I now have a strong understanding of issues impacting the LGBTQ+ community." (population = individuals reached in other program components)	Individual survey

PRIMARY CARE INTERFACE

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured	Data collection tool used
Individual information and demographics	5	Number of unduplicated individuals served in primary program component (counseling, case management, psychiatry – number who received services)	"Interface Episode by referral source" report in Avatar
	PEI Data Template	Demographics of unduplicated individuals served in primary program component (counseling, case management, psychiatry – number who received services)	Avatar report
Referrals to your PEI program	6A	Number of referrals to Primary Care Interface	"Interface Episode by referral source" report in Avatar
		Number of referrals that resulted in enrollment (number engaged – defined as having completed intake)	
		Average duration of untreated mental illness (*if available - time between the self-reported onset of symptoms that brought them into treatment this time and entry into treatment(intake)*)	
		Average interval between referral date and enrollment date (date assessment received)	
		Minimum length of time from referral to enrollment	
		Maximum length of time from referral to enrollment	
	PEI Data Template	Individual-level data on referrals into Primacy Care Interface	AVATAR
Mental health and substance use referrals to other agencies **and** within your agency	6B	Number of referrals by type of treatment referred to Region, SUD, or other MH within BHRS (Pre-to-3, TAY, AOD IMAT)	
		Programs or treatment referred to outside agencies (AOD In/out pt; PPN, CORA, KARA, School)	

	PEI Data Template	Individual-level data on mental health and substance use referrals to other agencies (from PCI, in disposition?) and within your agency (BHRS)		AVATAR
Referrals to other services (Other than SUD or MH)	6C	Number of referrals by type (Housing, food, Social worker, Job, etc.)		
	PEI Data Template	Individual-level data on referrals to other services		AVATAR
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: General Behavioral Health	Number who experience reduced anxiety symptoms (as measured by a change in their GAD-7 overall score)	AVATAR GAD-7 Scale
		Domain: General Behavioral Health	As a result of participation in this program, I learned skills and strategies to cope with stressors.	AVATAR PHQ-9 Scale
		Domain: General Behavioral Health	As a result of participating in this program, I am better able to manage my symptoms and participate in daily life.	AVATAR PHQ-9 Scale
		Domain: General Behavioral Health	Number who experience reduced depressive symptoms (as measured by a change in their PHQ-9 overall score)	AVATAR PHQ-9 Scale
Additional Individual/Program Outcomes	7C	Domain: Self-empowerment	As a result of participating in this program, I think more positively about challenges and I believe the decisions and steps I take impact my outcome.	Client Survey

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Individual information and demographics	5	Number of unduplicated individuals served through primary program component (group services and one-on-one counseling)		TheraNest platform; Excel spreadsheet
	PEI Data Template	Demographics of unduplicated individuals served through primary program component (group services and one-on-one counseling)		TheraNest platform; Excel spreadsheet
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or other MH)		TheraNest platform; Excel spreadsheet
		Programs or treatment referred to		TheraNest platform; Excel spreadsheet
	PEI Data Template	Individual-level data on mental health and substance use referrals		TheraNest platform; Excel spreadsheet
Referrals to other services	6C	Number of referrals by type		TheraNest platform; Excel spreadsheet
	PEI Data Template	Individual-level data on referrals to other services		TheraNest platform; Excel spreadsheet
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: Self-Empowerment	Due to this program, I learned skills that help me to express my emotions and opinions more effectively. (population = groups)	Group post survey

Individual Outcomes – Stigma Reduction	7B	Domain: Stigma reduction (Self/Internalized)	Due to this program, I feel more comfortable talking about my challenges with using alcohol and/or drugs. (population = groups)	Group post survey
Additional Individual/Program Outcomes	7C	Domain: General Behavioral health	Decrease in depressive symptoms for one-to-one counseling participants (as measured by change in their overall PHQ-9 score)	PHQ-9 – [indicate the collection/ reporting approach used (e.g., collecting every 6 months or once a year in the summer)]
			Decrease in anxiety symptoms for one-to-one counseling participants (as measured by change in their overall GAD-7 score)	GAD-7 - [indicate the collection/ reporting approach used (e.g., collecting every 6 months or once a year in the summer)]

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Individual information and demographics	5	Number of unduplicated individuals served in primary program components (early psychosis treatment and re(MIND) Alumni *(only count BEAM aftercare)*)		EHR
	PEI Data Template	Demographics of unduplicated individuals served in primary program components (early psychosis treatment and BEAM aftercare)		EHR
	5	Number of individuals served in other program components (family members/caregivers), may be duplicated		EHR
Referrals to your PEI program	6A	Number referrals to re(MIND)		EHR
		Number engaged/enrolled in re(MIND)		EHR
		Average duration of untreated psychosis		EHR
		Average interval between referral and enrollment		EHR
		Minimum length of time from referral to enrollment		EHR
		Maximum length of time from referral to enrollment		EHR
	PEI Data Template	Individual-level data on referrals to re(MIND)		EHR
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or other MH)		EHR
		Programs or treatment referred to		EHR
	PEI Data Template	Individual-level data on mental health and substance use referrals to other agencies and within your agency (internal transfers to BEAM)		EHR
Referrals to other services	6C	Number of referrals by type		EHR
	PEI Data Template	Individual-level data on referrals to other services		EHR
Individual Outcomes – Increased Protective Factors/Improved Recovery	7A	Domain: Utilization of emergency/crisis services	Reduction in hospitalizations (both number of days and number of episodes) for participants and alumni	EHR
		Domain: General Behavioral health	Improved engagement in meaningful activities	EHR

Indicators; Decreased Risk Factors/Symptoms			(employment, academic placement/progression, volunteerism) for participants and alumni (recovery indicator)	
Additional Individual/Program Outcomes	7C	Domain: Self-empowerment	"Due to this program, I am better able to control my life (adults) I deal more effectively with daily problems (youth)" Disagree Strongly; Disagree; Neither Agree/Disagree; Agree; Agree Strongly for participants and alumni	Program-administered survey
		Domain: Other - Satisfaction	"I am satisfied with the services I have received at (re)MIND/BEAM program" Disagree Strongly; Disagree; Neither Agree/Disagree; Agree; Agree Strongly for participants and alumni	Program-administered survey

Suicide Prevention

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Participant (client) information and demographics	5	Number of unduplicated individuals served in primary program component (Suicide Prevention participants)		Existing intake log
	~~PEI Data Template~~	~~Demographics of unduplicated individuals served in primary program component (Suicide Prevention participants)~~		~~Existing intake log~~
	5	Number of individuals reached in all other program components (those impacted by community outreach/presentations), may be duplicated		Existing intake log
	PEI Data Template	Demographics of individuals reached in all other program components, (those impacted by community outreach/presentations) may be duplicated (short)		Existing intake log
	~~PEI Data Template~~	~~Client-level data on SDOH responses~~		~~Referral/SDOH tracking log~~
Client/Participant Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: Access to services	Through my participation in this event/program/training, I have learned knowledge and skills that I can use to access behavioral health services (population = SP event participant).	Participant Survey
		Domain: Connection and Support	Due to my participation in this program/training/event, I am more willing to reach out and help someone if I think they may be at risk of suicide (population = SP event participant).	Participant Survey
Individual Outcomes – Stigma Reduction	7B	Domain: Stigma (Self/Internalized)	Due to this program/training/event, I feel more comfortable talking about *my* mental health or substance use (population = SP event participant).	Participant Survey
Additional Client/Program Outcomes	7C	Domain: Cultural identity/humility	I feel like my identity, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion, etc.) were affirmed by this program/training/event (population = SP event participant).	Participant Survey

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Participant (individual) information and demographics	5	Number of unduplicated individuals served in primary program component (cohort)		Demographics Survey - Cohort
	PEI Data Template	Demographics of unduplicated individuals served in primary program component (long)		Demographics Survey- Cohort
	5	Number of individuals reached in all other program components (those impacted by community outreach/presentations), may be duplicated		Audience survey
	PEI Data Template	Demographics of individuals reached in all other program components, may be duplicated (short)		Audience survey
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or MH) *Note: You can report on referrals provided to both cohort members and audience members.*		Survey, Excel Document
		Programs or treatment referred to		Excel Document
	PEI Data Template	Individual-level data on mental health and substance use referrals *Note: Please provide a individual ID with referrals made for cohort members. You do not need to report a individual ID for referrals made for audience members.*		Excel Document
Referrals to other services	6C	Number of referrals by type *Note: You can report on referrals provided to both cohort members and audience members.*		Excel Document
	PEI Data Template	Individual-level data on referrals to other services *Note: Please provide a individual ID with referrals made for cohort members. You do not need to report a individual ID for referrals made for audience members.*		Excel Document
Individual/Participant Outcomes – Increased Protective Factors/Improved Recovery Indicators;	7A	Domain: Community Advocacy	I am confident in my ability to create change in my community. (population = cohort)	Cohort Pre/Post Survey
			I am willing to use my voice to prevent discrimination against people with behavioral health challenges in my community. (population = cohort)	Cohort Pre/Post Survey

Decreased Risk Factors/Symptoms			Due to my participation in HAP-Y, I feel I have made a difference in advocating for behavioral health. (population = cohort)	Cohort Pre/Post Survey
Individual Outcomes – Stigma Reduction	7B	Stigma (Self/Internalized)	Due to this program, I feel comfortable discussing topics related to mental health and substance use. (population = cohort and audience)	Post-Survey and Audience Survey
		Stigma (Seeking Help/Treatment)	Due to this program, I feel comfortable seeking behavioral services. (population = cohort and audience)	Post-Survey and Audience Survey
Additional Individual/Program Outcomes	7C	Domain: Career Pathways/career pipelines	Due to participating in HAP-Y, I am interested in pursuing a career in behavioral health. (population = cohort)	Cohort Post Survey
		Domain: Career Pathways/career pipelines	Being in involved with HAPY-Y has introduced me to different careers with behavioral health (population = cohort)	Cohort Post Survey

YOUTH S.O.S.

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured	Data collection tool used
Individual information and demographics	5	Number of unduplicated individuals served in primary program component (mobile crisis response)	
	PEI data template	Demographics of unduplicated individuals served in primary program component (mobile crisis response)	
	5	Number of individuals served through other program components (family members or caregivers of youth served, individuals reached through outreach/education), may be duplicated	
	PEI data template	Demographics of individuals served through other program components (family members or caregivers of youth served, individuals reached through outreach/education), may be duplicated	
Referrals to your PEI program	6A	Number of referrals to Youth S.O.S. (crisis calls)	
		Number of referrals that resulted in enrollment/number engaged (Youth S.O.S. goes out)	
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals and types of treatment referred to (SMI, SUD, or other MH) *Note: Please report on referrals provided to youth here. Additional referrals made for family members/caregivers or outreach/education recipients can be included in the individual-level data.*	
		Programs or treatment referred to	
	PEI Data Template	Individual-level data on mental health and substance use referrals to other agencies and within your agency *Note: Please provide a individual ID with referrals made for youth. You do not need to report a individual ID for additional referrals made for family members/caregivers or outreach/education recipients.*	
Referrals to other services	6C	Number of referrals by type *Note: Please report on referrals provided to youth here. Additional referrals made for family members/caregivers or outreach/education recipients can be included in the individual-level data.*	
	PEI Data Template	Individual-level data on referrals to other services	

		Note: Please provide a individual ID with referrals made for youth. You do not need to report a individual ID for additional referrals made for family members/caregivers or outreach/education recipients.		
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: General behavioral health	Number of youth who learned a new coping strategy to increase mental, emotional, and relational functioning. (population = youth who received Youth S.O.S. services)	Intake form-Intervention section
		Domain: Connection and Support	Number of youths who can identify and feel safe reaching out and contacting at least one adult when they are experiencing emotional distress during a follow up session.	Follow-up rating form
Additional Individual/Program Outcomes	7C	Domain: Utilization of emergency services	Youth diverted from use of psychiatric emergency services (population = youth who received Youth S.O.S. services)	
		Domain: Utilization of emergency services	Youth will not require law enforcement intervention (population = youth who received Youth S.O.S. services)	
		Domain: access to services	Number of caregivers or family members who received psychoeducation and resources to increase youth's access to community and relational support. (population = family members/caregivers of youth)	

Appendix B: Outcome Domain Summary

Table 6 includes all outcome domains reported on by each program. Blue check marks represent outcomes for the program's primary components and orange check marks represent outcomes for the program's other components.

Table 6. PEI Program and Individual Outcome Summary

PEI Component	PEI Program	Access to services	Community advocacy	Connection and support	Cultural responsiveness	General behavioral health	Improved knowledge, skills, and/or abilities	Self-empowerment	Stigma reduction (Self/internalized)	Stigma reduction (Seeking help)	Stigma reduction (Public/external)	Utilization of emergency services
Prevention	HAP	✓	✓	✓	✓		✓	✓	✓	✓		
	HAP-Youth		✓						✓	✓		
	HEIs	✓	✓		✓			✓	✓		✓	
	MHFA	✓			✓							
	MBSAT						✓					
	GiraSol	✓		✓	✓		✓	✓	✓			
	The Parent Project@	✓			✓				✓			
	Photovoice	✓	✓		✓				✓	✓	✓	
	Suicide Prevention	✓		✓	✓				✓			
Prevention & Early Intervention	allcove®					✓	✓					
	ECCT			✓			✓					
	Project SUCCESS					✓		✓	✓			
	Cariño Project			✓	✓	✓	✓		✓			
	PEARLS			✓		✓		✓	✓			
	Peer Counseling	✓		✓		✓	✓		✓	✓		
	Youth S.O.S.	✓		✓		✓						✓
Early Intervention	Primary Care Interface					✓		✓				
	re(MIND)®					✓		✓				✓
	The Pride Center			✓		✓	✓	✓	✓			

Appendix C: Outcome Indicators

Table 7 provides an inventory of all indicators reported by PEI programs, by Outcome Domain.

Table 7. PEI Outcome Domains and Indicators

Outcome Domains	Sample outcome questions/statements	Program using indicator
Access to services	As a result of participating in this program, I am connected to community resources.	Peer Counseling
	Number of caregivers or family members who received psychoeducation and resources to increase youth's access community and relational support.	Youth S.O.S.
	I know at least one place I can go for mental health services.	Panche/GiraSol
	Through my participation in this event/program/training, I have learned knowledge and skills that I can use to access mental health and substance use services.	HAP, MHFA Parent Project®, Photovoice, Suicide Prevention
	Through my participation in this course, I and/or my family have been connected to mental health services/resources that have been helpful.	HAP
Community advocacy	Due to this program, I am more confident in my ability to create change in my community.	HAP-Y, HAP
	Due to this program, I am more willing to use my voice to prevent discrimination against people with mental health challenges in my community.	HAP-Y
	Due to my participation in HAP-Y, I feel I have made a difference in advocating for mental health.	HAP-Y
	Due to my participation in this event/program/training, I feel more confident in my ability to create change in my community around mental health or substance use conditions.	HEI's, Photovoice
Connection and support	Number who reported stronger relationships with family after receiving services (case management population).	Cariño Project
	Improved relationship between parent/sibling and daughter	Panche/GiraSol
	Number of parents/caregivers who improved their familial connection and support as measured by an improvement in their Protective Factors Survey score	ECCT
	Due to my engagement in this program, I feel more connected to other parents in my community.	ECCT

	As a result of participating in this program, I feel supported.	Peer Counseling
	Number of youth who can identify and feel safe reaching out and contacting at least one adult when they are experiencing emotional distress during a follow up session.	Youth S.O.S.
	Due to my participation in this program/training/event, I am more willing to reach out and help someone if I think they may be at risk of suicide.	Suicide Prevention
	Number of individuals who experienced improved support as measured by a reduction in their CANS Natural Supports subscale score for youth and by a reduction in their ANSA Community Connection subscale score for adults.	Pride Center
	I feel more socially connected by participating in Pride Center programs and services.	Pride Center
	Due to my participation in HAP courses and/or activities, I feel more connected to the service providers in my and my family's life.	HAP
	Due to my participation in HAP courses and/or activities, I feel more connected to my community.	HAP
	Due to my participation in HAP courses and/or activities, I feel more connected to my family.	HAP
Cultural Responsiveness	Due to participating in this program, I feel more connected to my culture (identity).	Cariño Project
	I feel proud and connected to my cultural roots (identity)	Panche/GiraSol
	I can name three positive values from my culture (identity).	Panche/GiraSol
	I feel like my identify, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion, etc.) were affirmed by this program/training/event.	HAP, HEI's, MHFA, Parent Project®, Photovoice Suicide Prevention, HAP
	As a result of this course, I have a better understanding of how mental health and substance use challenges affect different cultures.	MHFA, Photovoice
General Behavioral health	As a result of participating in this program, I feel less stressed.	Peer Counseling
	Decrease in depressive symptoms for one-to-one counseling participants (as measured by change in their overall PHQ-9 score)	Project SUCCESS, Primary Care Interface

	Due to the services I received, I feel fewer or less intense symptoms of depression.	allcove®
	Due to the services I received, I have decreased urges for self-harm and/or suicide.	allcove®
	Decrease in depression symptoms as measured by a reduction in their ANSA/CANS depression subscale score	Pride Center
	Decrease in anxiety symptoms for one-to-one counseling participants (as measured by change in their overall GAD-7 score)	Project SUCCESS, Primary Care Interface
	Decreased in anxiety symptoms as measured by a reduction in their ANSA/CANS anxiety subscale score	Pride Center
	Improvement engagement in meaningful activities (employment, academic placement/progression, volunteerism)	re(MIND)®
	Number who experience an overall improvement in their mental health	Cariño Project, Pride Center
	Number who reported an improved ability to manage mental health symptoms	Cariño Project, Primary Care Interface
	Number who reported an improved ability to cope with stressors	Cariño Project, Pride Center
	Number who reported that the services they are receiving are helping them to function better/participate in daily life	Cariño Project, PEARLS
Improved knowledge, skills, and/or abilities	Due to this program, I learned how to recognize and support my community/family.	Cariño Project
	Parent perception of improved behavior/academics of daughter	Panche/GiraSol
	Due to this workshop/event, I have more or better skills to cope with difficult things in my life.	allcove®
	Due to this workshop/event, I have more knowledge of how to best manage my behavioral health symptoms.	allcove®
	Number of parents/caregivers who improved their parenting knowledge, skills, and abilities as measured by an improvement in their Parent Stress Index score.	ECCT
	Due to my engagement in this program, I feel more confident in my parenting.	ECCT
	The program improved my knowledge and confidence in seeking support when I need it.	Peer Counseling

	Number of youth who learned a new coping strategy to increase mental, emotional, and relational functioning.	Youth S.O.S.
	Number of individuals who experienced improved social and relationship skills as measured by a reduction in their CANS Interpersonal subscale score for youth and by a reduction in their ANSA Interpersonal/social connectedness subscale score for adults	Pride Center
	After this training, I now have a strong understanding of issues impacting the LGBTQ+ community.	Pride Center
	Because I participated in this program, when I'm worried about something, I make myself think about it in a way that helps me feel better.	MBSAT
	When I want to feel better about something, I change the way I'm thinking about it.	MBSAT
	As a result of participating in this program, I learned that trauma affects physical, emotional, and mental well-being.	MBSAT
	As a result of participating in this program, I believe that recovery from trauma is possible.	MBSAT
	Due to my participation in this program, I practice self-care (taking care of my own needs and well-being).	MBSAT
	As a result of participating in this program, I believe in and support the principles of Trauma Informed Practice (TIP).	MBSAT
	As a result of participation in this program, I learned skills and strategies to cope with stressors.	Primary Care Interface
Self-empowerment	I am confident that I can affect my life through decisions that I make.	PEARLS, Pride Center
	I have "control" of my own narrative, design my own narrative, go for my dreams.	Panche/GiraSol
	Due to this program, I learned skills that help me to express my emotions and opinions more effectively.	Project SUCCESS
	"Due to this program, I am better able to control my life (adults) I deal more effectively with daily problems (youth)"	PEARLS, re(MIND)®
	Number of youth who can identify and feel confident accessing emergency mental health services when their emotional distress is high.	Youth S.O.S.
	Due to my participation in courses and/or activities, I am more confident in my ability to advocate for the	HAP, HEI's

	behavioral health needs of myself and/or advocate for my child/children.	
	As a result of participating in this program, I think more positively about challenges and I believe the decisions and steps I take impact my outcome.	Primary Care Interface
Stigma reduction (self/internalized)	Due to this program, I feel more comfortable talking about mental health since I began attending sessions.	Cariño Project
	Due to this program, I feel more comfortable talking about my challenges with using alcohol and/or drugs.	Project SUCCESS
	Due to this program, I feel more comfortable speaking about *my* mental health challenges.	Panche/GiraSol,
	Due to this program, I feel more comfortable talking about my problems.	PEARLS, Peer Counseling
	I feel comfortable discussing topics related to mental health and/or substance use.	HAP-Y
	I feel comfortable talking about my sexual orientation and/or gender identity.	Pride Center
	Due to this program/training/event, I feel more comfortable talking about *my* mental health or substance use.	HAP, HEI's, Suicide Prevention, Parent Project®, Photovoice
Stigma reduction (seeking help/ treatment)	Due to this program, I feel comfortable seeking behavioral health services.	HAP-Y
	Due to this program, I feel more comfortable reaching out for emotional support.	Peer Counseling
	Due to my participation in this course, I feel more comfortable seeking mental health services for myself and/or my family.	HAP
	As a result of this program, I am more willing to seek professional support for a mental health and/or substance use condition if I need it	Photovoice
Stigma reduction (public/external)	This program/training/event affirmed that people with mental illness are capable and able to make positive contributions to society.	HEI's, Photovoice
Utilization of emergency services	Reduction in hospitalizations (both number of days and number of episodes)	re(MIND)®
	Youth diverted from use of psychiatric emergency services	Youth S.O.S.
	Youth will not require law enforcement intervention	Youth S.O.S.

Other	Satisfaction: I am satisfied with the services I have received at (re)MIND/BEAM.	re(MIND)®
	Due to participating in HAP-Y, I am interested in pursuing a career in behavioral health.	HAP-Y
	Being involved with HAP-Y has introduced me to different careers within behavioral health.	HAP-Y

APPENDIX 7. PEI THREE-YEAR EVALUATION REPORT

MENTAL HEALTH SERVICES ACT

Prevention & Early Intervention Three-Year Evaluation

Fiscal Years 2021-22, 2022-23, 2023-24

SAN MATEO COUNTY HEALTH

BEHAVIORAL HEALTH & RECOVERY SERVICES

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Overview

San Mateo County Behavioral Health and Recovery Services (BHRS) funded 23 Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) programs across the fiscal years (FY) covered in this report, FY 2021-2022, FY 2022-2023, and FY 2023-2024. Most PEI programs were delivered by community-based providers that serve children, adults, and older adults, as well as marginalized and diverse populations. In each of the three fiscal years, over 5,000 unduplicated community members per year received services and over 35,000 community members were reached (duplicated). The activities included trainings, psychoeducation workshops, community capacity development, early intervention and short-term treatment services, and cultural events.

Clients Served (unduplicated)

7,061 in FY 2021-22
5,326 in FY 2022-23
5,860 in FY 2023-24

Individuals Reached (duplicated)

65,364 in FY 2021-22
62,035 in FY 2022-23
66,316 in FY 2023-24

Referrals Made

150+ for serious mental illness
85+ for substance use services
1,212+ for other mental health services
3,087+ for other types of services

Outcome Highlights

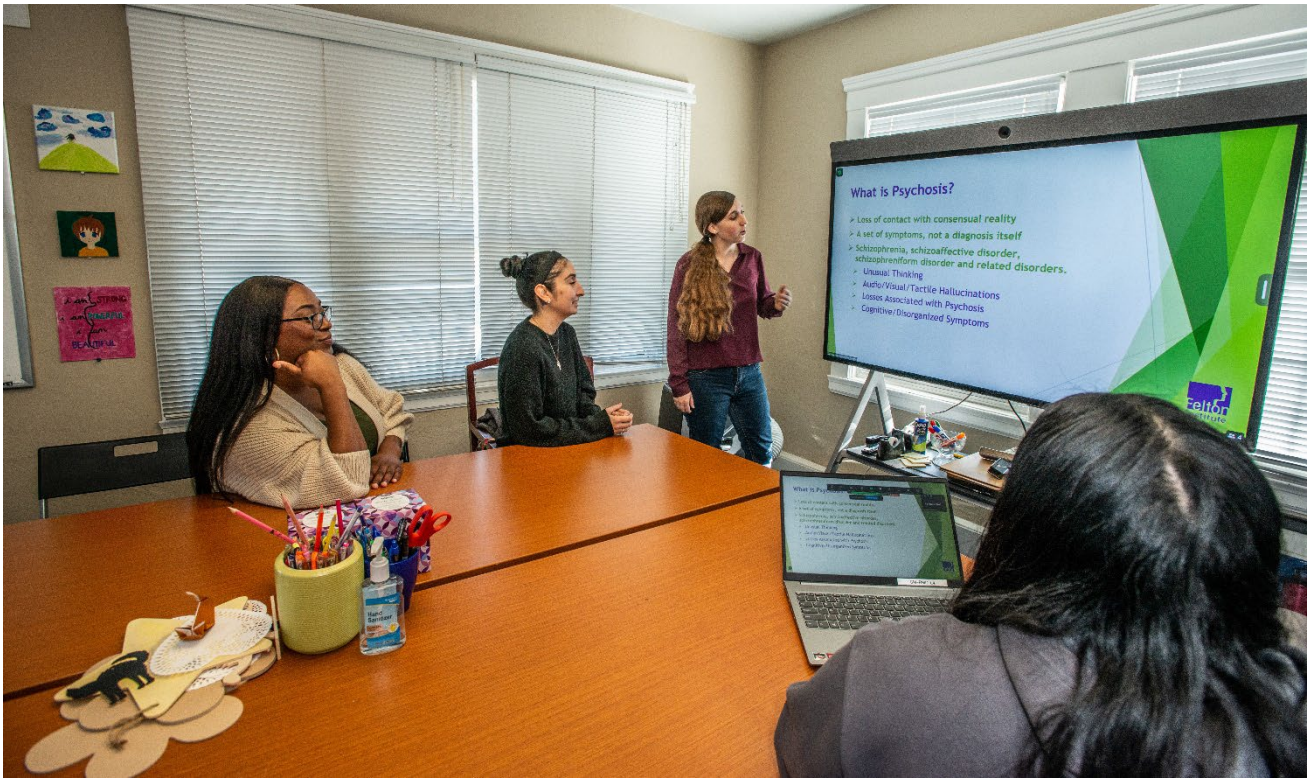
Overall, BHRS's MHSA-funded PEI programs have supported access to services and strengthened general behavioral health by promoting protective factors and reducing stigma around behavioral health and help seeking.

- **Increased knowledge and reduced stigma**. Participants in PEI programs focused on knowledge and stigma showed increases in self-reported knowledge about behavioral health topics and resources and reductions in stigma in all years, generally for the majority of participants and often for the large majority of participants.
- **Strengthened protective factors**. Participants in PEI programs reported increases in protective factors including knowledge and skills around mental health and substance use, coping strategies for strong emotions, and feelings of connection and support among both youth and adult clients/participants, though there was some variation in the proportion of respondents reporting positive results.
- **Increased access to services**. Participants across numerous PEI programs consistently demonstrated increases in their awareness of behavioral health services that they can access, and their ability and willingness to seek services if needed.
- **Consistent delivery of culturally informed programs**. On the whole, participants in PEI programs reported that the programs/trainings/events they attended affirmed their identity, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion, etc.).
- **Improved general behavioral health**. Self-reported general behavioral health outcomes were overall positive, with a majority of survey respondents in most PEI programs reporting feeling less stressed or better able to manage their symptoms and participate in daily life, though there was some variation in positive outcomes across years, programs, and modalities.
- **Decreased utilization of emergency services**. PEI programs that focused on decreased use of psychiatric emergency services had over 90% success rates in most cases. Programs that used validated instruments to measure a reduction in behavioral health symptoms indicated that the large majority of clients improved their scores or maintained a positive score.

PEI Data and Reporting Recommendations

The following are recommendations as BHRS continues to strengthen data collection and reporting for PEI programs.

1. Continue to increase consistency in existing data collection, specifically:
    a. Where appropriate, work toward greater standardization of indicators reported across programs.
    b. To the extent possible, increase response rates for surveys so that data are more representative of the clients/participants served.
    c. Work to improve consistency and completeness of demographic data collection.
2. Expand qualitative data collection to gather in-depth client perspectives, understand differences in outcomes, and inform opportunities for program improvement.



INTRODUCTION

PREVENTION AND EARLY INTERVENTION

Prevention and Early Intervention (PEI) is one of the five components of the Mental Health Services Act (MHSA). PEI focuses on 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 seven negative outcomes of untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes.

Through PEI, MHSA has supported investments in upstream prevention and early intervention strategies to design and implement community-defined, culturally responsive approaches that reduce risk factors (e.g., serious adverse childhood experiences, ongoing stress, alcohol and drug misuse, domestic violence, experience of racism and social inequality, having a previous suicide attempt, etc.) and increase protective factors (e.g., access to information and resources, stable employment or income, adequate food and housing, education, health care, connectedness and belonging, etc.).[1] Protective factors help reduce the significant personal, family, and social costs of mental health and substance use challenges.[2]

PEI programs (19% of funding allocation since inception, 51% of which funds programs for children and youth) serve individuals of all ages prior to or early in the onset of behavioral health challenges such as programs focused on early onset of psychotic disorders. PEI programs help create access and linkage to treatment and improve timely access to behavioral health services for individuals and families from underserved populations in ways that are non-stigmatizing, non-discriminatory, and culturally appropriate. San Mateo County Behavioral Health and Recovery Services (BHRS) has focused its PEI dollars on evidence-based and community-defined interventions in family, school, and community-based settings. As noted in the report, several PEI programs also receive funding through the Community Services and Supports (CSS) component of MHSA.

PEI Service Categories

- **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

[1] Risk factors are characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes. Protective factors are characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact. https://www.samhsa.gov/sites/default/files/20190718-samhsa-risk-protective-factors.pdf

[2] National Academies Press (US). (2009). *Preventive Intervention Research*. Preventing Mental, Emotional, and Behavioral Disorders Among Young People - NCBI Bookshelf. https://www.ncbi.nlm.nih.gov/books/NBK32766/

serious mental illness or emotional disturbance with psychotic features, in which case early intervention services shall not exceed four years.

- **Prevention** programs reduce risk factors for developing a potentially serious mental illness and build protective factors for individuals whose risk of developing a serious mental illness is greater than average and, as applicable, their parents, caregivers, and other family members. Services may include relapse prevention and universal strategies.
- **Outreach for Recognition of Early Signs of Mental Illness** to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.
- **Access and Linkage to Treatment** are activities to connect individuals with severe mental illness as early in the onset of these conditions as practicable to medically necessary care and treatment, including, but not limited to, care provided by BHRS programs.
- **Stigma and Discrimination Reduction** activities reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services.
- **Suicide Prevention** programs are not a required service category. Activities prevent suicide but do not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness.

PEI Strategies

All PEI programs are designed to advance the following strategies:

Access to linkage and treatment: To connect individuals with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by BHRS programs.

Timely access to mental health services for individuals and families from underserved populations: To increase the extent to which an individual or family from an underserved population that needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services. Services shall be provided in a convenient, accessible, acceptable, culturally appropriate setting.

Non-stigmatizing and non-discriminatory practices: Promoting, designing, and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services in ways that are accessible, welcoming, and positive.

Proposition 1 (Behavioral Health Transformation)—Local Impact to PEI

The recent passage of California's Proposition 1 in March 2024 introduced significant changes to the MHSA funding allocations. Proposition 1 emphasizes the need to focus on the most acute individuals living with serious mental illness and/or substance use disorders and enhanced integration of substance use and mental health services. Proposition 1 renames the MHSA as the Behavioral Health Services Act (BHSA) and reforms funding allocations as follows:

- 30% housing interventions (e.g., rental and operating subsidies, nonfederal share of rent, housing retention/maintenance, some capital investments)
    - 51% to chronically homeless populations
- 35% Full Service Partnerships (FSPs)
- 35% behavioral health services and supports
    - 51% to early intervention services and majority of this to services for ages 0-25
- Redirects 10% of annual revenues (currently 5%) for administration as well as statewide behavioral health workforce initiatives and population-based prevention and $20 million to establish the BHSA Innovation Partnership Fund.

With the shifting of MHSA Prevention funding to the state and prevention responsibilities to public health agencies, it is unlikely that local Prevention programs will continue, unless restructured to meet new Early Intervention requirements and/or non-behavioral health funding is identified for sustainability. BHRS has begun partnering with the local public health department on the Community Health Improvement Plan (CHIP) implementation and the Community Health Needs Assessment (CHNA) development. The MHSA Manager co-facilitates the mental health workgroup, and Office of Diversity and Equity (ODE) staff are participating in all three CHIP workgroups: Mental Health, Access, and Social Determinants of Health.

EVALUATION FRAMEWORK

In July 2018, the PEI regulations were amended by the California Mental Health Services Oversight and Accountability Commission (MHSOAC), and specific requirements were added that included indicators, data trackers, the explanation of a three-year evaluation plan, annual evaluation report, and the PEI component of a three-year plan.

Evaluation Approach

BHRS contracted with RDA Consulting (RDA) to provide outcome data planning and technical assistance for San Mateo County's PEI programs that provide some component of individual-level services. The project aimed to identify a reporting framework in which PEI data and individual outcomes could be analyzed across all PEI-funded programs. The framework that was developed uses a set of nine Outcome Domains that were identified in alignment with MHSA requirements, ODE strategic planning, and through this project's exploration with contracted providers and BHRS staff of the expected outcomes across the current PEI-funded programs.

The initial implementation of this framework, completed in June 2022, focused on programs that collect individual-level data, or unduplicated individuals served. Starting in May 2023, non-individual level programs—those that primarily collect population-level data, or duplicated individuals served—were incorporated to allow for a broader assessment of the impact of PEI programs. Additional PEI programs such as the Outreach Collaboratives and newly launched programs such as PEARLS (Program to Encourage Active, Rewarding Lives) for older adults and allcove® youth drop-in centers will be incorporated starting in the Spring 2024. Programs that focus exclusively on systems development, such as Trauma- and Resiliency Informed Systems Initiative (TRISI), are not captured in the framework, as the evaluation focus of these programs is on measuring organizational capacity building and not individual or population level impacts.

For the purposes of this reporting framework and data collection activities, programs are categorized to reflect this spectrum of prevention and early intervention: (1) Prevention Programs, (2) combined Prevention and Early Intervention Programs, and (3) Early Intervention Programs.

- **Prevention Programs:** focus on *outreach and education*.
- **Prevention & Early Intervention Programs:** include both an *outreach/education* component as well as early intervention *clinical services*.
- **Early Intervention Programs:** primarily provide one-on-one early intervention *clinical services*.

The San Mateo County MHSA PEI funded programs included are listed below according to the three reporting categories and the PEI Service Categories for each program.

Evaluation Reporting Category	PEI Program	*PEI Service Category*
Prevention	Health Ambassador Program	*Prevention*
	Health Ambassador Program - Youth	*Prevention*
	Health Equity Initiatives (HEIs)	*Prevention*
	Help@Hand	*Prevention*
	Mental Health First Aid	*Recognition of Early Signs of Mental Illness*
	Outreach Collaboratives	*Access and Linkage to Treatment*
	Parent Project	*Prevention*
	Photovoice/Storytelling	*Stigma and Discrimination Reduction*
	Stigma Reduction Program - Mental Health Awareness	*Stigma and Discrimination Reduction*
	Suicide Prevention Program	*Suicide Prevention*
	Trauma-Informed Co-occurring Services for Youth	*Prevention*
	Trauma-Informed Systems for 0-5 Providers*	*Prevention*
Prevention & Early Intervention	Early Childhood Community Team	*Prevention & Early Intervention*
	Project SUCCESS	*Prevention & Early Intervention*
	The Cariño Project	*Prevention & Early Intervention*
	Older Adult Peer Counseling	*Prevention & Early Intervention*
	Youth S.O.S. Team and Crisis Hotline	*Prevention & Early Intervention*
Early Intervention	Primary Care Interface	*Early Intervention*
	(re)MIND Early Psychosis Program	*Early Intervention*
	The Pride Center	*Access and Linkage to Treatment*
	Ravenswood Family Health Center	*Early Intervention*
	SMC Mental Health Assessment and Referral Team (SMART)	*Early Intervention*

**Because TRISI serves providers, the evaluation does not include its numbers and outcomes in the overall calculations for the Prevention category.*

PEI Outcome Domains

To allow BHRS to assess the impact across all its PEI-funded programs, the PEI Data Collection and Reporting Framework uses a set of **Outcome Domains** under which programs report their specific indicators.

The **PEI Outcome Domains** used in the framework are:

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

Programs report on **primary** and **additional outcomes**. Primary outcomes reflect the intended results of the program's primary component(s). For example, if a program's primary component is short-term clinical therapy for youth, but also offers workshops for families, primary outcomes focus on the youth receiving clinical therapy. Programs can also elect to report on additional outcomes that they expect their program to achieve.

The table below documents the **primary outcomes** for each PEI program *(Source: Prevention and Early Intervention Data Collection and Reporting Framework, Updated November 2024)*.

PEI Component	PEI Program	Access to services	Community advocacy	Connection and support	Cultural responsiveness	General Behavioral health	Improved knowledge, skills, and/or abilities	Self-empowerment	Stigma reduction	Utilization of emergency services	Other
Prevention	Health Ambassador Program			✓	✓			✓	✓		
	Youth Health Ambassador Program		✓						✓		
	Health Equity Initiatives	✓			✓			✓	✓		
	Mental Health First Aid	✓			✓						
	Mindfulness-Based Substance Abuse Treatment						✓				
	Panche/GiraSol	✓			✓			✓	✓		
	The Parent Project®	✓							✓		
	Photovoice		✓						✓		
	Suicide Prevention	✓		✓					✓		
Prevention & Early Intervention *and* Early Intervention	allcove®					✓					
	Early Childhood Community Team			✓			✓				
	Project SUCCESS							✓	✓		
	The Cariño Project					✓					
	PEARLS			✓		✓					
	Peer Counseling			✓		✓					
	Youth S.O.S.			✓		✓					
	re(MIND)® Early Psychosis Program					✓				✓	
	The Pride Center			✓		✓	✓				

The following table illustrates how the PEI Outcome Domains align with the MHSOAC Regulations for the PEI Three-Year Evaluation Report.

Program Component or Strategy	MHSOAC Reporting Requirements	PEI Outcome Domains Measured
Prevention Programs	Reduction of prolonged suffering that may result from untreated mental illness by measuring a reduction in risk factors, indicators, and/or increased protective factors that may lead to improved mental, emotional, and relational functioning.	Protective factors including: • Connection and support • Cultural identity/cultural humility • Improved knowledge, skills, and/or abilities • Self-empowerment
Early Intervention (and some Prevention Programs)	For programs that reduce negative outcomes that may result from untreated mental illness, the County shall select, define, and measure appropriate indicators that the County selects that are applicable to the Program.	Protective factors listed above, plus: • General mental health • Utilization of emergency services
Stigma and Discrimination Reduction Program	Changes in attitudes, knowledge, and/or behavior related to mental illness that are applicable to the specific Program; changes in attitudes, knowledge, and/or behavior related to seeking mental health services that are applicable to the specific Program.	• Stigma reduction
Suicide Prevention Program	Validated method to measure changes in attitudes, knowledge, and/or behavior regarding suicide related to mental illness that are applicable to the specific Program	• Improved knowledge, skills, and/or abilities ○ Including pre/post test for Be Sensitive Be Brave trainings

Access and Linkage to Treatment	Number of referrals; number of persons who followed through on the referral; duration of untreated mental illness; the interval between the referral and engagement in treatment/services.	• Access to services (all programs)
		  ○ Self-reported access to programs
		  ○ Number of referrals made
		• Linkage to services (for PCI)
		  ○ Number of referrals, numbers engaged, duration of untreated mental illness, interval between referral and engagement

Program Component or Strategy	MHSOAC Reporting Requirements	PEI Outcome Domains Measured

Improve Timely Access to Services for Underserved Populations	Number of referrals; number of persons who followed through on the referral; interval between the referral and engagement in treatment/services	• Access to services (all programs)
		  ○ Self-reported access to programs
		  ○ Number of referrals made
		• Cultural humility

Indicators

Each program defines **indicators** to measure their selected outcome domains. To further the practice of standardizing indicators, **ODE Indicators** and survey questions were developed in five PEI Outcome Domains: 1) self-empowerment, 2) community advocacy, 3) cultural humility/identity, 4) access to treatment, and 5) stigma discrimination reduction (see Appendix A for full list of indicators). Beginning in FY 2023-24, PEI programs were asked to start incorporating a minimum of two ODE Indicators (one question for each indicator chosen) in their client/participant surveys. Because it takes some time for programs to adapt their data collection practices, some PEI programs (mostly Prevention programs) had begun the process of incorporating the ODE Indicators as of their FY 2023-24 annual report. In FY 2024-25, ODE will continue the process of moving toward greater standardization of indicators to support evaluation.

Data Sources and Reporting

The PEI Data Collection and Reporting Framework includes individualized PEI Program Crosswalks that outline the specific reporting expectations for each program. This approach allows programs to clearly identify how their specific program data align with the framework. Each program's individualized crosswalk identifies annual MHSA reporting for:

1. Individuals served (unduplicated)
2. Individuals reached (duplicated)
3. Demographics
4. Referrals
5. Individual-level outcomes

How PEI programs report unduplicated vs. duplicated data:

- **Unduplicated Individuals Served:** During the initial phase of the rollout of this framework that focused on individual-level programs, all programs identified at least one primary

program component for which they would report the required unduplicated number of individuals served. A program could select more than one primary component but will be required to report an unduplicated count for their program. For example, if a program's primary components are short-term clinical therapy and case management, an individual receiving both services would only be captured once in the unduplicated number of individuals served.

- **Individuals "Reached":** Programs also identified components through which they may have a broader reach, such as outreach or educational activities. The number reported under this "reach" category does not need to be an unduplicated count. For example, if a program offers workshops as another program component, they can report on the number of workshops attendees over the course of the reporting period, which may include some duplicate individuals who attended multiple activities.
- **Demographics:** Programs will collect full demographic data on unduplicated individuals served through their primary program components. Full demographics will be reported in the standardized San Mateo County format, which addresses the MHSA PEI requirements and local community input received regarding how to ask sensitive questions regarding race, ethnicity, and language (REAL) and sexual orientation, gender identity, and expression (SOGIE). For individuals "reached," the program may collect a standardized shortened list of demographic data. For example, in group settings, such as workshops or classes, or at large events. Demographic information is not required for light-touch outreach activities.

How PEI programs report on referrals:

- **Referrals into Early Intervention Programs:** Collecting extensive data on referrals into the PEI programs is not possible for prevention-focused programs. Therefore, referral to and enrollment into a PEI program will only be collected from Early Intervention programs. Individuals enrolling into an Early Intervention program will likely have a period of untreated mental illness to report as part of a formal intake process. These Early Intervention programs will also collect referral data into their programs and report on the MHSA requirements for the average duration of untreated mental illness and the interval between a referral and participation in early intervention treatment.
- **Referrals to Services:** Prevention-focused programs often make referrals to a higher level of care for serious mental illness (SMI), substance use disorders (SUD), and other mental health needs. As these referrals are made to different programs within an agency or to outside agencies that generally use different electronic health record systems or other data systems, collecting additional data on the duration of untreated mental illness or interval between referral and actual enrollment is not feasible. Therefore, Prevention programs that make referrals to SMI, SUD, or other mental health services will only report on the number of

referrals made for each category of referrals and indicate whether those referrals were made within the PEI-program's agency, or to a County service or other outside agency.

The PEI Data Collection and Reporting Framework uses standardized reporting templates through which all PEI programs report their data on an annual basis.

- **MHSA Annual Report Templates:** Each PEI program provider is responsible for completing this report on an annual basis. The report template collects metrics such as unduplicated number of clients served, demographics, and outcomes, as well as narrative regarding program activities, interventions, program successes and challenges.
- **PEI Data Template:** The template includes preset spreadsheets for programs to report individual-level and population-level data. PEI programs may use their own tracking logs and sign-in sheets to document the number of clients, outreach, and referrals made, and transfer these to the PEI Data Template for their annual reporting. Some tracking sheets are also online through Survey Monkey and are analyzed by an external consultant.
- **Program Tools/Surveys**: Many of the PEI programs use client/participant surveys to collect outcome data as well as client satisfaction with the program. These surveys include Likert scales and open-ended questions and capture a variety of outcomes, such as changes in attitudes, knowledge, and behaviors. Measures also capture the increase in protective factors to mental illness as well as social-emotional wellbeing and use of new skills.

Considerations and Limitations

While San Mateo County has made significant strides in data collection and evaluation since the previous Three-Year Evaluation, there remain several considerations and limitations to programs' data collection and the resulting PEI evaluation.

- **Most outcomes are self-reported.** The most feasible way for most programs to measure outcomes is by self-report from clients/participants after a program/training/event. While this approach allows programs to hear directly from participants about perceived changes due to the program, issues such as different interpretations of questions, social desirability bias, and the level of attention paid to the survey can affect the validity of responses.
- **There were generally low response rates to client/participant surveys.** For various reasons, it is often difficult for programs to ensure that all clients/participants complete post-program surveys. As a result, some programs collected surveys from somewhat low or very low percentages of their overall client/participant population. Therefore, the reported outcomes should be understood as the outcomes for the clients/participants surveyed, rather than necessarily representing outcomes for all program clients/participants.
- **There are missing demographic data for some programs**. Some programs collect demographic data during intake/enrollment; others collect it on surveys later in the process.

Some programs were not able to collect demographic data from all clients/participants, some programs did not report on all of the required demographic variables, and some programs did not report any demographic data. Therefore, it is important to keep in mind that demographic data may not fully represent the demographics served, thus making it difficult to assess how well programs reached underserved populations. In addition, because demographics rely on self-report, it is possible that some clients/participants did not feel comfortable sharing truthfully about areas including gender identity, sexual orientation, or disability status.

- **Referral tracking is incomplete for some programs.** The number of referrals made were not tracked/reported by all programs, and some programs may not have documented all referrals made, so the numbers of referrals made for SMI, SUD, and other mental health issues are likely undercounted. As mentioned in the PEI Data Collection and Reporting Framework, collecting additional data on follow-through on referrals, duration of untreated mental illness or interval between referral and actual enrollment is not feasible for most programs.
- **There are limitations in attributing outcomes to programs**. For programs that use self-reported measures of change, the client/participant post-surveys are worded to ask whether clients/participants experienced outcomes "Due to this program." This allows the programs to reasonably attribute clients/participants' perceived changes to the program itself, though there may be cases where other factors also influenced client outcomes. Some Early Intervention programs measure the use of psychiatric emergency services or changes in behavioral health symptoms. While the evaluation design cannot directly attribute these outcomes to programs, the overall high success rates for these programs make it reasonable to infer that the outcomes are at least in part due to the programs.
- **Differences in indicators and variations in survey response rates make it difficult to compare outcomes across programs and across years.** In many cases, reported indicators changed over the evaluation period—both within and across programs. Methods used to collect surveys may have changed, different amounts of data were collected in each year, and program operations/curricula may have changed between years. This makes it difficult to compare outcomes for the same program from year to year, as well as to compare outcomes across programs. For example, when programs had differences across years in the percent of clients reporting positive outcomes, it is not possible to determine whether this was due to changes in the program approach or curriculum, program implementation issues, changes in program quality, external challenges such as COVID-19, or other reasons.

Organization of the Report

Evaluation Highlights

- The first section of the report presents aggregate data across the categories in the PEI Data Collection and Reporting Framework: Prevention, Prevention & Early Intervention, and Early Intervention. For each category the report presents:
    - Overview of programs
    - Numbers served
    - Number of referrals made
    - FY 2023-24 demographics
    - FY 2023-24 outcome highlights
- The section concludes with an overarching discussion of PEI outcomes and recommendations for PEI improvement.

Program-Level Summaries

- For all individual programs in each reporting category, the report presents:
    - Program description
    - Numbers served (fiscal years based on data availability)
    - Program outcomes (fiscal years based on data availability)

EVALUATION HIGHLIGHTS

PREVENTION PROGRAM HIGHLIGHTS

Programs

- Health Ambassador Program (HAP)
- Health Ambassador Program – Youth (HAP-Y)
- Health Equity Initiatives (HEIs)
- Help@Hand
- Increasing Recognition of Early Signs of Mental Illness (Mental Health First Aid)
- Outreach Collaboratives
- Parent Project
- Storytelling Program/Photovoice
- Stigma Reduction Program
- Suicide Prevention Program
- Trauma-Informed Co-occurring Services for Youth (Mindfulness Based Substance Abuse Treatment (MBSAT); Panche/GiraSol)

By The Numbers

Clients served (unduplicated)		
FY 2021-22	FY 2022-23	FY 2023-24
1,795	**2,492**	**2,768**

Individuals reached (duplicated)		
FY 2021-22	FY 2022-23	FY 2023-24
45,531	**36,638**	**38,701**

Referrals made (all fiscal years)			
SMI	SUD	Other Mental Health	Other Programs
6	**2**	**16**	**4**

Demographics (Unduplicated, FY 2023-24)

Programs included: HAP, HAP-Y, MBSAT (StarVista and YMCA), Parent Project, AMHFA, YMHFA, Stigma Reduction Program, Suicide Prevention Program [3]

Programs not included: MBSAT Puente, Girasol/Panche, HEIs, Help@Hand, Outreach Collaboratives, Digital Storytelling/Photovoice

	Number	Percent
Age (n=731)		
0–15	19	3%
16–25	178	24%
26–59	465	64%
60-73	49	7%
74+	20	3%

[3] Data exclude "Prefer not to Answer/Unknown" responses. Data were only available for some programs and categories, so the number (n) differs for each demographic section. Primary language was not available for Suicide Prevention programs. There were insufficient data to report on sex assigned at birth, intersex, disability status, and veteran status.

	Number	Percent
Primary language (n=706)		
English	447	63%
Spanish	179	25%
Another language	80	11%
Race/Ethnicity (n=728)		
Asian/Asian American	157	22%
Black or African American	43	6%
Native American/American Indian or Indigenous	8	1%
Native Hawaiian or Pacific Islander	47	6%
White/Caucasian	133	18%
Latino/a/x or Hispanic	315	43%
Another race, ethnicity or tribe	43	6%
Gender Identity (n=729)		
Female/Woman/Cisgender Woman	549	75%
Male/Man/Cisgender Man	149	20%
Transgender Woman/Trans Woman/ Trans-Feminine/Woman	3	0%
Transgender Man/Trans Man/ Trans-Masculine/Man	2	0%
Questioning or unsure of gender identity	2	0%
Genderqueer/Gender Non-conforming/Gender Non-binary/ Neither exclusively female or male	10	1%
Indigenous gender identity	1	0%
Another gender identity	5	1%
Sexual orientation (n=677)		
Gay or Lesbian	22	3%
Straight or heterosexual	557	82%
Bisexual	46	7%
Queer	12	2%
Pansexual	9	1%
Asexual	10	1%
Questioning or unsure of sexual orientation	6	1%
Indigenous sexual orientation	1	0%
Another sexual orientation	6	1%

Outcome Highlights (FY 2023-24)

Stigma Reduction *Prevention programs reduced stigma around mental health and seeking help.*	**Access to Services** *Prevention programs increased clients' ability to navigate and access mental health services for themselves or their loved ones.*	**Cultural Humility/Identity** *Prevention programs increased knowledge about cultural humility and helped participants feel affirmed in their identities.*	**Knowledge, Skills, Abilities; Self-Empowerment** *Prevention programs helped participants increase their knowledge, skills, and confidence related to mental health and/or substance use.*
95% of Health Ambassador Program adults surveyed (n=44) agreed that due to the program, they **feel more comfortable seeking behavioral health services** for themselves or their family. **82%** of Stigma Reduction Program participants surveyed (n=179) agreed or strongly agreed that as a direct result of this program, they are more likely to **believe people with mental health and/or substance use conditions contribute much to society**; and **83%** reported that they are **more willing to seek professional support** for a behavioral health condition if needed. **71%** of Suicide Prevention Program participants surveyed (n=24) and **67%** of Parent Project participants surveyed (n=27) reported that due to the program, they **feel more comfortable talking about their mental health and/or substance use**.*	Through PEI programs, many participants have **learned knowledge and skills they can use to access mental health and substance use health services.*** • **100%** of HAP respondents (n=44) • **100%** of AMHFA respondents (n=73) • **98%** of YMHFA respondents (n=53) • **88%** of Suicide Prevention Program respondents (n=24) • **77**% of Parent Project respondents (n=26) **87%** of Stigma Reduction Program participants surveyed (n=179) indicated that as a result of the program, that they have **learned more about behavioral health services** they can reach out to. **62%** of audience members surveyed in HAP-Y presentations (n=644) reported that they **know who to call or access if they need mental health services**.	In many PEI programs, the majority of participants said that **their identity, cultural background, and experiences (race, ethnicity, gender, sexuality, religion, etc.) were affirmed** by the program/training/event.* • **95%** of HAP respondents (n=44) • **93%** of AMHFA respondents (n=120) • **86%** of YMHFA respondents (n=134) • **75**% of Parent Project respondents (n=24) • **58%** of Suicide Prevention Program respondents (n=24) **94%** of participants surveyed in AMHFA trainings (n=48) and **85**% of participants surveyed in YMHFA trainings (n=81) reported having a **better understanding of how mental health and substance use challenges affect different cultures**. **90%** of Stigma Reduction Program participants surveyed (n=179) reported that the **program was relevant to them and other people of similar cultural backgrounds and experiences**.	**100%** of HAP-Y ambassadors surveyed (n=37) reported that the program provided them with **knowledge and skills that they continue to use**. **98%** of HAP adults surveyed (n=44) reported that due to the program, they are **more confident in their ability to advocate for themselves and/or their child/children**. **100%** of MBSAT StarVista participants surveyed (n=15) reported that due to the program, they **feel in control of their life and future** and they **overcome challenges in a more positive way**. **72%** of MBSAT YMCA participants surveyed (n=50) reported that due to the program, they **practice self-care**. Among Be Sensitive Be Brave for Suicide Prevention participants surveyed (n=125 pre/n=100 post), **confidence in their ability to make a referral for someone in a suicide crisis** increased from 3.01 to 4.22 out of 5 from before to after the training.

**ODE Standard Indicator*

PREVENTION & EARLY INTERVENTION PROGRAM HIGHLIGHTS

Prevention & Early Intervention Programs

- Early Childhood Community Team (ECCT)
- Project SUCCESS
- The Cariño Project
- Older Adult Peer Counseling Program
- Youth Stabilization, Opportunity, and Support (Youth S.O.S.) Team

By The Numbers

Clients served (unduplicated)		
FY 2021-22	FY 2022-23	FY 2023-24
1,147	**1,317**	**1,550**

Individuals reached (duplicated)		
FY 2021-22	FY 2022-23	FY 2023-24
15,315	**14,382**	**13,600**

Referrals made (all fiscal years)			
SMI	SUD	Other Mental Health	Other Programs
70	**39**	**456**	**1,525**

Demographics (Unduplicated, FY 2023-24)

Programs included: ECCT, The Cariño Project, Older Adult Peer Counseling[4]

Programs not included: Project SUCCESS, Youth S.O.S.

	Number	Percent
Age (n=687)		
0–15	111	16%
16–25	15	2%
26–59	110	16%
60-73	119	17%
74+	332	48%
Primary language (n=687)		
English	277	40%
Spanish	301	44%
Another language	109	16%
Race/Ethnicity (n=817)		
Asian/Asian American	46	6%
Black or African American	8	1%
Native American/American Indian or Indigenous	5	1%
Native Hawaiian or Pacific Islander	0	0%
White/Caucasian	175	21%
Latino/a/x or Hispanic	334	41%
Another race, ethnicity or tribe	377	46%
Gender Identity (n=797)		
Female/Woman/Cisgender Woman	533	67%
Male/Man/Cisgender Man	254	32%
Transgender Woman/Trans Woman/ Trans-Feminine/Woman	0	0%
Transgender Man/Trans Man/ Trans-Masculine/Man	0	0%
Questioning or unsure of gender identity	0	0%
Genderqueer/Gender Non-conforming/Gender Non-binary/ Neither exclusively female or male	10	1%
Indigenous gender identity	0	0%
Another gender identity	0	0%

[4] Data exclude "Prefer not to Answer/Unknown" responses. Data were only available for some programs and categories, so the number (n) differs for each demographic section. There were insufficient data to report on sex assigned at birth, intersex, sexual orientation, disability status, and veteran status.

Outcome Highlights (FY 2023-24)[5]

Knowledge, Skills, and Abilities *PEI programs helped participants increase their knowledge, skills, and confidence related to mental health and/or substance use.*	**Connection and Support** *PEI programs increased feelings of support and connection to community, family, and/or providers.*	**General Behavioral Health and Utilization of Emergency Services** *PEI programs improved mental health symptoms for therapy/counseling clients.*
100% of youth surveyed (n=30) who received support from Youth S.O.S. crisis staff reported that they **learned a new coping strategy to increase mental, emotional, and relational functioning.** **100%** of Project SUCCESS middle schoolers surveyed (n=11) said that due to the program, they **understand the risks with the use of alcohol and substances**. **100%** of parents/caregivers in ECCT group services (n=3) reported that they **improved their parenting knowledge, skills, and abilities,** and **know where to go in their community for resources and support**. **86%** of Cariño Project participants surveyed (n=37) reported that they **learned something that is useful to them**. **75%** of Older Adult Peer Counseling individual clients surveyed (n=26) and **40%** of group clients surveyed (n=17) reported that the program improved their **knowledge and abilities to seek support**. **48%** of Project SUCCESS middle schoolers and fifth graders surveyed (n=29) reported that because of the program they have **ways to manage their big feelings**.	**100%** of parents/ caregivers in ECCT (n=3) reported that due to the program, they **feel more connected to other parents in their community**. **95%** of Older Adult Peer Counseling individual clients surveyed (n=26) and **73%** of group clients surveyed (n=17) reported as a result of the program, they **feel supported**. **86%** of Cariño Project participants surveyed (n=73) reported feeling **more connected to their community**. **78%** of Project SUCCESS fifth graders surveyed (n=18) reported that because of the program they can **identify trusted adults in their life and when to tell adults about their mental concerns.** **93%** of youth surveyed (n=30) who received support from Youth S.O.S. crisis staff reported that they can now identify and **feel safe reaching out and contacting at least one adult** when they are experiencing emotional distress.	**100%** of youth who received Youth S.O.S. services (n=30) were **diverted from the use of psychiatric emergency services** and **did not require law enforcement intervention**. **72%** of Older Adult Peer Counseling individual clients surveyed (n=26) and **42%** of group clients surveyed (n=17) reported **feeling less stressed** as a result of participating in the program. **71%** of Cariño Project clinical clients surveyed (n=7) reported an **improved ability to cope with stressors** due to participating in the program.

[5] Outcome data for Youth S.O.S. were not available for FY 2023-24, so data are from FY 2022-23.

EARLY INTERVENTION PROGRAM HIGHLIGHTS

Early Intervention Programs

- Primary Care Interface (PCI)
- (re)MIND Early Psychosis Program
- The Pride Center
- Ravenswood
- SMART

By The Numbers

Clients served (unduplicated)		
FY 2021-22	FY 2022-23	FY 2023-24
4,119	**1,517**	**1,542**

Individuals reached (duplicated)		
FY 2021-22	FY 2022-23	FY 2023-24
4,518	**11,015**	**14,015**

Referrals made (all fiscal years)			
SMI	SUD	Other Mental Health	Other Programs
74	**44**	**740**	**1,558**

Demographics (Unduplicated, FY 2023-24)

Programs included: (re)MIND, Primary Care Interface (PCI), San Mateo County Pride Center[6]

Programs not included: Ravenswood, SMART

	Number	Percent
Age (n=1,109)		
0–15	225	20%
16–25	222	20%
26–59	470	42%
60-73	192	17%
74+	0	0%
Primary language (n=218)		
English	212	97%
Spanish	4	2%
Another language	2	1%

[6] Data exclude "Prefer not to Answer/Unknown" responses. Data were only available for some programs and categories, so the number (n) differs for each demographic section. Language, intersex, gender identity, disability status, and veteran status were not available for PCI. There were insufficient data to report on intersex.

	Number	Percent
Race/Ethnicity (n=883)		
Asian/Asian American	56	6%
Black or African American	30	3%
Native American/American Indian or Indigenous	2	0%
Native Hawaiian or Pacific Islander	19	2%
White/Caucasian	133	15%
Latino/a/x or Hispanic	621	70%
Another race, ethnicity or tribe	643	73%
Sex assigned at birth (n=895)		
Male	376	42%
Female	519	58%
Gender Identity (n=220)		
Female/Woman/Cisgender Woman	50	23%
Male/Man/Cisgender Man	53	24%
Transgender Woman/Trans Woman/ Trans-Feminine/Woman	1	0%
Transgender Man/Trans Man/ Trans-Masculine/Man	66	30%
Questioning or unsure of gender identity	6	3%
Genderqueer/Gender Non-conforming/Gender Non-binary/ Neither exclusively female or male	43	20%
Indigenous gender identity	1	0%
Another gender identity	0	0%
Sexual orientation (n=292)		
Gay or Lesbian	35	12%
Straight or heterosexual	157	54%
Bisexual	33	11%
Queer	23	8%
Pansexual	21	7%
Asexual	7	2%
Questioning or unsure of sexual orientation	10	3%
Indigenous sexual orientation	0	0%
Another sexual orientation	8	3%
Disability Status (n=148)		
Yes	52	35%
No	96	65%
Veteran Status (n=137)		
Yes	0	0%
No	137	100%

Outcome Highlights (FY 2023-24)

General Behavioral Health *Early Intervention programs improved mental health symptoms for therapy/counseling clients.*	**Utilization of Emergency Services** *Early Intervention programs reduced the use of psychiatric emergency services.*	**Knowledge, Skills, Abilities; Self-Empowerment** *Early Intervention programs helped participants increase their knowledge, skills, and confidence related to mental health and/or substance use.*
96% of (re)MIND participants and alumni surveyed (n=79) experienced **improved engagement in meaningful activities** after the program; **82%** of (re)MIND clients assessed for psychosis (n=17) had their **psychosis score improve or maintained a positive score**. **89%** of the PCI clients surveyed (n=123) agreed or strongly agreed that they are better able to **manage their symptoms and participate in daily life**. **86%** of Pride Center clinical clients assessed post-intervention for depression (n=35) had their **depression score improve or maintained a positive score**; **83%** of Pride Center clinical clients surveyed (n=35) reported that their **mental health improved or remained consistent** in the past 30 days.	**95%** of (re)MIND participants and alumni surveyed (n=79) had a **reduction in hospitalizations** (number of days and number of episodes) The SMART program received **245 calls** and **met or exceeded its goal of diverting at least 10% of calls from psychiatric emergency services admission** (where a 5150 hold was not already placed). In each of the first three quarters of FY 2023-24, over 30% of calls were diverted.	**93%** of (re)MIND participants and alumni surveyed (n=27) reported that due to the program, they **can take control of personal aspects of their life**. **88%** of PCI participants surveyed (n=123) reported that they I **learned skills and strategies to cope with stressors**. **86%** reported that they **think more positively about challenges** and believe the decisions and steps they take impact their outcome. **74%** of Pride Center clinical clients surveyed (n=35) reported that their **confidence in affecting their life through the decisions they make** improved or remained consistent.

Overall, BHRS's MHSA-funded PEI programs have supported access to services and strengthened general behavioral health by promoting protective factors and reducing stigma around behavioral health and help seeking. Protective factors—including social connection, cultural identity formation, and self-empowerment—build resilience and lower the risk of developing mental health and substance use challenges.[7] Reducing stigma around behavioral health can increase the potential of help seeking for behavioral health challenges.[8]

PEI Program and Strategy Outcomes

Prevention Programs | *Goal: Reduction in risk factors, indicators, and/or increased protective factors*

Despite limitations in the evaluation, there is enough consistency in results within and across programs and years to reasonably conclude that MHSA-funded Prevention programs are increasing knowledge and access for large proportions of participants. Programs that focused on behavioral health awareness and stigma showed increases in self-reported knowledge about behavioral health topics and resources and reductions in stigma in all years, generally for the majority of participants and often for the large majority of participants. In general, survey responses indicated higher increases in knowledge than in skills/abilities/confidence, as the latter require more time and practice. As mentioned in the limitations section, there were some variations in outcomes within and across programs and years (e.g., drops or increases in self-reported positive outcomes from one year to the next) that are difficult to understand without knowing more about why those differences occurred. Data also suggest that Prevention programs strengthened protective factors including connection and support, self-empowerment, community advocacy, and cultural identity for the participants surveyed.

Stigma and Discrimination Reduction Program | *Goal: Changes in attitudes, knowledge, and/or behavior related to mental illness and seeking mental health services*

Mental health awareness events as part of ODE's Stigma and Discrimination Reduction Program positively impacted the attitudes that survey respondents may have held around others with

[7] Kapil, R. (2022, January 18). *How Protective Factors Can Promote Resilience - Mental Health First Aid*. Mental Health First Aid. https://www.mentalhealthfirstaid.org/2022/01/how-protective-factors-can-promote-resilience/; Substance Abuse and Mental Health Services Administration. (n.d.). *Risk and Protective Factors for Mental, Emotional, and Behavioral Disorders Across the Life Cycle*. https://iod.unh.edu/sites/default/files/media/Project_Page_Resources/PBIS/c3_handout_hhs-risk-and-proetctive-factors.pdf

[8] Beers, N., & Joshi, S. V. (2020). Increasing Access to Mental Health Services Through Reduction of Stigma. *Pediatrics, 145(6).* https://doi.org/10.1542/peds.2020-0127

behavioral health challenges. The events also impacted attitudes and intended behavior around seeking behavioral health services for themselves if needed. Events also increased access to services by improving respondents' knowledge about behavioral health services that they can reach out to.

Suicide Prevention Program | ***Goal: Changes in attitudes, knowledge, and/or behavior regarding suicide related to mental illness***

Though surveys were only available for a smaller subset of participants in Suicide Prevention Month events, survey results indicate that event participants learned critical information that they can use for themselves and to support others. Many participants learned about warning signs and resources, and most reported being more willing to reach out and help others in their community who may be at risk of suicide. Participants also reported that due to the events, they were more comfortable talking about their mental health, gained knowledge and skills to care for themselves and seek help if needed, and gained information and skills they can use to access mental health and substance use services.

Early Intervention Programs & Some Prevention Programs| ***Goals: Reduction in risk factors, indicators, and/or increased protective factors; improved general behavioral health***

Prevention and Early Intervention programs strengthened protective factors including knowledge and skills around mental health and substance use, coping strategies for strong emotions, and feelings of connection and support among both youth and adult clients/participants, though there was some variation in the proportion of respondents reporting positive results. In several youth programs, a majority of survey respondents expressed that they can identify and reach out to trusted adults; in several adult programs, a majority of survey respondents reported feeling more connected to their families and communities.

Programs that focused on decreased use of psychiatric emergency services had over 90% success rates in most cases. Programs that used validated instruments to measure a reduction in behavioral health symptoms (e.g., depression and anxiety) indicated that the large majority of clients improved their scores or maintained a positive score.

Self-reported general behavioral health outcomes were overall positive, with a majority of survey respondents in most programs reporting feeling less stressed or better able to manage their symptoms and participate in daily life, though there was some variation in positive outcomes across years, programs, age groups, and individual and group services.

Access and Linkage to Treatment Strategy | *Goal: Early connection of individuals with severe mental illness to necessary care and treatment*

In terms of self-reported access to services, clients across numerous PEI programs consistently reported increases in their awareness of behavioral health services that they can access, and their ability and willingness to seek services when needed.

Available data show that over the evaluation period, PEI programs made **150** referrals for serious mental illness, **85** referrals for substance use services, and **1,212** referrals for other mental health services, with Early Intervention programs making the highest numbers of referrals. As mentioned in the limitations section, these numbers are likely undercounted.

Improving Timely Access to Services for Underserved Populations Strategy | *Goal: Early connection of individuals or families from underserved populations to necessary culturally informed behavioral health services*

Having MHSA housed under ODE forms a foundation of diversity, equity, and inclusion for PEI programs. Sustained relationships between ODE and communities, especially underserved communities, have developed into meaningful partnerships that optimize BHRS's ability to stay connected to community so that the voice of marginalized communities is at the center of the Community Program Planning (CPP) process, and community voice is included in the design, implementation and evaluation of programs. Demonstrating a commitment to understanding and addressing how health disparities, health inequities, and stigma impact an individual's ability to access and receive behavioral health and recovery services, ODE works to promote cultural humility and inclusion within BHRS and in partnerships with communities through the following programs:

- Health Equity Initiatives (HEIs)
- Health Ambassador Program (HAP)
- Adult Mental Health First Aid (AMHFA)
- Digital Storytelling and Photovoice
- Parent Project
- Stigma Free San Mateo – Be the ONE Campaign
- San Mateo County Suicide Prevention Committee

During the three-year evaluation period, PEI programs continued to be either adapted or developed based on identified community needs. Efforts to reach diverse populations included new programs and trainings in different languages (e.g., cultural and linguistic adaptations of trainings in Tongan, Cantonese, Mandarin). The HEIs and Outreach Collaboratives partnered with community-based organizations to put on events led by and for members of underserved populations.

People are more likely to trust and engage in behavioral health programs and services if they feel respected and understood. On the whole, clients/participants surveyed through PEI programs felt that the programs/trainings/events they attended affirmed their identity, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion, etc.).

San Mateo County's population is 35.5% White, 24.8% Hispanic/Latinx, 33.1% Asian/Asian American, 5.0% mixed race, 2.7% Black/African American, 1.4% Native Hawaiian and Other Pacific Islander, and 1.0% American Indian and Alaska Native.[9] Over one-third (35.6%) immigrated from another country, and 45.3% speak a language other than English at home.[10] BHRS data on penetration rates show that youth, substance use services, and Latinx and Native Hawaiian and Pacific Islander communities have lower engagement in behavioral health services compared to like-size counties or the state. Given that a number of programs were missing demographic data or only collected data for a subset of their clients, it is difficult to make conclusions based on the available demographic data. Based on the available data for FY 2023-24 for *unduplicated clients*, PEI programs served a higher proportion of Hispanic/Latinx individuals compared to the county population, and lower proportions of Asian/Asian American and White individuals compared to the county. The available data show that Prevention programs served the highest proportion of Asian/Asian American clients (22%), while Prevention & Early Intervention or Early Intervention programs served limited numbers of Asian/Asian American clients (6% in each reporting category). *Note that these numbers do not include unduplicated clients reached, so they are not a full measure of the extent to which PEI programs reached underserved populations.*

PEI Data and Reporting Recommendations

The following are recommendations as BHRS continues to strengthen data collection and reporting for PEI programs.

1. Continue to increase consistency in existing data collection, specifically:
    a. Where appropriate, work toward greater standardization of indicators reported across programs.
    b. To the extent possible, increase response rates for surveys so that data are more representative of the clients/participants served.
    c. Work to improve consistency and completeness of demographic data collection.
2. Expand qualitative data collection to gather in-depth client perspectives, understand differences in outcomes, and inform opportunities for program improvement.

[9] U.S. Census QuickFacts: San Mateo County, California. https://www.census.gov/quickfacts/fact/table/sanmateocountycalifornia/PST045224
[10] San Mateo County Demographics. County of San Mateo, County Executive's Office, Office of Community Affairs. https://www.smcgov.org/ceo/san-mateo-county-demographics-0

PREVENTION PROGRAM SUMMARIES

HEALTH AMBASSADOR PROGRAM (HAP)

The Health Ambassador Program (HAP) was created in 2014 out of a desire for community members—who are committed to helping their families and neighbors—to improve their quality of life, continue learning, and increase their involvement in community services. HAP was developed in recognition of the important role that community members serve in effectively reaching out to others. To become a Health Ambassador, community members must complete five courses related to behavioral health knowledge and skills, stigma reduction, lived experience, and community advocacy. HAP goals include:

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

Numbers Served

Health Ambassador Program	FY 2021-22	FY 2022-23	FY 2023-24
Clients served (unduplicated)	56	63	96
Cost per client	$2,723	$2,420	$1,719
Duplicated Clients Served (# of participants in HAP workshops/trainings	*No data*	*No data*	192
Individuals reached (duplicated)	16,000	5,000	187
Total individuals served	16,056	5,063	475

** Unduplicated clients served include only the Health Ambassadors that were engaged during the FY, individuals reached includes the community that received training, education, workshops, etc.*

Program Outcomes

Data Collection Methods

- Health Ambassador/Prospective Health Ambassador Annual Survey[11]

[11] Outcome data were collected primarily in FY 2023-24. Two questions on the FY 2022-23 survey were aligned with the PEI outcomes and are included in the table below. Outcome data were not collected in FY 2021-22.

Outcome Highlights

- Health Ambassadors who completed the annual survey reported high levels of agreement across the various indicators, including: stigma reduction and increased access to services for themselves and their families; increased protective factors such as connection to family and community; and an increase in public-facing skills such as advocacy for their family and community.

Outcome Indicators

Domain	Indicators/Questions: HAP Annual Survey for Health Ambassadors and Prospective Health Ambassadors	Percent Agree or Strongly Agree (2022-23 n=23/ 2023-24 n=44)
Connection and Support	Due to my participation in HAP courses and/or activities, I feel more connected to my community/family.[12]	100%/93%
Cultural identity/ humility	I feel like my identity, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion, etc.) were affirmed by HAP courses.	95%
Community Advocacy	Due to my participation in HAP courses and/or activities, I am more confident in my ability to create change in my community.	93%
Self-Empowerment	Due to my participation in HAP courses and/or activities, I am more confident in my ability to advocate for myself and/or advocate for my child/children.	100%/98%
Stigma Reduction	Due to my participation in this course, I feel more comfortable seeking mental health and/or substance use services for myself and/or my family.	95%
Improved knowledge, skills, and/or abilities	Through my participation in this course, I've learned knowledge and skills that I can use to access mental health and/or substance use health services.	100%
Access to services	Through my participation in this course, I and/or my family have been connected to mental health and/or substance use services/resources that have been helpful.	86%

[12] FY22-23 asked about "community"; FY23-24 asked about "family."

Quotes from Ambassadors:

"In the classes and the support groups I facilitate, I reach a large group of people to whom I refer different services. It is a calling to help others; for me, it's especially in the mental health field. I have a passion for what I do, and helping others fulfills me."

"Personally, I am very happy to have finished this program. It has contributed to my self-development, as a woman and as a human being. It has helped me understand my fellow community members more, to not judge anyone, and to always move forward. Thank you very much to all of you who make all this possible."

Photo: Health Ambassadors tabling at an event

HEALTH AMBASSADOR PROGRAM - YOUTH (HAP-Y)

The Health Ambassador Program for Youth (HAP-Y) engages youth ages 16-24 in training and workshops on behavioral health and mental wellness. HAP-Y aims to train participants as mental health ambassadors in their communities to help reduce stigma, increase mental health awareness, and share resources. To prepare youth to support their peers, participants engage in a 14-week training program that focuses on psychoeducation and suicide prevention workshops.

To encourage youth to be active advocates, participants are required to participate in three community involvement activities in which they educate their peers, share resources, and share personal lived experiences (when appropriate). The community presentation that ambassadors conduct entails an introduction to mental health; discussing stigma and how it plays a role in whether individuals seek support for their mental health; depression, stress, anxiety, and healthy coping skills to address those symptoms; and a suicide prevention component on recognizing the signs, helpful things to say, and resources available.

Numbers Served

HAP-Y*	FY 2021-22	FY 2022-23	FY 2023-24
Clients served (unduplicated)	31	43	47
Cost per client	$8,065	$5,988	$6,471
Individuals reached (duplicated)	143	739	1,167
Total Served	174	782	1,214

** Unduplicated clients served are the youth Health Ambassadors, individuals reached includes the broader community receiving training, education from the ambassadors.*

Program Outcomes

Data Collection Methods

- Cohort/Ambassador exit survey
- Audience surveys at HAP-Y presentations

Outcome Highlights

- Youth Ambassadors increased their comfort in discussing mental health topics, which helped them feel able to contribute to other people's learning about mental health. Many continue to use the knowledge and skills they learned in the program. Over two-thirds of Ambassador survey respondents reported that participating in HAP-Y led them to consider a career in mental health in FYs 2021-22 and 2022-23 (when this survey question was asked). Levels of agreement with most survey questions were lower in FY 2023-24 than in previous years.

- Speaking to access to services, the most common outcome for audience survey respondents was learning about resources to access if they needed mental health services. Speaking to stigma reduction, at least 40% of audience survey respondents in each year reported that they feel comfortable seeking mental health services. Generally, survey respondents in FY 2021-22 had higher levels of agreement with survey questions than FYs 2022-23 and 2023-24.

Outcome Indicators

Outcome Domain	HAP-Y Ambassador Survey	Percent Agree or Strongly Agree		
		2021-22 (n=20)	2022-23 (n=43)	2023-24 (n=37)
Stigma reduction	I feel comfortable discussing topics related to mental health.	70%	86%	41%
Stigma reduction	I was able to speak up about difficult topics, including mental health.	-	-	41%
Community advocacy	After participating in HAP-Y, I am able to contribute to other people's learning about mental health.	80%	93%	49%
Self-empowerment	Participating in HAP-Y, led me to consider a career in mental health-related field	65%	77%	-
Self-empowerment	Due to participating in this program, I think more positively about challenges in my life.	-	-	49%
Knowledge, skills, and/or abilities	HAP-Y provided me with knowledge and skills that I continue to use.	-	65%	100%
Connection and support	I feel part of a community.	-	-	49%

Outcome Domain	Audience Survey	Percent Agree or Strongly Agree		
		2021-22 (n=174)	2022-23 (n=624)	2023-24 (n=644)
Stigma reduction	I feel comfortable discussing topics related to mental health.	67%	48%	27%
Stigma reduction	I feel comfortable seeking mental health services.	60%	47%	42%
Access to services	I know who to call or access online if I need mental health services.	74%	59%	62%

Quotes from Youth Ambassadors:

"Something that I feel so blessed to have gotten from HAP-Y was being able to share my personal experiences with my peers and letting them know that they are not alone. Hearing everyone talk about their mental health made it feel like an extremely safe place."

"My experience with presentations was greatly beneficial to myself, being able to show facts to others and enlighten not only them but myself is a great experience. Before I was unsure, but after I was more confident about my ability to share this knowledge."

Photo: Youth Ambassadors

"I was so excited to present what I had learned through HAP-Y and share all the new information I had gathered through my training. I felt very proud and as if I was contributing a positive thing for the environment."

Quotes from Audience Members:

"It helped me understand that I am not alone on my journey and that there are others around who are willing to help me."

"The presentation was helpful, as I am someone who struggles with mental health from time to time, especially with having depression. Now I know I have access to more resources than I thought."

HEALTH EQUITY INITIATIVES (HEI)

Out of both opportunity and great need, BHRS created Health Equity Initiatives (HEIs) that have become vehicles to promote cultural humility and community empowerment. The HEIs address health disparities, inequities, and stigma by working collaboratively to bring together mental health professionals, residents, clinicians, organizations, and stakeholders on a regular basis to provide outreach, programs, and advocacy towards meaningful solutions for our communities.

ODE provides oversight to nine HEIs representing specific ethnic and cultural communities that have been historically marginalized. Below is a high-level statement of purpose for each initiative:

- **African American Community Initiative (AACI)** aims to be a known resource and support system for African American community members facing challenges with finding and utilizing mental health services while addressing inequalities faced by African Americans in the County.
- **Chinese Health Initiative (CHI)** works with the community to empower and to support better outcomes for prevention, outreach, and referrals, while also advocating for services to be in the appropriate language and culturally relevant to community members.
- **Filipino Mental Health Initiative (FMHI)** seeks to connect and empower Filipinos towards mental health and social services and reducing stigma, while advocating for culturally appropriate services through provider collaboration.
- **Latino/a/x Collaborative (LC)** promotes holistic practices that integrate Latino/a/x heritage, culture, spirituality, and family values to destigmatize mental health services and treatments in the community.
- **Native and Indigenous Peoples Initiative (NIPI)** was created to bring a comprehensive revival of Native American community in San Mateo County through awareness, health education, and outreach which honors culturally appropriate, traditional, Native healing practices.
- **Pacific Islander Initiative (PII)** aims to address health disparities experienced by Pacific Islander families and to help change systems and policies to better meet community needs through awareness, prevention, capacity building, and leadership.
- **PRIDE Initiative** uses an interdisciplinary and inclusive approach to support and advocate for the well-being of lesbian, gay, bisexual, transgender, queer, questioning, intersex, and two-spirit (LGBTQQI or LGBTQ+) communities across the county.

- **Spirituality Initiative (SI)** works to build opportunities for community members, families, and providers to collaboratively explore, increase awareness of, and support spirituality and its relationship to health and well-being.
- **Diversity and Equity Council (DEC)** is an advisory board to assure BHRS policies are designed and implemented in a manner that strives to decrease health inequalities and increase access to services.

Numbers Served

Health Equity Initiatives	FY 2021-22	FY 2022-23	FY 2023-24
Individuals reached (duplicated) Through HEI Monthly Meetings	*See totals below*	*See totals below*	1,262
Individuals reached (duplicated) Through HEI Trainings and Events	*See totals below*	*See totals below*	8,231
Total individuals served (duplicated)	5,585	7,763	9,493
Total cost per client	$55	$21	$41

** Unable to report unduplicated clients; HEIs focused on broad community awareness and system change strategies (presentations, events and trainings).*

Program Outcomes

Data Collection Methods

- Program participant post-program evaluation form[13]

Outcome Highlights

- Of the sample of HEI events shown below, average ratings were at least an 8 out of 10 for all ODE indicators, and highest for cultural humility, stigma discrimination reduction (external), self-empowerment, and access to services.

Outcome Indicators

- **In FY 2023-24**, HEIs held **23** community-driven events and **21** presentations related to behavioral health throughout the year. Below are highlights from post-program surveys from several HEI events.

[13] FY 2023-24 data are presented. In FY 2023-24, all HEIs began using the ODE indicators for their evaluation forms. In previous years, different evaluation questions and rating scales were used.

ODE Indicators: FY 2023-24	**AACI**: Black History Month Celebration (n=83)	**CHI**: "What I Wish My Parents Knew" Workshop (n=9)	**LC**: Sana Sana Colita de Rana! (n=58)	**PII**: Journey to Empowerment (J2E) (n=19)	**PRIDE Initiative**: Pride "Love at our Core, 2024" (n=454)	**Spirituality Initiative**: Interfaith Day of Prayer (n=25)
	Average Ratings on a Scale of 1-10					
1. Self-Empowerment: Due to my participation in this program/training/ event, I am more confident in my ability to advocate for the behavioral health needs of myself and/or my child/ren and/or another family member.	8.29	8.78	9.22	7.58	8.9	7.88
2. Community Advocacy: Due to my participation in this program/training/ event, I feel more confident in my ability to create change in my community.	8.29	7.89	8.47	7.53	8.8	7.48
3. Cultural Humility/ Identity: I feel like my identity, cultural background, and experiences (race, ethnicity, gender, religion, etc.) were affirmed by this program/training/event.	8.29	8.78	9.79	7.42	9.1	7.96
4. Access to Services Through my participation in this event/program/training, I have learned knowledge and skills that I can use to access behavioral health services.	8.35	8.78	8.98	7.84	8.7	8.08
5a. Stigma Discrimination Reduction (self/internal): Due to this program/training/event, I feel more comfortable talking about my mental health and/or substance use.	8.12	8.11	8.31	7.47	8.7	7.96
5b. Stigma Discrimination Reduction (external): This program/training/ event affirmed that people with mental illness are capable and able to make positive contributions to society.	8.68	8.67	8.78	8.16	8.9	8.24

HELP@HAND

The purpose of Youth Leadership Institute's (YLI) Help@Hand program, a new PEI initiative implemented in FY 2023-24 as part of the broader Help@Hand project, is to support youth ages 15-25 years old in San Mateo County by reducing the stigma associated with mental health through innovative, youth-led initiatives. This YLI program within Help@Hand promotes access to behavioral health services, social connectivity through peers, and supports self-directed mental wellness and recovery goals. Help@Hand is dedicated to improving timely access and creating vital linkages for underserved populations, particularly youth living in Half Moon Bay, by connecting them with guest speakers, service providers, and opportunities that offer mental health support, education, and resources. Help@Hand youth have expanded their mental health education by creating podcast episodes based on youth's mental health presentations. Youth also developed a mental health youth needs survey in collaboration with other youth programs in San Mateo County to understand the mental health challenges, resource accessibility, and support needs among young people.

Numbers Served

YLI Help@Hand	FY 2023-24
Clients served (unduplicated)	10
Cost per client	$15,000
Individuals reached (duplicated)	109
Total Served	**119**

*Unduplicated clients served are youth in the Help@Hand program; duplicated individuals reached are youth reached through community outreach presentations, tabling events, and the mental health youth needs survey.

Program Outcomes

Data Collection Methods

- Survey data will be collected beginning in FY 2024-25.

Outcome Highlights

- While no quantitative data have been collected yet, YLI observed that targeted education and outreach led to youth promoting open conversations about mental health in their peer groups, family, school, and communities. YLI observed that by addressing youth-identified mental health topics such as school climate, social media and mental health, technology and mental health, and cultural stigma, youth fostered meaningful discussions that resonated with both youth and adults.
- By sharing information in a podcast, youth ambassadors reach their peers and San Mateo County youth outside of the school setting, further promoting and destigmatizing seeking mental health support and breaking down barriers of stigma.

ADULT MENTAL HEALTH FIRST AID (MHFA)

Adult Mental Health First Aid (AMHFA) is an 8-hour public education provided by ODE, which partners with community organizations to facilitate AMHFA courses. The course introduces participants to the unique risk factors and warning signs of mental health issues in adults, builds understanding of the importance of early intervention, and teaches participants how to help an individual in crisis or experiencing a mental health challenge. AMHFA aims to teach community members and partners in San Mateo County by:

- Incorporating culturally humble questions, examples, and resources to help participants to intervene with and refer behavioral health services to marginalized populations in a more culturally responsive way.
- Sharing mental health facts and stories of hope and recovery which both help reduce stigma of mental health issues and conditions.
- Sharing local resources participants can refer to for professional behavioral health support, including public health services.
- Partnering with agencies that connect marginalized communities to care, including those serving older adults and immigrant communities to reduce disparities in access to care.

Numbers Served

Adult Mental Health First Aid	FY 2021-22	FY 2022-23	FY 2023-24
Total clients served	165	124	183
Total cost per client	$436	$580	$962

Program Outcomes

Data Collection Methods

- Pre-program assessment, post-program assessment, and 3-to-6-month follow-up survey (administered by an external consultant).

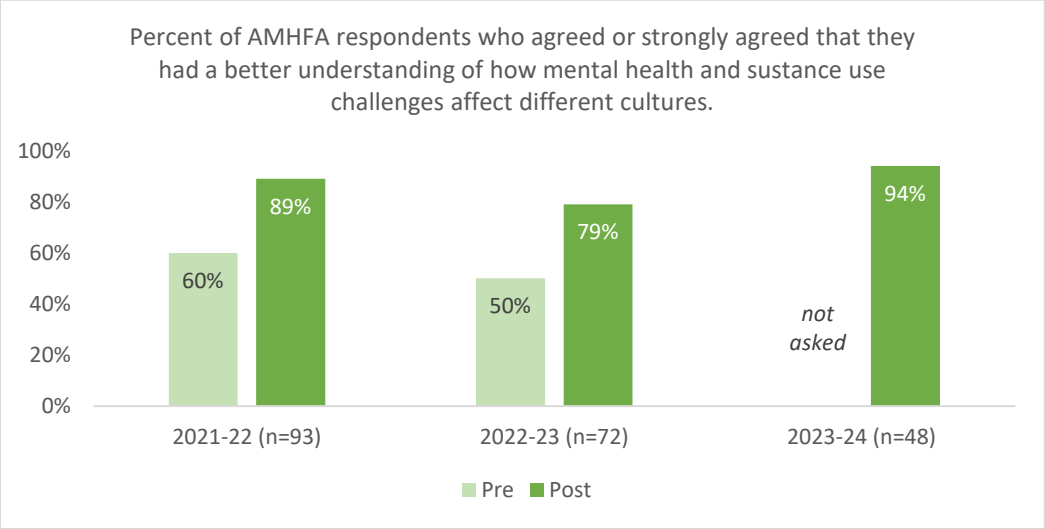
Outcome Highlights

- On average, participants' knowledge, confidence, and cultural awareness increased in almost all areas from before to after the course. The largest increases in knowledge appeared to be in unlearning misconceptions, whereas the majority participants came into the course already having some knowledge about trauma, risk factors, and cultural responsiveness.

Outcome Indicators[14]

Cultural identity/humility

Participants in all fiscal years reported an increase in understanding of how behavioral health challenges affect different cultures.



ODE Indicators[15]

Domain	ODE Indicators: FY 2023-24	Number	Percent
Cultural Identity/humility	As a result of this training, I have a better understanding of how mental health and substance use challenges affect different cultures.	45 of 48	94%
	I feel like my identity, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion, etc.) were affirmed by this program/training/event.	112 of 120	93%

[14]New surveys were implemented in February 2024. While the new surveys were finalized, participants completed the old versions of the surveys, which had some differing questions. This resulted in some questions being asked on some surveys and not others, which impacted the total number of respondents for certain questions and the ability to compare across years. Separate tables are presented for each fiscal year highlighting the survey questions asked.

[15] Data available for FY 2023-24

Access to Services	Through my participation in this event/program/training, I have learned knowledge and skills that I can use to access behavioral health services.	73 of 73	100%

Increases in knowledge, skills, and/or abilities[16]

- FY 2022-23
  - Participants demonstrated increases in knowledge related to asking others about suicidal feelings, distinguishing a panic attack from a heart attack, understanding common mental health disorders, and identifying a misconception around mental illness and violent crimes (n=80).
  - All indicators of confidence in assisting someone in crisis or experiencing a mental health challenge doubled from course application to the six-month follow-up assessment, including confidence in recognizing signs and misconceptions around behavioral health challenges, as well as reaching out and assisting someone in seeking help and support when in crisis (n=9).
- FY 2021-22
  - Participants demonstrated increases in knowledge, with an increase in correct answers across all questions from the pre-program to post-program survey (n=110).
  - In the six-month follow-up survey, all respondents indicated they have confidence that they can reach out to a person who may be dealing with a mental health problem, substance use challenge or crisis; and can recognize and correct misconceptions about mental health, substance use, and mental illness (n= 8).

[16] Data available for FYs 2021-22 and 2022-23

YOUTH MENTAL HEALTH FIRST AID (MHFA)

Youth Mental Health First Aid (YMHFA) is a 6-8-hour public education training program provided by ODE, which works in partnership with other community organizations to facilitate YMHFA courses. Specifically, the course introduces participants to the unique risk factors and warning signs of mental health issues in adolescents, builds understanding of the importance of early intervention, and teaches individuals how to help a youth in crisis or experiencing a mental health challenge.

Numbers Served

Youth Mental Health First Aid	FY 2021-22	FY 2022-23	FY 2023-24
Total clients served	*No data*	89	152
Total cost per client	*No data*	*No data*	$962

Program Outcomes

Data Collection Methods

- Pre-program assessment, post-program assessment, and 3-to-6-month follow-up survey (administered by an external consultant).

Outcome Highlights

- On average, participants' knowledge, confidence, and cultural awareness increased after the course, improving their ability to help young people experiencing mental health distress or crisis. Speaking to access to services, respondents also reported gaining information that they can use to access behavioral health services.

Outcome Indicators[17]

ODE Indicators: 2023-24

Domain	ODE Indicators: FY 2023-24	Number	Percent
Cultural Identity/Humility	As a result of this training, I have a better understanding of how mental health and substance use challenges affect different cultures. I feel like my identity, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion, etc.) were affirmed by this program/training/event.	69 of 81 115 of 134	85% 86%
Access to Services	Through my participation in this event/program/training, I have learned knowledge and skills that I can use to access behavioral health services.	52 of 53	98%

Knowledge, skills, and/or abilities: 2022-23

- From the pre to post assessment (n=58), participants demonstrated significant increases in knowledge related to understanding and communicating with youth about suicide. Participants improved their understanding about language to use when asking a young person about suicide (45% to 93%), understanding that when talking to a young person in crisis it is not necessarily best to give them advice (63% to 100%), and understanding that self-harm should not be equated with a failed suicide attempt (66% to 97%), among other topics.
- There were no six-month follow-up assessment responses available at the time of this report, which does not allow for reporting changes in confidence. Data from the pre-assessment show that overall, around two-thirds of participants indicated confidence in each area before attending the YMHFA course.

Cultural responsiveness: 2022-23

- From pre to post assessment (n=54), the percent who agreed or strongly agreed that they have a better understanding of how mental health and substance use challenges affects different cultures increased from 70% to 94%.

[17]Data were available for FYs 2022-23 and 2023-24 only. New surveys were implemented in February 2024. While the new surveys were finalized, participants completed the old versions of the surveys, which had some differing questions. This resulted in some questions being asked on some surveys and not others, which impacted the total number of respondents for certain questions and the ability to compare across years. Separate tables are presented for each fiscal year highlighting the survey questions asked.

OUTREACH COLLABORATIVES

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

NORTH COUNTY OUTREACH COLLABORATIVE (NCOC)

The NCOC comprises five partner agencies located in the north sector of San Mateo County: Daly City Partnership, Daly City Youth Health Center, Pacifica Collaborative, StarVista, and Asian American Recovery Services/HealthRight360. NCOC's objectives are to connect individuals with mental health services, alcohol and substance use treatment, and other social services. The collaborative aims to reduce stigma and discrimination surrounding mental health, alcohol, and other drug issues within the community by increasing awareness of available resources through education and improving access to care. This approach enhances the BHRS's capacity and overall system performance in addressing the needs of prominent populations in North San Mateo County, including Filipino, Pacific Islander, Latinx, Chinese, and LGBTQ+ communities.

Numbers Served

NCOC	FY 2021-22	FY 2022-23	FY 2023-24
Total clients served	7,577	4,573	8,322
Total cost per client	$15	$26	$42

Program Outcomes

Data Collection Methods

- Various agency-specific methods (e.g., client databases)

Outcome Highlights: FY 2023-24[18]

- **Daly City Youth Health Center (DCYHC)** participated in 25 outreach events in FY 2023-24, conducted 108 outreach efforts, and had a 100.8% increase in account engagement and growth in self-referrals. 71.1% of DCYHC clinical clients overall achieved reliable or clinically significant change (evidence-based outcome measurement system, PCOMS)

[18] Outreach Collaboratives were not required to collected quantitative outcome data in the same way as other PEI programs. Instead, each agency involved in the collaborative shared highlights of their successes. Program highlights from FY 2023-24 are presented here.

- **Asian American Recovery Services (AARS)** reached 41,323 individuals through their Essence of MANA program and Talanoa Tuesday live podcast, increasing Pacific Islander engagement with services. A participant in the Essence of MANA Parent Project shared:
    - *"Growing up in a Polynesian household, you know, you don't really hear 'I'm proud of you', or 'I love you' so I just really use a lot of positive words of affirmation. And, I love you a lot. Another thing is I definitely learned like a lot more about myself, you know. Instead of being mad at my daughter for not knowing how to do her homework. I learned to take a step back and learn patience with her instead of yelling at her."*
- **The Daly City Partnership (DCP)** community outreach efforts included social media presence and a quarterly newsletter reaching nearly 2,000 subscribers.
- **The Pacifica Collaborative (PAC)** and **Pacifica Resource Center (PRC)'s** Houseless on the Coast team implements consistent outreach to individuals living in RVs, vehicles, and encampments in Pacifica. In collaboration with Coast House, they supported a 69-year-old woman with complex needs secure a housing voucher and move into the Half Moon Bay Villages senior living facility. Their Safe Parking Permit Program has helped six individuals transition into permanent housing.
- **CoastPride** has delivered sexual orientation and gender identity (SOGI) training for all Pacifica School District staff, holds GSA clubs at both Pacifica high schools, and a middle school after-school group for LGBTQ issues. Pacifica's 3rd Annual Pride Parade attracted 2,000 attendees.

EAST PALO ALTO PARTNERSHIP FOR BEHAVIORAL HEALTH OUTREACH

The EPAPBHO collaborative is composed of community-based agencies from the East Palo Alto region of San Mateo County to provide culturally appropriate outreach, psychoeducation, screening, referral and warm hand-off services to East Palo Alto region residents. One East Palo Alto (OEPA) served as the lead agency and work in collaboration with El Concilio of San Mateo County, Free at Last and 'Anamatangi Polynesian Voices. The program goals are to increase access for marginalized ethnic, cultural and linguistic communities accessing and receiving behavioral health services, strengthen collaboration and integration, and establish strong linkages between the community and BHRS, and reduce stigma, including self-stigma and discrimination related to being diagnosed with a mental illness, substance use disorder or seeking behavioral health services.

Numbers Served

EPAPBHO	FY 2021-22	FY 2022-23	FY 2023-24
Total clients served	384	946	606
Total cost per client	$265	$116	$367

Program Outcomes

Data Collection Methods

- Various agency-specific methods (e.g., client databases, self-report)

Outcome Highlights: FY 2023-24[19]

- **Anamatangi Polynesian Voices (APV)** works within the County Juvenile system with young people referred by County Probation, providing cultural and linguistic support for these young men and their families and connecting them to other community programs.
    - **Client Success Story**: Mr. H arrived in the U.S. in 2019 from the Kingdom of Tonga and resides at the Good Samaritan Shelter in San Mateo while seeking employment. Mr. H successfully completed the 12-week Parent Project, applying the tools and strategies he learned to support his children in Tonga. He has become an integral part of Anamatangi's cultural initiatives and Cultural Practitioner Training.
- **El Concilio of San Mateo County (ECSMC)** engages community members, assesses them for mental health needs, and refers them to services.
    - **Client Success Story**: In one case, a single mother of two children came to ECSMC offices because her electricity had been shut off for two days. She was very distressed and nervous because her food had spoiled. ECSMC's Case Worker assisted her with submitting a financial assistance application and had her electricity restored within a few hours. While working with this client, staff also recognized she could benefit from mental health counseling and referred her accordingly.
- **Free at Last (FAL)** supports clients with co-occurring disorders or mental health issues who have successfully completed residential treatment by helping them find employment, referring them to housing, shelters, or reuniting them with their families.
    - **Client Success Story**: One client was facing incarceration, financial hardship, and substance dependency when she entered FAL's treatment program. Upon graduation, she successfully secured employment and continues to maintain her sobriety, embodying the positive change she set out to achieve.
- **The Barbara A. Mouton Multicultural Wellness Center (The Mouton Center/TMC)** has gradually reopened its programming hours and activities to the community since the pandemic. A significant success for The Mouton Center was the launch of Wellness Wednesdays for the community in May 2023. These sessions are open to the community to focus on wellness while enjoying healing activities. Topics have included painting, candle making, journaling, sharing one's narrative, musical breathing, and coloring for calm.
    - **Client Success Story**: One of TMC's clients, a mother of a child with special needs, shared that she attends the evening painting sessions as a self-care activity.

[19] Outreach Collaboratives were not required to collected quantitative outcome data in the same way as other PEI programs. Instead, each agency involved in the collaborative shared highlights of their successes. Program highlights from FY 2023-24 are presented here.

COASTSIDE COLLABORATIVE

The Coastside Collaborative provides culturally responsive outreach to the Coastside community and targets a broad community network with the goal of strengthening service collaboration, coordination, and integration into the Coastside region of San Mateo County. The Collaborative is co-chaired by the Youth Leadership Institute (YLI) and Ayudando Latinos a Soñar (ALAS).

Numbers Served

Coastside Collaborative	FY 2021-22	FY 2022-23	FY 2023-24
Total members	*No data*	94	*No data*
Total cost per client	*No data*	$478	*No data*

Program Outcomes

Data Collection Methods

- Various agency-specific methods (e.g., client databases)

Outcome Highlights: FY 2023-24[20]

- **Community Resource Guide**: The Coastside Collaborative revised the resource guide, incorporating information about Coastside services. Special emphasis was placed on highlighting the need for Mental Health resources. Distribution includes various platforms such as city websites, the chamber's local website, and ALAS.
- **allcove Presentation on Youth Mental Health Integrated Centers**: Collaboration with allcove aimed to enhance youth mental health services through integrated centers, reflecting a commitment to the well-being of young individuals in the community.
- **COVID-19 Updates and Vaccine Equity**: The Collaborative prioritized COVID-19 concerns by emphasizing preventive measures, including vaccination, ventilation, and mask usage.
- **Communication Challenges During Storms**: A focus was placed on identifying and strategizing solutions for communication challenges that arise during adverse weather conditions, ensuring effective communication within the community during such events.
- **Storm/Flood Impacts and Youth Assessments**: The Collaborative created a youth needs and challenges survey to better understand and address the needs of young people in the area.
- **Fire Season Preparedness**: The Collaborative ensured community preparedness for fire seasons by hosting CalFire presentations, focusing on educating and preparing the community for potential fire incidents.
- **Half Moon Bay Shooting Incident**: In response to the shooting incident in Half Moon Bay, the Collaborative addressed the aftermath and impact, with a focus on providing community support and considering mental health implications.

[20] Outreach Collaboratives were not required to collected quantitative outcome data in the same way as other PEI programs. Instead, each agency involved in the collaborative shared highlights of their successes. Program highlights from FY 2023-24 are presented here.

PARENT PROJECT®

The Parent Project® (PP, the program, or the course) is a free, 12-week course provided by ODE focusing on caregivers with children and adolescents who display challenging behavior(s). Classes meet weekly for three hours and the course is offered in both English and Spanish in virtual, in-person, and blended models. The PP course was created for anyone who cares for a child or adolescent and wants to learn how to respond to children's behaviors in a way that decreases unhealthy or dangerous behaviors while strengthening family relationships in a culturally informed manner. Throughout the course, parents and caregivers learn parenting skills and get information about resources and other support available in their communities. They learn specific prevention and intervention strategies and practice effective parenting skills such as appropriate ways to discipline, preventing or stopping alcohol and drug use, improving communication skills, and improving school attendance and performance. ODE works in partnership with other community organizations to facilitate PP courses.

Numbers Served

Parent Project®	FY 2021-22	FY 2022-23	FY 2023-24
Clients served (unduplicated): Program participants	110	152	50
Cost per client	*No data*	*No data*	$5,776
Individuals reached (duplicated)	*N/A*	*N/A*	*N/A*
Total Served	110	152	50

Program Outcomes

Data Collection Methods

- Pre-program assessment, post-program assessment, and six-month follow-up assessment

Outcome Highlights

- From before to after the course, participants reported increases in satisfaction with their parenting skills and their relationship with their child, as well as increases in knowledge and skills around relational practices, communication, and parenting skills.
- The majority of survey respondents demonstrated reduced stigma and increased access to behavioral health services.

Outcome Indicators

Domain	ODE Indicators/Questions (Asked in FY 2023-24 only)	Number	Percent
Access to services	Through my participation in the Parent Project® course, I have learned knowledge and skills that I can use to access behavioral health services.	20 of 26	77%
Cultural identity/humility	I feel like my identity, cultural background, and experiences (race, ethnicity, gender, religion) were affirmed by taking the Parent Project course.	18 of 24	75%
Stigma reduction	Due to this program, I feel more comfortable talking about my mental health and/or substance use.	18 of 27	67%

Outcome Domain	Participant Pre/Post Survey: FY 2023-24[21]	Change from Pre to Post Survey	
		Pre-survey (n=22-23)	Post-survey (n=26-29)
Self-empowerment	Percent satisfied or very satisfied with their parenting skills.	64%	90%
Knowledge, skills, and/or abilities	Percent satisfied or very satisfied with their relationship with their child(ren).	70%	86%
Knowledge, skills, and/or abilities	Percent who often or always define clear expectations for their child(ren).	74%	86%

Survey responses from 2022-23

- **Knowledge, skills, and/or abilities**: The number of respondents reporting satisfaction with their relationship with their child increased from 88% to 97% from pre to post survey (n=72). The number of respondents reporting satisfaction with their parenting skills increased from 87% to 97% from pre to post survey (n=71).
- **Connection and support**: After taking the course, 95% of respondents (n=70) reporting feeling supported, compared to 74% (n=55) before the course.

[21] Survey responses are shown in the table for FY 2023-24. While surveys were administered in FY 2021-22 and FY 2022-23, data were analyzed differently, and therefore results are not comparable across years. While only FY 2023-24 numbers are shown here, previous years also saw similar increases in participants' satisfaction with their parenting skills and their relationship with their child, as well as increases related to relational practices, communication, and parenting skills.

- **General behavioral health**: Of the nine respondents who that their child had been suspended prior to the Parent Project, six reported that their child had not been suspended since the Parent Project. Of the 21 respondents who reported disciplinary problems on the pre-program assessment, eight reported that their child has not had disciplinary problems since starting the course. Of the 13 that reported Child Protective Services (CPS) involvement in their pre-program assessment, 11 cited no CPS involvement in their post-program assessment. Half of the eight respondents who reported police involvement on the pre-program assessment indicated that there was no involvement in the post-program assessment.

Survey responses from 2021-22

- **Knowledge, skills, and/or abilities**: 94% of respondents reported being satisfied with their parenting skills; 100% reported being satisfied with the relationship with their child. Additionally, respondents reported fewer difficulties relating to communication with their child (89% at pre to 56% at post).
- **Connection and support**: 94% of respondents reported that they feel supported as a parent

Quotes from Parents

"Hearing from other parents what they experience with their children and how they handle it, even though the class explains it step by step…it is better to hear it from someone who lives it." – Survey Respondent, 2024

"I'm thankful for this amazing program, with wonderful facilitators…love the group of great parents sharing with each other about our parenting experiences. I learned so much." – Survey Respondent, 2024

Photo: Parent Project graduates

STORYTELLING PROGRAM/PHOTOVOICE

The 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.

In FY 2023-24, Storytelling/Photovoice devoted efforts to its program relaunch taking place in October 2024. The Photovoice program is expected to be fully operational in FY 2024-25.

No participant or outcome data are available from FYs 2021-22, 2022-23, or 2023/24. Below is an image from a Storytelling/Photovoice project where participants expressed their experiences with behavioral health challenges.

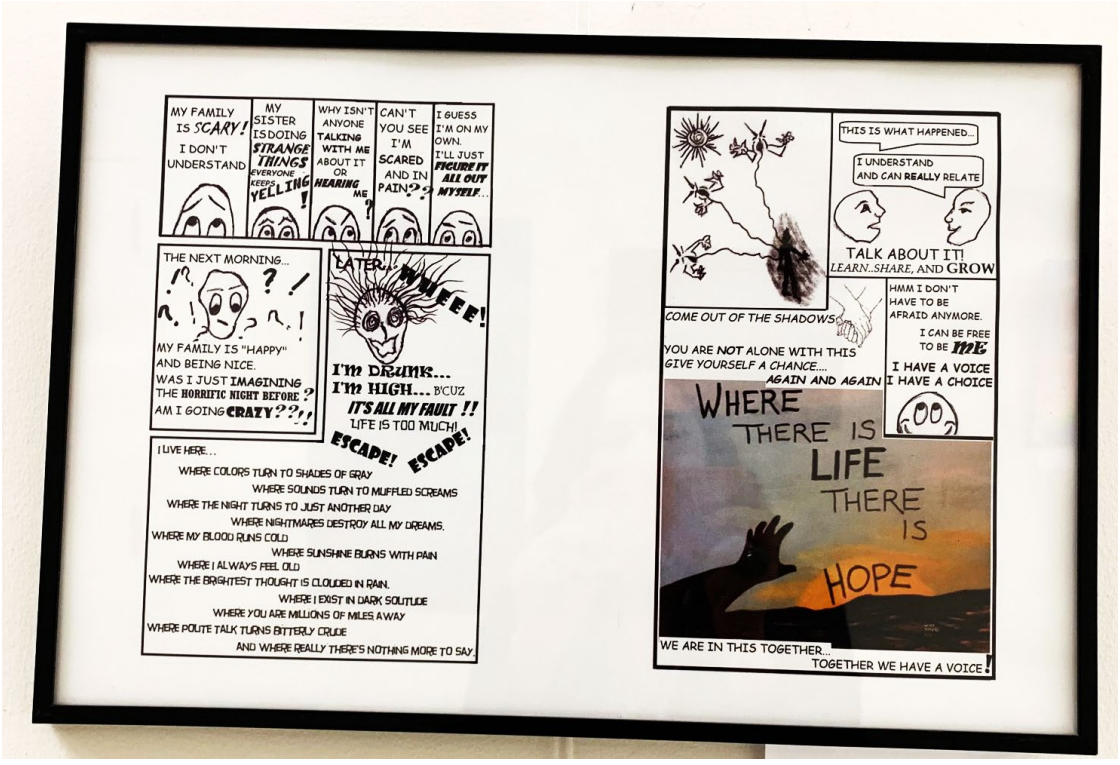


Photo: Photovoice example

STIGMA AND DISCRIMINATION REDUCTION

MENTAL HEALTH AWARENESS AND #BETHEONESMC CAMPAIGN

#BeTheOneSMC is San Mateo County's anti-stigma initiative. #BeTheOneSMC seeks to eliminate stigma against mental health and/or substance use by providing education and sharing stories of those with lived experience; improve timely access and linkage to treatment for underserved populations by raising awareness in the community; and reduce disparities and inequities to access to care by hosting activities that target specific marginalized communities in different regions of the county. #BeTheOneSMC's main message is that you can be that ONE who can make a difference in reducing stigma and promoting wellness in our community. Program activities center around the annual observance of May Mental Health Month (MHM) and include Advocacy Days, Mini-Grants and Event Support, and a widespread Communications Campaign.

Numbers Served

Mental Health Awareness	FY 2021-22	FY 2022-23	FY 2023-24
Total unduplicated individuals served through trainings and events	500	1,200	1,321
Total duplicated individuals reached through other outreach efforts (website, social media, etc.)	15,831	17,200	18,573
Total cost per client	$164	$123	$133
Total individuals served	16,331	18,400	19,894

Program Outcomes

Data Collection Methods

- Survey of MHM event participants
  - FY 2021-22: 160 survey responses collected from 20 out of 43 MHM events
  - FY 2022-23: 83 survey responses collected from 13 out of 23 MHM events
  - FY 2023-24: 179 survey responses collected from 21 out of 36 MHM events

Outcome Highlights

- MHM events impacted the stigma that survey respondents may have held around others with behavioral health challenges and around seeking behavioral health services for themselves if needed. Events also increased access to services by improving respondents' knowledge about behavioral health services that they can reach out to.

Outcome Indicators

Domain	Indicator/Question	Percent Agree or Strongly Agree 2021-22 (n=158-60)	2022-23 (n=83)	2023-24 (n=179)
Stigma reduction	As a direct result of this program, I am MORE likely to believe people with mental health and/or substance use conditions contribute much to society.	Not asked	88% *(out of 73)*	82%
Stigma reduction	As a direct result of this program, I am MORE willing to seek professional support for a mental health and/or substance use condition if I need it.	94%	82%	83%
Access to services	As a direct result of this program, I've learned MORE about mental health and/or substance use services that I can reach out to.	90% *(out of 68)*	93%	87%
Cultural identity/humility	This program was relevant to me and other people of similar cultural backgrounds and experiences (race, ethnicity, gender, religion, etc.).	90%	88%	90%

Photo: San Mateo County Board of Supervisor Proclamation for 2024 May Mental Health Month, Redwood City, May 21, 2024

SUICIDE PREVENTION PROGRAM

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

- **Suicide Prevention Committee (SPC).** The SPC is composed of suicide prevention advocates and representatives of key county agencies and community partners. The SPC provides oversight and direction to suicide prevention efforts in San Mateo County, using its strategic plan to prioritize and connect efforts to reduce suicide overall and among specific high-risk communities.
- **September Suicide Prevention Month (SPM).** The purpose of SPM is to encourage all in the community to learn how we all have a role in preventing suicide. SPM activities include Advocacy Days, Mini-Grants and Event Support, and a Communication Campaign.
- **Be Sensitive Be Brave Trainings**. San Mateo County provides free Be Sensitive, Be Brave (BSBB) workshops on Mental Health (MH) and Suicide Prevention (SP) for community members. The BSBB: MH workshop prepares community members to help friends and loved ones during times of distress. The BSBB: SP workshop teaches community members to act as eyes and ears for suicidal distress and to connect individuals to help. Workshops are held in English, Cantonese, Mandarin, Spanish, Samoan, and Tongan.

Numbers Served

Suicide Prevention	FY 2021-22	FY 2022-23	FY 2023-24
Number of individuals served in the primary program component(s), unduplicated counts. (SPC Members)	337*	184*	200*
Number of individuals served in all other components. (Suicide Prevention Month Attendees and Suicide Prevention Training Participants)			400*
Be Sensitive Be Brave Training Participants	463	516	266
Total cost per client	*No data*	$210	$237
All individuals served across all program components (Unduplicated Clients Served + Individuals Reached).	800	700	866

*Estimated numbers

Program Outcomes: Suicide Prevention Events

Data Collection Methods

- Suicide Prevention Event post-surveys[22]

Outcome Highlights: Suicide Prevention Events

- Though surveys were only available for a smaller subset of participants in suicide prevention events, survey results indicate that event participants learned critical information about warning signs and resources, are more comfortable talking about mental health, and are more willing to reach out and help ithers in their community who may be at risk of suicide.

Outcome Indicators

Outcome Domain	Participant Post Survey (Starred Questions are ODE Indicators)	Percent Agree or Strongly Agree	
		2021-22 (n=26)	2023-24 (n=24)
Community advocacy	Due to my participation in this program/training/event, I am more willing to reach out and help someone if I think they may be at risk of suicide.	89%	100%
Access to services	I am more knowledgeable about professional and peer resources that are available to help people who are at risk of suicide.	81%	-
Access to services	Through my participation in this event/program/training, I have learned knowledge and skills that I can use to access mental health and substance use health services.*	-	88%
Stigma reduction	Due to this program/training/event, I feel more comfortable talking about my mental health and/or substance use.*	-	71%
Knowledge, skills, and/or abilities	I am better able to better able to recognize the signs, symptoms and risks of suicide.	58%	-
Self-empowerment	I learned how to better care for myself and seek help if I need it.	85%	-

[22] Surveys were not available for FY 2022-23

Quotes from Participants

"The 'What I Wish My Parents Knew' Forum provided the space to have a deeper reflection on my own relationships with loved ones and with my mental health. It was wonderful to engage in dialogue with my local community to raise awareness about suicide prevention and mental health, and I was really inspired to see the amount of motivation and willingness to learn from the parents. It's empowering to know that our voices are being heard and that we are making positive changes in our communities!" – Youth leader of 'What I Wish My Parents Knew' Forum

Photo: "What I Wish My Parents Knew" Forum, Redwood Shores Library, September 2023

Photo: San Bruno City Hall lit up for Suicide Prevention Month, September 2023

Program Outcomes: Be Sensitive, Be Brave Trainings

BSBB FOR SUICIDE PREVENTION

Data Collection Methods

- BSBB: SP training pre/post surveys

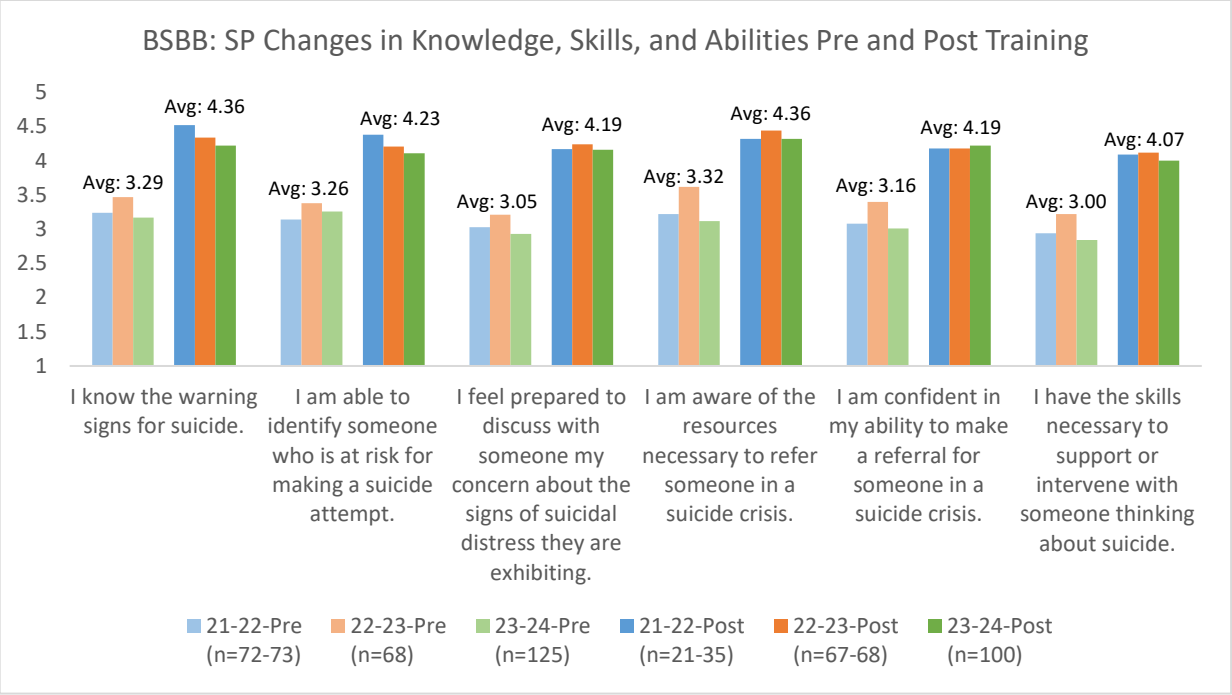
Outcome Highlights

- On average, BSBB: SP training participants experienced increases in all survey questions in all three years. For the most part, participants came into the training rating their knowledge, skills, abilities, and cultural awareness between a 3 and 4 on a 1-5 scale, indicating that they did not fully "agree" that they had the capabilities that the training addressed. After the training, participants' capabilities increased to between a 4 and a 5 on the scale, indicating they felt stronger in their capacity to respond and support their community in suicide prevention. On average, the area with the lowest post-training rating was feeling prepared to support individuals of diverse cultural backgrounds with their suicidal distress.

Outcome Indicators

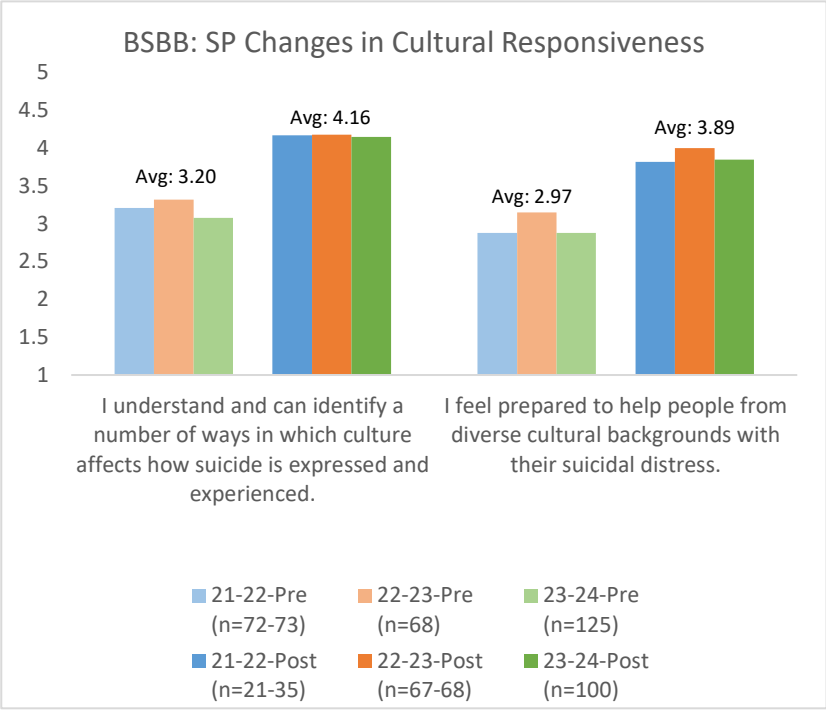
Knowledge, skills, and/or abilities

- BSBB: SP participants demonstrated similar results across all three years and survey questions. Participants experienced increases in both knowledge and skills. On the pre-survey, participants had the lowest scores in areas related to their confidence, preparation, and skills to discuss or support someone related to suicide (between a 2 and a 3, or between "disagree" and "neither disagree or agree"). Questions related to confidence, preparation, and skills increased to at least a mean of 4 ("agree") after the training, but on average still had lower ratings than questions related to knowledge.
- When asked what participants will do differently as a result of the training, participants planned to have more conversations asking about signs and thoughts of suicide, referring others for help or support, and integrating culture and diversity into community mental health support efforts.



Cultural responsiveness

BSBB: SP participants showed improvements in their comprehension of ways in which culture affects how suicide is expressed and experienced, and in their preparedness to help people from diverse cultural backgrounds in suicidal distress. Participants expressed higher capacity in identifying how culture affects how suicide is expressed/experienced than in feeling prepared to help people from diverse cultural backgrounds with suicidal distress.



BSBB FOR MENTAL HEALTH

Data Collection Methods

- BSBB: MH training pre/post surveys[23]

Outcome Highlights

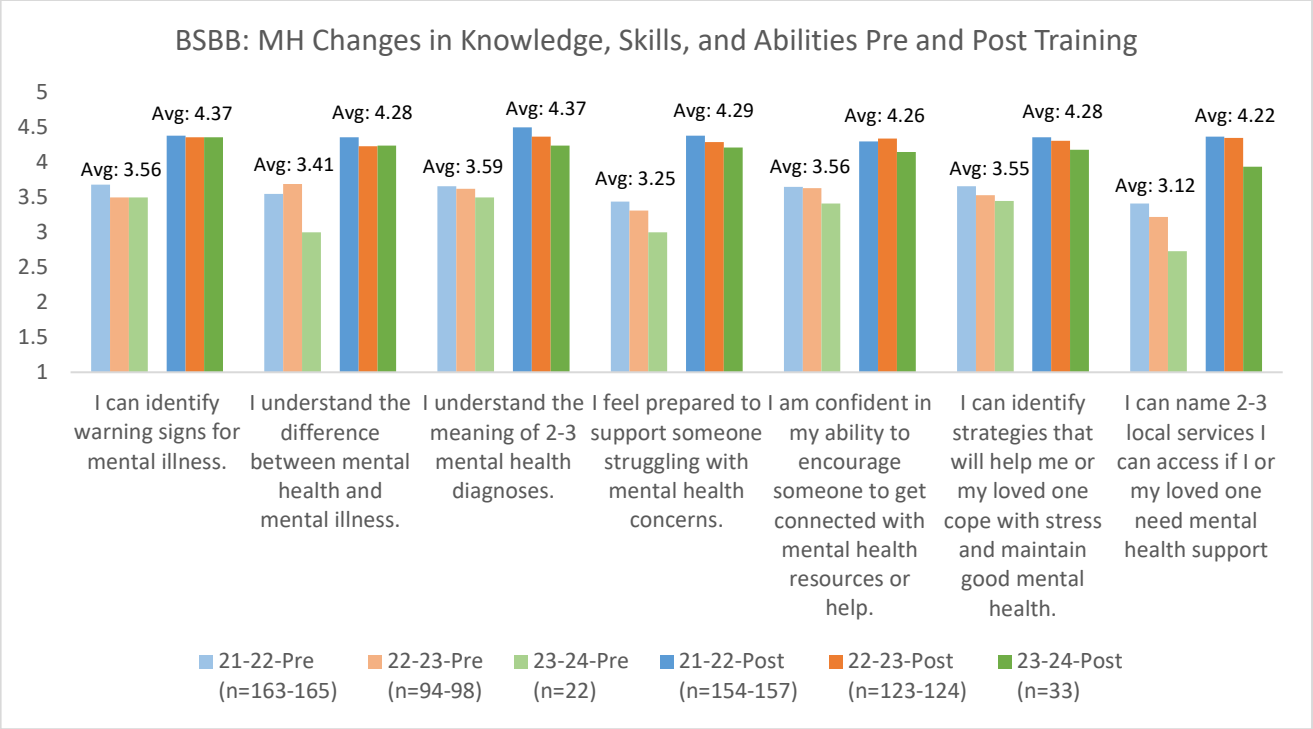
- On average, BSBB: MH training participants experienced increases in all survey questions related to their knowledge, skills, abilities, and cultural awareness in all three years. On average, participants came into the training with a rating between a 3 and 4 on a 1-5 scale, indicating that they did not fully "agree" that they had the capabilities that the training addressed. In most cases after the training, participants' capabilities increased to between a 4 and a 5 on average, indicating they felt stronger in their capacity to respond and support their community, family, and themselves in the case of mental health challenges. On average, the area with the lowest post-training rating was feeling prepared to support individuals of diverse cultural backgrounds with their mental health concerns.
- Participants indicated some degree of mental health stigma in their communities, reporting relatively neutral views on the question of whether individuals who had sought mental health treatment would be treated equally in their community.

Outcome Indicators

Knowledge, skills, and/or abilities

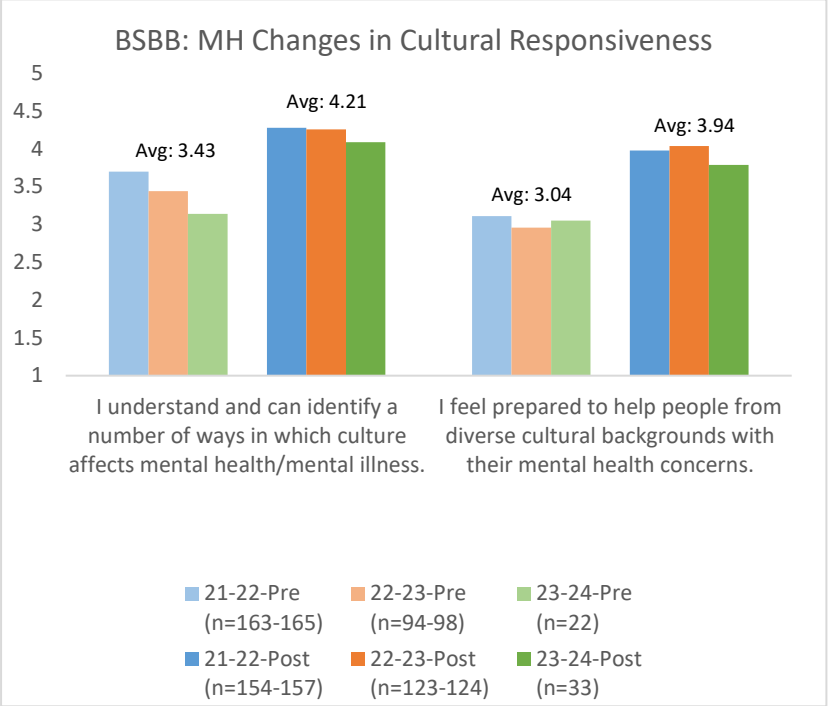
- BSBB: MH participants demonstrated similar results across all three years and survey questions. Ratings in FY 2023-24 were somewhat lower for many questions, which may be due in part to the low survey response rate. Participants experienced increases in knowledge about mental health, skills and confidence in supporting someone with mental health concerns, and awareness of mental health services. The questions with the lowest pre-training ratings were in being able to name local mental health resources and feeling prepared to support someone with mental health concerns; after the training, on average both of these areas increased to an average above 4 ("agree") on the 1-5 scale.
- When asked what participants will do differently as a result of the training, examples included having more conversations about mental health, inviting people to seek help or support, and practicing more wellness and self-care.

[23] Results are for BSBB: MH trainings conducted in English. In FY 2022-23, a cultural and linguistic adaptation was conducted for the Tongan-speaking Pacific Islander community. In FY 2021-22, a cultural and linguistic adaptation was conducted for the Mandarin and Cantonese speaking Chinese community. Note that sample sizes in FY 2023-24 were small due to incomplete survey results (e.g., participants not completing the pre- or post-training questionnaires or skipped items).

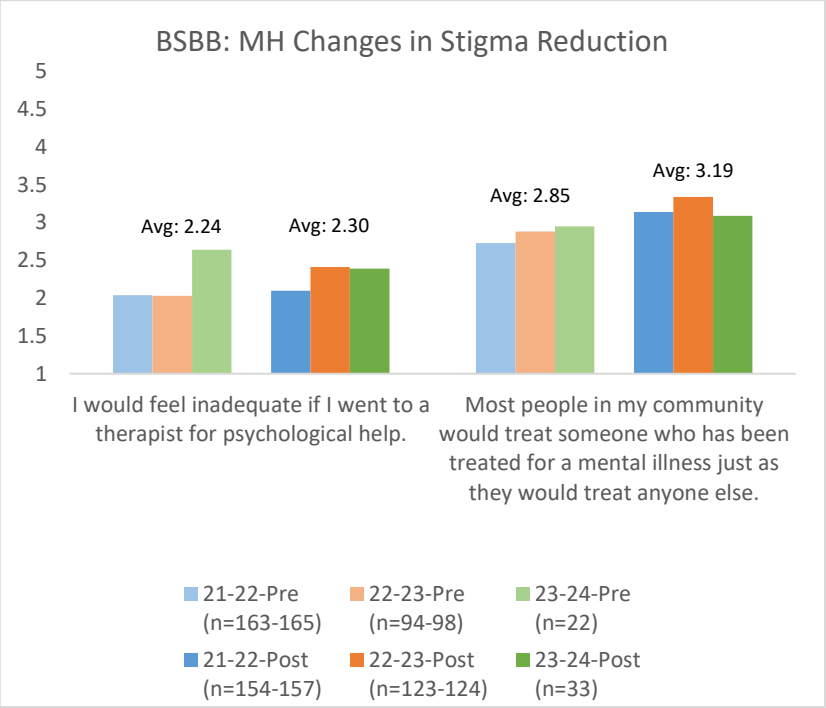


Cultural responsiveness

BSBB: MH participants showed improvements in their comprehension of ways in which culture affects mental health/mental illness, and in their preparedness to help people from diverse cultural backgrounds with mental health concerns. Participants expressed higher capacity in identifying how culture affects mental health than in feeling prepared to help people from diverse cultural backgrounds with mental health concerns.



Stigma Reduction



Regarding internalized stigma, across the three-years, the average rating of feelings of inadequacy for seeking psychological help were between "disagree" and "neither disagree or agree" both pre- and post-training, suggesting that participants held neutral or positive-leaning feelings about seeking psychological help from a therapist. There was little change from pre- to post-training.

Participants reported some degree of mental health stigma in their communities. When asked whether most people in their community would treat individuals with mental health conditions equally, across the three years the average pre-training response was between "disagree" and "neither agree nor disagree," while the average post-training response was slightly higher, suggesting that after the training, more participants agreed that people with mental health conditions would be treated equally.

QUOTES FROM TRAINING ATTENDEES

BSBB: SP training*: "It was really in depth and provided great information on identifying potential signs of suicide and how we can support individuals experiencing suicidal thoughts."*

BSBB: MH training*: "It was a great training and I definitely learned a lot about both the signs of mental health in different cultures and how different groups of people react."*

TRAUMA-INFORMED CO-OCCURRING SERVICES FOR YOUTH

The Trauma-Informed Co-occurring Services for Youth program focuses on youth and transitional age youth (TAY) ages 15-25 who are at greatest risk for adverse childhood experiences; children of color and children who grow up in poverty show the greatest risk for Adverse Childhood Experiences (ACEs). Other groups can include juvenile justice involved, immigrant youth, homeless youth, youth in foster care, etc. Trauma-Informed Co-occurring Services for Youth consists of three required components: Group-Based Intervention; Community Engagement; and Social Determinants of Health (SDOH) Screening and Referrals.

- The Group-Based Intervention component utilizes evidence-based or promising practice intervention or curriculum to address trauma and substance use issues with youth. Agencies can opt to provide the Mindfulness-Based Substance Abuse Treatment (MBSAT), which was piloted with youth throughout San Mateo County or an alternate culturally relevant intervention/curriculum. Agencies target at least 8 youth per cohort and each cohort consists of at least 8 sessions for the intervention and 1 session for youth engagement opportunities.
- The Community Engagement component address community-level challenges that are necessary for positive youth outcomes. Agencies provide at least two foundational trauma-informed trainings for adults that interact with their youth cohort participants (parents, teachers, probation officers, service providers, etc.) to create trauma-informed supports for youth. This component also encourages agencies to connect the cohort youth to leadership opportunities such as the BHRS Office of Diversity and Equity (ODE) Health Ambassador Program for Youth and the Alcohol and Other Drug (AOD) youth prevention programs.
- The Social Determinants of Health (SDOH) Screening and Referrals component acknowledges that social determinants of health (e.g., food insecurity, housing, transportation, medical treatment, etc.) can account for up to 40 percent of individual health outcomes. Agencies screen youth participants at to support appropriate referrals and identifying community-based social service resources and social needs and/or gaps.

Four agencies provide interventions as follows:

- Mindfulness-Based Substance Abuse Treatment (MBSAT)
    - StarVista provides 6 cohorts per year in North County and South County
    - Puente de la Costa Sur provides two cohorts per year in the South Coast region
    - YMCA Bureau of San Mateo County provides 2 cohorts per year in South San Francisco
- GiraSol (formerly Panche Be Youth Project)
    - The Latino Commission provides two cohorts per year in South County for girls.

MINDFULNESS-BASED SUBSTANCE ABUSE TREATMENT (MBSAT)

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

- **Puente de la Costa Sur**: Community Mental Health and Wellness (CMHW) clinical staff, trained in cultural humility and trauma-informed care, facilitate this group. MBSAT is offered to high school students in the La Honda-Pescadero Unified School District, as well as young adults in the community.
- **StarVista**: The StarVista Insights Program offers MBSAT to improve the lives of transition-age youth (TAY) dealing with substance use, trauma, emotional regulation, family conflict, unhealthy relationships, and other factors limiting their healthy development and overall happiness. The program continually adapts its offerings by working with various community-based organizations and San Mateo County school districts. It welcomes any transition-aged youth (typically ages 15-25) to participate and is open to collaborating with organizations serving this population. This flexibility has allowed the program to serve 36 youth, with groups organized by appropriate age ranges (14-17 and 18-25).
- **YMCA**: The Youth Service Bureau (YSB) of the YMCA provides mental health services at two South San Francisco high school campuses: South San Francisco High School and El Camino High School. The YSB's focus is on adolescents aged 14 to 18 who are enrolled in high school. The services provided by YSB School Safety Advocates (SSAs) are free of charge and accessible to all students on campus.

Numbers Served

MBSAT - Puente*	FY 2021-22	FY 2022-23	FY 2023-24[24]
Clients served (unduplicated)	34	11	0
Cost per client	$882	$882	0
Individuals reached (duplicated)	0	242	0
Total Served	34	328	0

[24] During FY 2023-24, Puente faced significant challenges in implementing the Mindfulness-Based Substance Abuse Treatment (MBSAT) program. Despite various recruitment efforts, no students attended the offered sessions.

MBSAT - StarVista*	FY 2021-22	FY 2022-23	FY 2023-24
Clients served (unduplicated)	93	87	32
Cost per client	$968	$1,034	$108
Individuals reached (duplicated)	11	81	2
Total Served	104	168	34

MBSAT - YMCA*	FY 2021-22	FY 2022-23	FY 2023-24
Clients served (unduplicated)	6	15	11
Cost per client	$5,000	$2,000	$30
Individuals reached (duplicated)	0	0	50
Total Served	6	15	61

** Unduplicated clients served are the youth that participated MBSAT group sessions, individuals reached would include community member trauma-informed presentations to support youth.*

Program Outcomes

Data Collection Methods

- Post-survey for group participants[25]

Outcome Highlights

- While in some cases there were small numbers of survey respondents, MBSAT participants reported that as a result of the MBSAT program, they gained knowledge and skills about recovery from trauma, have a greater ability to overcome challenges, and have an improved ability to participate in daily life.

Outcome Indicators

Outcome Domain	Participant Post Survey	Percent Agree or Strongly Agree		
		2021-22 (n=SV: 88)	2022-23 (n=SV: 70/ *YMCA: 6*)	2023-24 (n=SV: 15/ *YMCA: 50*)
Knowledge, skills, and/or abilities	Due to participating in this program, I feel in control of my life and future.	87%	-	100%
Knowledge, skills, and/or abilities	When I want to feel better about something, I change the way I'm thinking about it.	-	69%/*50%*	*67%**

[25] Survey questions changed over the years and differed between the StarVista and YMCA programs. YMCA indicators are in italics. For 2021-22, YMCA had no data. There are no outcome data from Puente for MBSAT for the three fiscal years (in 2021-22, Puente reported combined Project SUCCESS and MBSAT data, included in the Project SUCCESS section of this report; in 2022-23, no post-surveys were collected due to staff shortages; in 2023-24, no students were served).

Knowledge, skills, and/or abilities	Because I participated in this program, when I'm worried about something, I make myself think about it in a way that helps me feel better.	-	69%/*50%*	*100%**
Knowledge, skills, and/or abilities	As a result of participating in this program, I believe that recovery from trauma is possible.	-	-	*86%*
Knowledge, skills, and/or abilities	Due to my participation in this program, I practice self-care (taking care of my own needs and wellbeing)	-	-	*72%*
General behavioral health	Due to this program, I am better able to participate in daily life.	-	-	100%
Self-empowerment	Due to participating in this program, I overcome challenges in a more positive way.	87%	-	100%

**Due to survey administration issues, these questions were only answered by three participants.*

Quotes from Participants

"This program/experience has been very helpful and very calming. This program opened me and made me realize a lot that I should have known better." – South San Francisco High School MBSAT Participant

"*This is important information, and I appreciate as someone who works with students with emotional disturbance.*" – Provider Participant at El Camino High School Presentation

"*Ms. V was very nice and helpful to me, and she made me feel comfortable talking about my feelings"* – South San Francisco High School MBSAT Participant

GIRASOL (FORMERLY PANCHE BE YOUTH PROJECT)

The Latino Commission provides a culturally relevant intervention/curriculum for Trauma-Informed Co-occurring Services for Youth. The program took slightly different forms in FY 2021-22 and FY 2023-24. This program will not receive MHSA funding in fiscal year 2024-25.

FY 2021-22: The Panche Be Youth Project combined the curricula of El Joven Noble and Xinachtli programs and were delivered as an afterschool activity. The Xinachtli program assists teen girls in maintaining self-esteem, self-image and self-confidence to continue on to higher education. It is based on indigenous principals, and provides dialectic process designed to support and build on the strengths of the individual. El Joven Noble program incorporates social-cognitive behavioral skills building activities with culturally sensitive video clips, games, brainstorming, role playing to create group cohesion. The goal is to help prevent young men from participating in gangs, reduce crime, increase numbers of youth attending college, improve prevention and health knowledge.

2022-23 and 2023-24: Under a new name, GiraSol, the program consists of three components: Group-Based Intervention; Community Engagement; and Social Determinants of Health (SDOH) Screening and Referrals. The GiraSol curriculum debuted at The Latino Commission's San Bruno location in Spring 2023 serving female-identified youth in the South Bay Area. Youth participants engaged in educational and skill-building sessions of an integrative, unique, and culturally-rooted curriculum, and offered culturally-rooted educational workshops in the community.

Numbers Served

Data were available for FY 2022-23 only. In FY 2021-22, The Latino Commission had not started groups due to ongoing challenges from the COVID-19 pandemic. Program activities occurred in FY 2023-24, but no data were provided.

MBSAT - GiraSol	FY 2021-22	FY 2022-23	FY 2023-24
Clients served (unduplicated)	0	8	*No data*
Cost per client	0	$3,750	*No data*
Individuals reached (duplicated)	0	0	*No data*
Total Served	0	8	*No data*

** Unduplicated clients served are the youth that participated MBSAT group sessions, individuals reached would include community member trauma-informed presentations to support youth.*

Program Outcomes

Data Collection Methods *(data available for 2022-23 only)*

- Youth pre-post survey; parent post-survey

Outcome Highlights

- After the completion of the program, youth participants reported feeling more comfortable speaking about mental health challenges, more connected to their culture, and more in control of their own narratives and futures.
- After the completion of the program, parents reported improved behavior for their daughters.

Outcome Indicators

Domain	Indicators/Questions: FY 2022-23	Pre-Survey	Post-Survey
Stigma reduction	I feel more comfortable speaking about mental health challenges. (population = youth)	25% (2 of 8)	100% (6 of 6)
Cultural identity	I feel proud and connected to my cultural roots. I can name three positive values from my culture. (population = youth)	63% (5 of 8)	100% (6 of 6)
Self-empowerment	I have "control" of my own narrative, design my own narrative, go for my dreams.	63% (5 of 8)	100% (6 of 6)
Knowledge, skills, and/or abilities	Reported improved behavior with daughter. (population = parents)	*N/A*	100% (6 of 6)

TRAUMA INFORMED 0-5 SYSTEMS

The Trauma- and Resiliency- Informed Systems Initiative (TRISI) is a countywide effort in collaboration with First 5 San Mateo County (F5SMC) to transform the service sector for young children and their families. The goal is to integrate a comprehensive commitment to address trauma and promote resiliency into local programs, structures, and culture with a long-term goal of embedding trauma- and resiliency-informed policies and practices at every level. Strategies and targets for the Initiative include 1) training and support for child- and family-serving organizations to imbed trauma- informed practices in their internal operations; 2) training and resources on trauma-informed practices for professionals working with children and families, and 3) education for parents to help recognize the signs and symptoms of trauma.

Note: TRISI is not included in the PEI Evaluation Framework as it serves staff and providers, rather than clients/consumers. It is included in the Three-Year Evaluation Report to demonstrate the system-level efforts and outcomes in BHRS's approach to PEI.

Numbers Served

Trauma-Informed 0-5 Systems	FY 2021-22	FY 2022-23	FY 2023-24
Total clients served*	346	446	336
Total cost per client	$434	$336	$336

*For the purposes of this project, the "clients" served are, most directly, the staff and providers working within the target agencies that serve children and families in San Mateo County. In this context, the MHSA Intended Outcomes would be sought for providers within our community who work to serve the public.

System-Level Impacts

Progress to date includes:

- *Online Resource Hub*: Development of a local online resource hub for providers and other interested community members.
- *Countywide Trauma Convening*: Hosting of a full-day Culture of Care Convening focused on supporting trauma-informed organizational practices for child- and family-serving organizations attended by over 150 individuals and 40+ agencies.
- *Organizational Assessment Tool*: Through the trauma-Informed Organizational (TIO) Practices Assessment Tool, TRISI supports partners to understand what a trauma-informed organization looks like and to assess their organization's current stage.
- *TRISI 1.0 Cohort and Coaching:* Supported the deepening of TIO practices by offering ongoing training, support, and action plans through group work in cohorts and specific agency-focused goals through coaching. Two TIO cohorts commenced in May 2021 with six agencies participating and 23 individual participants for the duration of the eight-month cohort.
- *TRISI 2.0 Cohort and Coaching*: Implemented the second phase of the assessment, cohort, and coaching model with three of the largest child- and family-serving public agencies in San Mateo County, of which BHRS is one.

Through TRISI 2.0, BHRS has utilized the support of an organizational coach to update an existing plan focused on multicultural organization development (MCOD) with a more trauma-informed overlay. In the second half of the year, the work of the coach has been spent supporting the dissemination of the updated MCOD plan with new leaders and alongside racial equity, diversity, and inclusion (REDI) efforts so that the work is comprehensive and aligned rather than seen as just another short-term initiative. The coaching has been targeted to a small group of agency leaders and change-makers in this phase, with an eye toward broader agency expansion in the future.

In 2023, six TRISI 2.0 participants completed a survey about their experiences (all participants in cohorts and coaching were invited).

- 83% of respondents *agreed* or *strongly agreed* that they acquired more knowledge through participating in TRISI activities about what it means to be a trauma-and resiliency-informed organization.
- 67% of respondents who participated in the organizational coaching (with Dr. Tasha Parker, Dr. Ken Epstein, or Antoine Moore) found it to be *extremely valuable*.
- 50% of respondents found that completing the Trauma Informed Organization Assessment survey was *extremely valuable*.
- 50% of respondents reported that the cohort meetings with other participating organizations (facilitated by Dr. Tasha Parker) found them to be *extremely valuable*.
- 50% of respondents *strongly agreed* that TRISI activities were a productive use of their time.

PREVENTION & EARLY INTERVENTION PROGRAM SUMMARIES

ALLCOVE YOUTH DROP-IN CENTER

The allcove model, inspired by successful international models in Australia, Canada, and Ireland, creates stand-alone, “one-stop-shop" health centers for young people ages 12 to 25 to access support for mild to moderate needs with mental health, physical health, substance use, peer support, supported education and employment, and family support, as well as linkages to community referrals in the continuum of care for more intensive needs. Allcove approaches youth wellness in a comprehensive and youth-friendly way, led by members of an active local Youth Advisory Group, who help design the service and environment they most want to see in their community, and a Community Consortium. The allcove San Mateo Youth Drop-in Center provides young people ages 12-25 years old with access to, but not limited to, the following specific services:

a. Drop-in behavioral health services, resources, and wrap-around services and supports
b. Education and awareness about mental health issues via existing relationships with school-based partners
c. Outreach via school-based relationships
d. Behavioral health education and service pathways for local school districts and community colleges
e. Therapy and peer-support groups for youth

Allcove San Mateo opened its doors to the community on January 22, 2024. Since the program began mid-fiscal year, complete data collection and analysis will be available in FY 2024-25.

EARLY CHILDHOOD COMMUNITY TEAM (ECCT)

The Early Childhood Community Team (ECCT) aims to provide targeted, appropriate, timely responses to the needs of underserved families with children ages 0 through 5 or pregnant mothers in the Half Moon Bay community. ECCT focuses on the parent/child relationship as the primary means for intervention. Team members also focus on child development and strive to individualize services to ensure each child and family's unique needs are met. Identifying challenges early and providing families with the proper assessments, interventions and supports can make a difference in a child's earliest years and for many years thereafter. ECCT is made up of three interconnected roles that support the community and families in different ways.

1. The Community Worker (CW) provides case management, parent education to the families, facilitates play and support groups, and develops and maintains community partnerships.
2. The Mental Health Clinician (MHC) provides Child Parent Psychotherapy (CPP) informed therapeutic support to families as well as using other attachment/relationship based clinical modalities as appropriate. CPP is a specific intervention model for children aged 0-5 who have experienced at least one traumatic event and/or are experiencing challenges related to attachment, and/or behavioral problems, including posttraumatic stress disorder. The primary goal of CPP is to support and strengthen the relationship between a child and his/her caregiver as a vehicle for restoring the child's cognitive, behavioral, and social functioning.
3. The Early Childhood Mental Health Consultants (ECMHC) provide ongoing support to childcare providers in preschool settings with the goal of establishing a safe and trusting relationship that supports teachers in building their capacity of self-reflection, understanding of the child's experience and fostering an inclusive classroom where all children can receive high quality care. Consultation services also provide more intensive case support for children who have been identified with significant needs or who are at risk of losing placement at their site. For this more intensive work, ongoing support is provided for parents in hopes of bridging the child's home and school experience and creating a feeling of continuity of care.

Numbers Served

Early Childhood Community Team*	FY 2021-22	FY 2022-23	FY 2023-24
Clients served (unduplicated)	62	19	193
Cost per client	$7,137	$23,986	$2,505
Individuals reached (duplicated)	150	270	57
Total Served	212	289	250

** Unduplicated clients served are the children/families that participated in individual or group therapy, individuals reached includes parent/caregiver groups, teacher consultations, etc.*

Program Outcomes

Data Collection Methods

- End of year survey for group and one-on-one clients
- Protective factors survey
- Client database

Outcome Highlights

- In each fiscal year, survey data were available for between three to five participants. In all years and all survey questions, participants in group services reported improvements in knowledge, access to services, and stigma reduction.
- Out of the children who were provided with intensive case consultation services, none were expelled or suspended.

Outcome Indicators

Domain	Indicators/Questions	2021-22	2022-23	2023-24
Connection & Support	Number of parents/caregivers who improved familial connection and support as measured by improvement in Protective Factors Survey Score	80% *(4 of 5)*	100% *(4 of 4)*	100% *(2 of 2)*
Improved knowledge, skills, and/or abilities	Due to my engagement in this program, I feel more confident in my parenting (group services)	100% *(4 of 4)*	100% *(4 of 4)*	100% *(4 of 4)*
Connection & Support	Due to my engagement in this program, I feel more connected to other parents in my community (group)	100% *(4 of 4)*	67% *(2 of 3)*	100% *(3 of 3)*
Stigma Reduction	I feel more comfortable talking about my and my child's mental health/ children in my classroom (population: group, teacher consultations, and one-on-one services)	100% *(5 of 5)*	100% *(4 of 4)*	100% *(3 of 3)*
	I feel more comfortable seeking out resources for myself and/or my child	100% *(5 of 5)*	100% *(5 of 5)*	100% *(3 of 3)*
Knowledge/ access to services	Due to my engagement, I know where to go in my community for resources and support. (population = groups, teacher consultations, and one-on-one services)	80% *(4 of 5)*	100% *(4 of 4)*	100% *(3 of 3)*
Self-Empowerment	Due to my engagement, I feel more empowered to advocate for myself and my child's needs. (population = group and 1:1)	100% *(5 of 5)*	100% *(4 of 4)*	100% *(3 of 3)*
Cultural Identity/ Humility	I feel like my identity is affirmed by this program. (population = groups, teacher consultations, one-on-one services)	100% *(5 of 5)*	100% *(4 of 4)*	100% *(3 of 3)*

PROJECT SUCCESS

Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) is an evidence-based program that uses interventions that are effective in reducing risk factors and enhancing protective measures. Project SUCCESS is a Substance Abuse and Mental Health Services Administration (SAMHSA) model program that prevents and reduces substance misuse and associated behavioral problems among high-risk youth ages 9-18. Project SUCCESS is offered by a local non-profit Puente de la Costa Sur.

Project SUCCESS is designed for use with youth ages 9-18 and includes parents as collaborative partners in prevention through parent education programs. Clinical staff trained in culturally competent practices ran all the groups. All of Puente's staff are either licensed or pre-licensed by the Board of Behavioral Sciences (BBS). Project SUCCESS groups are offered to all three school campuses in the La Honda-Pescadero Unified School District. The school district's small size provides an opportunity for every student in the district, ages 9 to18, to participate in one or more Project SUCCESS activities. Each academic school year, a passive consent letter explaining Project SUCCESS curriculum is sent to all parents with children ages 9 to 18. There is an opportunity for parents to have their child opt out with a signature at the bottom of the consent letter. Project SUCCESS activities include:

1. Social Emotional Learning
2. Psychoeducation workshops with students, parents, and community members
3. Individual and family counseling services
4. Parent and Teacher consultation
5. Mental health community awareness and education

Numbers Served

Project SUCCESS	FY 2021-22	FY 2022-23	FY 2023-24
Clients served (unduplicated)*	154	75	35
Cost per client	$1,986	$14,997	$9,268
Individuals reached (duplicated)	217	242	57
Total Served	371	328	92

** Unduplicated clients served are the students that participated in the intervention and individual and family therapy, individuals reached includes parent/teacher consultations, and community awareness and education.*

Program Outcomes

Data Collection Methods

- Project SUCCESS group participant post survey[26]

Outcome Highlights

- In FY 2023-24, the questions with the highest levels of agreement were in understanding the risks with the use of alcohol and substances, and in identifying and reaching out to trusted adults for help. The questions with the lowest levels of agreement were related to identifying emotions in the body and managing emotions.
- In FY 2021-22, on average students reported relatively low levels of agreement on the survey; no question had more than 50% agreement. Note that there were fewer respondents and the survey included different questions than FY 2023-24.

Outcome Indicators

Domain	Indicators/Questions: FY 2023-24	Number	Percent
Connection & Support	Due to this program, I can identify trusted adults in my life and when to tell adults about my mental concerns. (5th grade students, n=18)	14	78%
Improved knowledge, skills, and/or abilities Improved knowledge, skills, and/or abilities	Due to participating in this program, I can identify how drugs and alcohol affect the brain. (Middle School (MS), n=11)	9	82%
	Due to participating in this program, I understand the risks with the use of alcohol and substances. (Middle School (MS), n=11)	11	100%
	Due to participating in this program, I have many ways to manage my big feelings. (Middle School (MS) & 5th grade students), n=29	14	48%
Self-Empowerment	Due to this program, I am comfortable asking for help for myself or others with an adult. (5th grade students, n=18)	13	72%
	Due to participating in this program, I can recognize when I need help. (Middle School (MS), n=11)	7	64%
General Behavioral Health	Due to participating in this program, I can identify my emotions and notice how I experience them in my body. (5th grade students, n=18)	10	56%
	Due to this program, I can identify anxiety and notice how I experience them in my body (Middle School (MS), n=11)	8	72%

[26] Note: The survey asked different questions in different years so the years are presented separately. In FY 2022-23, no post-surveys were collected due to significant staff shortages.

Domain	Indicators/Questions: FY 2021-22	Number	Percent
Self-Empowerment	I learned about myself and my thoughts and feelings in this program (5th graders, n=15)	4	36%
	I learned about myself and my thoughts and feelings in this program (8th graders, n=19)	5	26%
	Being in this program helped me understand how to better manage how I respond to my thoughts and feelings (5th graders, n=15)	4	36%
	Being in this program helped me understand how to better manage how I respond to my thoughts and feelings (8th graders, n=19)	9	47%
Improved knowledge, skills, and/or abilities	Because I was in this program, I learned skills that help me express my emotions and opinions more effectively (5th graders, n=15)	4	27%
	Because I was in this program, I learned skills that help me express my emotions and opinions more effectively (8th graders, n=19)	6	32%
Stigma Reduction	Because I was in this program, I feel more comfortable talking about challenges with using alcohol and/ or drugs (5th graders, n=15)	5	33%
	Because I was in this program, I feel more comfortable talking about challenges with using alcohol and/ or drugs (8th graders, n=19)	4	21%

THE CARIÑO PROJECT

The Cariño Project is funded 80% CSS, 20% PEI. The program opens pathways for increased services on the Coastside, limited in services. Counseling services include crisis counseling, family counseling, and counseling at schools, local churches and community spaces. Staff often use a home visiting model to serve families. Ayudando Latinos a Soñar (ALAS) is committed to meeting the client where they are, both emotionally and physically. The Cariño Project was founded on the opportunity to create new models of mental health and wellness wrap-around services that are grounded in cultural frameworks of intervention. The program opens pathways for increased services on the Coastside, limited in services. MHSA funding has allowed growth in programming and staff to increase wellness support services across the Coast. ALAS is centered on honoring the client and their cultural wealth. The program believes that each person and family is rooted in a history of tradition and culture that strengthens who they are, which should be honored and valued. Operating from a strengths-based and cultural wealth perspective, ALAS values each person, family, and child, embracing each person's identity, sexual orientation, race, ethnicity, and cultural background/s. The Cariño Project strengthens opportunities to work closely with expanded community groups.

Numbers Served

Cariño Project *	FY 2021-22	FY 2022-23	FY 2023-24
Clients served (unduplicated)	355	590	572
Cost per client	$1,016	$536	$603
Individuals reached (duplicated)	1,435	2,159	2,028
Total Served	1,790	2,749	2,600

** Unduplicated clients served are individuals that received therapy and/or case management services, individuals reached includes the community at-large, families and others engaged through support groups, events, arts and other activities.*

Program Outcomes

Data Collection Methods

- Clinical self-assessment survey
- Case management survey
- Event/workshop participant survey

Outcome Highlights

- *Clinical clients*: Of those who completed the discharge clinical self-assessment, a majority reported improvements in their general behavioral health and in their comfort in talking about mental health. More respondents reported being better able to cope with stressors were higher than reported improvement in overall mental health and ability to participate in daily life.

- *Case management clients*: Of those who completed the case management survey, a majority reported being better able to support themselves or their family.
- *Event/workshop participants*: Of those who completed the participant survey, large majorities reported learning useful information and strengthening protective factors of connection to community and culture.

Outcome Indicators

Domain	Indicators/Questions	2021-22	2022-23	2023-24
General behavioral health	Due to this program, I am better able to cope with stressors in my life. (clinical population)*	69% (9 of 13)	100% (9 of 9)	71% (5 of 7)
General behavioral health	Due to participating in this program, I have experienced an improvement in my overall mental health. (clinical population)*	54% (7 of 13)	89% (8 of 9)	57% (4 of 7)
General behavioral health	Due to participating in this program, I have an improved ability to participate in daily life. (clinical population)*	*Not asked*	89% (8 of 9)	57% (4 of 7)
Stigma Reduction	Due to the Cariño Project, I feel more comfortable talking about mental health (clinical population)**	92% (14 of 15)	91% (20 of 22)	90% (9 of 10)
Connection and Support	Due to the Cariño Project, I am better able to support myself and/or my family. (case management population)**	62% (8 of 13)	*Not asked*	87% (72 of 83)
Knowledge, Skills, and/or Abilities	Due to the Cariño Project, I learned something that is useful to me. (participant population)**	96% (52 of 54)	87% (45 of 52)	86% (32 of 37)
Cultural Identity	Due to the Cariño Project, I feel more connected to my culture. (participant population)**	96% (52 of 54)	89% (65 of 73)	86% (32 of 37)
Connection and Support	Due to the Cariño Project, I feel more connected to my community. (participant population)**	94% (51 of 54)	93% (68 of 73)	86% (34 of 73)

**Calculated as improved rating from intake to follow-up*

***Calculated as participants who selected somewhat agree or agree*

PEARLS OLDER ADULT OUTREACH PROGRAM

The Daly City Partnership's Healthy Aging Response Team began implementing the PEARLS (Program to Encourage Active, Rewarding Lives) program in spring 2024, partially funded by MHSA PEI funds. As this marks the initial phase of the program, a full year of data is not yet available; that comprehensive dataset will be compiled in the upcoming year. However, these first months have been dedicated to crucial start-up outreach efforts. The Healthy Aging Response Team conducted several outreach initiatives at various venues throughout San Mateo County. These preliminary efforts have already shown promising results, with one hundred ninety-nine individuals expressing interest in the PEARLS program. Outreach events were held at diverse locations, including:

- Northeast Medical Services
- Stanford Hospital
- VA Hospital
- Burlingame Community Center
- South San Francisco Community Center
- Doelger Senior Center

Full PEARLS program implementation and comprehensive data collection will occur in FY 2024-25.

OLDER ADULT PEER COUNSELING PROGRAM

The Older Adult Peer Counseling Program (formerly Senior Peer Counseling Program) from Peninsula Family Service (50% CSS, 50% PEI) deploys over 100 trained volunteer counselors to support older adults in San Mateo County through weekly visits. These counselors help manage transitions and life changes, including health concerns, mobility issues, caregiver needs, and grief. Targeting residents ages 55 and older who may be depressed, lonely, or isolated, the program offers one-on-one meetings and group support. Volunteers are matched with participants based on shared cultures, languages, and backgrounds, focusing on underserved communities such as Chinese-speaking, Filipino, Spanish-speaking, and LGBTQ+ older adults. They meet weekly with participants via phone, Zoom, or in person. Some volunteers receive additional training to lead support groups.

Numbers Served

Older Adult Peer Counseling	FY 2021-22	FY 2022-23	FY 2023-24
Total Individual clients served	*Shown in total below*	159	89
Total Group clients served	*Shown in total below*	444	514
Total cost per client	$637	$542	$686
Total Clients Served	539	603	603

Program Outcomes

Data Collection Methods

- Participant follow-up/discharge survey[27]

Outcome Highlights

- There was variation across the fiscal years in survey results. Overall, survey results were more positive in FY 2022-23 than in 2023-24, particularly for group service respondents.
    - **Individual service participants** reported some of the most positive outcomes in stigma reduction and support-seeking (comfort talking about their problems, comfort and ability to seek emotional support).
    - **Group participants** reported some of the most positive outcomes in knowledge and access to services (getting connected to community resources), and the protective factor of connection and support (feeling supported).

[27] FY 2021-22 survey results are not presented as the survey asked open-ended questions.

Outcome Indicators

Domain	Indicators/Questions	Percent Agree or Strongly Agree	
		2022-23 (Ind: n=25; Group: n=41)	2023-24 (Ind: n=26; Group: n=17)
Stigma Reduction	Due to this program, I feel more comfortable talking about my problems.	**87% (I)** **86% (G)**	**77% (I)** 71% (G)
Stigma Reduction	Due to this program, I feel more comfortable reaching out for emotional support.	63% (I) **84% (G)**	**75% (I)** *40% (G)*
Improved knowledge, skills, and/or abilities	The program improved my knowledge and abilities to seek support.	67% (I) **82% (G)**	**75% (I)** *40% (G)*
Improved knowledge, skills, and/or abilities	As a result of participating in this program, I am connected to community resources.	**84% (I)** **85% (G)**	58% (I) **81% (G)**
Connection and Support	As a result of this program, I feel supported.	**85% (I)** **84% (G)**	58% (I) **81% (G)**
Self-Empowerment	Due to this program, I think more positively about challenges in my life	63% (I) **86% (G)**	58% (I) **77% (G)**
Self-Empowerment	Due to participating in this program, I believe that I can affect my life through decisions that I make	61% (I) **78% (G)**	71% (I) *36% (G)*
General Behavioral Health	As a result of participating in this program, I feel less stressed	67% (I) **89% (G)**	72% (I) *42% (G)*

Client Success Story

The program worked “Norma,” who had been confined to her home and unable to operate a standard wheelchair. The peer counselor engaged with Norma and sought out a donated electric wheelchair to meet her needs. Norma was elated and stated, "I am so happy the program was able to help me get around." Norma reported, *"It's not about the chair, but what I can do with the chair that matters."* She added, *"I can really feel independent again,"* and *"I think [my peer counselor] really listened to me and cared enough to make this happen."*

YOUTH S.O.S.

The Youth Stabilization, Opportunity, and Support (Youth S.O.S) Team was a program under StarVista's Crisis Center, in partnership with BHRS that provided over-the-phone and/or in-person response to youth (ages 0-25) living in San Mateo County who were experiencing an escalation in mental health symptoms. Symptoms ranged from suicidal ideation to undiagnosed mental health disorders. The Youth S.O.S team was staffed with mental health clinicians and family partners (and one youth peer partner). Together those roles provided comprehensive suicide and crisis assessment, psychoeducation, brief individual counseling, and case management for family needs. In addition to responding to families in crisis, the Youth S.O.S team provided San Mateo County schools assistance with suicide assessments and/or crisis intervention.

This program prioritized marginalized ethnic, linguistic, and cultural communities in San Mateo County. This included youth that had experienced abuse, were currently or had formerly been in foster care, experienced unstable housing/homelessness as well as youth that belonged to the LGBTQ+ community. The Youth S.O.S Team was also responsible for in-person mobile crisis response for the California Family Urgent Response System (CAL-FURS) to support current and former foster youth as well as their caregivers when crisis occurred. The CAL-FURS program states that, "FURS is a coordinated statewide, regional, and county-level system designed to provide collaborative and timely state-level phone-based response and county-level in-home, in-person mobile response during situations of instability, to preserve the relationship of the caregiver and the child or youth."

The overall goals of the Youth S.O.S. team were to decrease youth psychiatric emergency service visits, decrease hospitalization for self-harm, decrease emergency calls to law enforcement for youth in crisis, and improve family/caregivers' ability to navigate crisis and increase access of services. As the mobile responders for CAL-FURS, the team's goal also strove to maintain and support stability of youth in foster care placement and improve trust between youth and caregivers. This program became fully staffed in March 2022. The Youth S.O.S program began in February-March 2021 and closed on August 31, 2024.

Numbers Served

Youth S.O.S.*	FY 2021-22	FY 2022-23	FY 2023-24
Clients served (unduplicated)	37	30	147
Cost per client	$22,082	$31,401	$7,067
Individuals reached (duplicated)	72	141	10
Hotline phone calls	13,441	11,570	11,448
Total Served	13,550	11,741	11,605

** Unduplicated clients served are youth served by the mobile crisis response, individuals reached includes the family members or caregivers of youth served and/or individuals reached through outreach/education.*

24/7 Crisis Hotline	FY 2022-23	FY 2023-24
Total number of calls	11,570	11,448
Average length of calls (minutes)	9.3	7.5
Number of follow up requests	89	176
Number of follow ups provided	115	249
Number of 988 Texts Received	*N/A*	585
Number of 988 Texts Answered	*N/A*	518
Number of 988 Chats Received	*N/A*	240
Number of 988 Chats Answered	*N/A*	213
Percentage of callers who receive service linkages and referrals to service providers as appropriate	100%	100%
Teen Crisis Services (Web Based Services, Text Suite Pilot)		
Total number of chats	42	33
Total number of texts	25	21
Total site views	11336	7371
Suicide Prevention Presentations and Outreach		
Total Number of Tabling Events	14	22
Total Number of Contacts at Tabling Events	735	3843
Total number of presentations	78	34
Number of adults served	776	396
Number of youth served	949	882
Number of youth requesting follow up	36	23
Number of youth who received follow up	17	0
Youth Stabilization Opportunity and Support (YSOS)		
Total number of referrals	127	157
Total number of in person responses	21	10
Total number of youth served with in-person response	16	9
Response Time		
Immediate (1 hour)	6	24
Delayed (3 hours)	0	0
Follow Up (24+ hours)	14	4
Phone Consultations / De-escalation		
School /Community Provider	35	1
Youth	8	3
Caregiver/Family Member	60	9
Percentage of youth deferred from psychiatric hospitalization through means of Safety Plan	100%	100%
Total number of youth deferred from use of psychiatric emergency services through means of safety plan	72	NA
Total number of youth referred to psychiatric emergency services after in-person crisis response	0	3

Total number of youth whose in-person crisis response resulted in incarceration	0	0
Family Urgent Response System (FURS)		
Total number of referrals	7	8
Total number of in person responses	0	7
Total number of youth served with in person response	0	2
Response Time		
Immediate (1 hour)	0	6
Delayed (3 hours)	0	0
Follow Up (24+ hours)	0	1
no in person response occurred	6	1

Program Outcomes

As noted above, outcome data are available for FY 2021-22 and FY 2022-23.

Data Collection Methods

- Youth intake form
- Youth follow-up rating form

Outcome Highlights

- 100% of youth who received Youth S.O.S. services were diverted from use of psychiatric emergency services and did not require law enforcement intervention.
- Youth who received Youth S.O.S. services increased protective factors such as self-empowerment and connection, increased access to services by learning about emergency mental health resources, and feel able to reach out for support from an adult or from emergency mental health services when their distress is high.

Outcome Indicators

Domain	Indicators/Questions	2021-22 (n=37 youth, n=35 parents)	2022-23 (n=30 youth, n=30 parents)
Improved knowledge, skills, and/or ability	Number of youth who learned a new coping strategy to increase mental, emotional, and relational functioning.	100%	100%
Connection and Support	Number of youth who can identify and feel safe reaching out and contacting at least one adult when they are experiencing emotional distress during a follow up session.	92%	93%

Self-Empowerment	Number of youth who can identify and feel confident accessing emergency mental health services when their emotional distress is high.	91%	97%
Knowledge & Access to Services	Number of caregivers or family members who received psychoeducation and resources to increase youth's community and relational support. (Population: family members/caregivers of youth)	100%	100%
Utilization of Emergency Services	Number of youth diverted from use of psychiatric emergency services (population: youth who received Youth S.O.S. services) Number of youth that did not require law enforcement intervention (population: youth who received Youth S.O.S. services)	100% 100%	100% 100%

EARLY INTERVENTION PROGRAM SUMMARIES

PRIMARY CARE INTERFACE

The Primary Care Interface (PCI) program is funded 20% CSS, 80% PEI. The purpose of the PCI program is to integrate mental health services into primary care. The program partners with San Mateo County primary care clinics to provide easier access to mental health services. It started in 1995 at one clinic and is now embedded in five primary care clinics throughout the county. The program serves all age groups, from children as young as three to older adults. The program is offered to those with mild to moderate mental health issues. Around 60% to 70% of clients are covered by Medi-Cal, while the remaining clients are covered through the County health insurance program, Access, and Care for Everyone.

- Primary Program Screenings, Activities, and Interventions Provided: The primary care clinics use the Patient Health Questionnaire-2 and -9 as well as the Adverse Childhood Experiences (ACEs) Questionnaire to screen adults and children visiting the clinics. Once diagnosed with a mild or moderate mental health condition or risk factor, clients are referred, based on their needs, to psychiatry, therapy, and/or case management. Referrals are also made to provide support for treating alcohol and substance use issues.

- New Activities and Interventions Targeting Substance Use: New interventions and activities undertaken in FY 2022-23 included the creation of a virtual alcohol and other drug services (AOD) resource group and the implementation of a contingency management group, which refers to a type of behavioral therapy, for AOD clients through Pear Therapeutics. Through this external agency, PCI was able to purchase prescriptions that were issued by the clients' psychiatrists. Additionally, to address opioid use, Pear Therapeutics provided a curriculum and modules for clients to complete. A new intervention undertaken in FY 2023-24 was weekly wellness group sessions that were offered in both English and Spanish.

Numbers Served

Primary Care Interface*	FY 2021-22	FY 2022-23	FY 2023-24
Clients served (unduplicated)	2,846	617	685
Individuals reached (duplicated)	No data	1,618	1,821
Cost per client	$470	$424	$287

**Unduplicated clients are those with completed intakes. Duplicated clients were referrals from outreach or triage and did not result in completed intakes. These referrals also included duplicates because one individual could be referred more than once.*

Program Outcomes

Data Collection Methods

- Participant post-survey[28]

Outcome Highlights

- A majority of PCI clients who completed the post-program survey reported that they learned coping strategies and think more positively about challenges in their lives, and as a result of the program their overall behavioral health improved. Respondents answered the survey more positively in FY 2023-24 than in FY 2022-23.

Outcome Indicators

Domain	Indicators/Questions	Percent Agree or Strongly Agree		
		2021-22	2022-23 (n=92)	2023-24 (n=123)
General behavioral health	As a result of participating in this program, I am better able to manage my symptoms and participate in daily life.	*No data*	67%	89%
Knowledge, skills, and/or abilities	As a result of participating in this program, I think more positively about challenges and I believe the decisions and steps I take impact my outcome.	*No data*	60%	86%
Knowledge, skills, and/or abilities	As a result of participating in this program, I learned skills and strategies to cope with stressors.	*No data*	64%	88%

Additional Data on Program Outcomes

PCI Referrals Received and PCI Clients' Health Care Use

Referral information	FY 2022-23	FY 2023-24
Total number of referrals received to the program	2,316	2528
Total number of referrals that resulted in program enrollment (number engaged)	678 (606)	685
Clinical Services		
Average duration of untreated mental illness (days)	29.12	22.1
Average length of time between referral date and enrollment date (days)	22.53	21.0
Minimum length of time (days)	0	0
Maximum length of time (days)	370	85

[28] No outcome data were available for FY 2021-22.

(RE)MIND EARLY PSYCHOSIS PROGRAM

The (re)MIND® program is a coordinated specialty care model for prevention and early intervention of severe mental illness that specializes in early intervention for schizophrenia spectrum disorders. (re)MIND® delivers comprehensive assessment and treatment grounded in wellness, recovery, and resilience to youth and young adults experiencing early symptoms of psychosis with evidence-based and culturally responsive interventions. The (re)MIND/Bipolar Disorder Early Assessment and Management (BEAM) aftercare program – (re)MIND® Alumni – was developed to provide program graduates and caregivers with a specialized safety net to sustain gains achieved through engagement in psychosis early intervention.

The (re)MIND® and BEAM programs serve the following, regardless of insurance status:

- Residents of San Mateo County *and*
- Individuals between the ages of 14 and 35 *and*
- Those 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*
- Individuals who have developed symptoms of psychosis for the first time in the past two years.

In addition, (re)MIND® Alumni serves individuals who have graduated from (re)MIND/BEAM and elect to receive active support to maintain engagement in educational or vocational activities, and further develop skills to self-navigate community resources.

Numbers Served

(re)MIND *	FY 2021-22	FY 2022-23	FY 2023-24
Clients served (unduplicated)	77	79	79
Cost per client	$3,425	$3,338	$7,458
Individuals reached (duplicated)	62	40	54
Total Served	139	119	133

** Unduplicated clients served are individuals that receive early psychosis treatment and aftercare, individuals reached includes families and caregivers.*

Program Outcomes

Data Collection Methods

- Hospitalization data through Electronic Health Record
- Child and Adolescent Needs and Strengths (CANS)
- Participant and alumni post-survey

Outcome Highlights

- In most cases, over 90% of participants and alumni experienced each outcome.
- In all years, over 95% had improved engagement in meaningful activities.
- In FYs 2022-23 and 2023-24, over 95% experienced an improvement in their CANS Psychosis score; in FY 2021-22, over 80% did.
- At least 95% of participants and alumni experienced a reduction in hospitalizations in FYs 2021-22 and 2023-24; based on data provided, a lower percent did in FY 2022-23 (70%).

Outcome Indicators

Domain	Indicators/Questions	2021-22	2022-23	2023-24
General behavioral health	Improved engagement in meaningful activities (employment, academic placement/ progression, volunteerism) for participants and alumni	**97%** *(75 of 77)*	**97%** *(77 of 79)*	**95%** *(75 of 79)*
General behavioral health	CANS – psychosis (improvement in score by at least one point or maintenance in score of 1 from initial to follow-up for participants and alumni)	**82%** *(27 of 33)*	**97%** *(77 of 79)*	**96%** *(76 of 79)*
Utilization of emergency/ crisis services	Reduction in hospitalizations (both number of days and number of episodes) for participants and alumni	**96%** *(74 of 77)*	**70%** *(16 of 23)*	**95%** *(75 of 79)*
Self-empowerment	"Due to this program, I can take control of aspects of my life" Agree; Agree Strongly for participants and alumni	*No data*	**93%** *(26 of 28)*	**93%** *(25 of 27)*
Stigma (self-internalized)	"*Due to this program, I am able to understand myself better*" Agree; Agree Strongly for participants and alumni	*No data*	*No data*	**100%** *(5 of 5)*
Satisfaction	"*I am satisfied with the services I have received at (re)MIND/BEAM program"* Agree; Agree Strongly for participants and alumni	*No data*	*No data*	**93%** *(25 of 27)*

Quotes from Clients

"Nicole was my first therapist…devoted to combating the stigma, both external and internal, surrounding the bipolar diagnosis…. She helped me see the beginnings of what bipolar really was—a devastating diagnosis that takes a lot of hard work to manage, but is possible to heal from. The recovery can only begin when one has the will to get stable, and that was the first step for me—to want stability more than anything else…. With the bipolar expertly managed, I am now free to dream big, once again. I am currently writing a memoir about my recovery journey…I am teaching yoga, dance, and fitness at community and corporate gyms, as well as high schools…. I am leading a full life and have such a bright future ahead. It's an ongoing journey, but I will carry everything I've learned these past four years into the rest of my life. Thank you for giving me my life back. I am forever indebted to you all."

THE SAN MATEO COUNTY PRIDE CENTER

The Pride Center (35% CSS, 65% PEI) creates a welcoming, safe, inclusive, and affirming space for individuals of all ages, sexual orientations, and gender identities through education, counseling, advocacy, and support. The Pride Center takes a holistic approach to improving the health and wellbeing of the LGBTQ+ community by providing direct mental health services to individuals living with severe mental health challenges and individuals in the community seeking support groups, resources, community building activities, and social and educational programming ("LGBTQ+" refers to any non-heterosexual and non-cisgender individuals, including, but not limited to, people who identify as lesbian, gay, bisexual, transgender, gender non-conforming/variant, queer, questioning, intersex, two-spirited, and more).

The Clinical Program of the Pride Center provides LGBTQ+ affirming behavioral and mental health services to marginalized and at-risk LGBTQ+ community members in San Mateo County. Clinical services include individual therapy, relationship therapy, family therapy, group therapy, and case management. The Pride Center work is strength-based and trauma-informed, engaging both natural supports and the whole family whenever possible. The primary purpose is to assist clients, their families, and their communities in reducing stigma and supporting the creation of safe, affirming environments for LGBTQ+ clients. To this end, services are aimed at not only reducing high-risk symptoms such as self-harming behaviors and trauma symptoms, but also at providing family support and education to non-affirming family members. In addition to offering direct clinical care, the program's clinical team provides extensive consultation and LGBTQ+ training for other mental health and medical service providers; school administrators and educators; parents of LGBTQ+ youth; students; LGBTQ+ older adults; and the general public.

Numbers Served

Pride Center	FY 2021-22	FY 2022-23	FY 2023-24
Clients served (unduplicated)	169	149	147
Cost per client	$3,334	$2,138	$2,138
Individuals reached (duplicated)	4,456	9,357	12,140
Total Served	4,625	9,506	12,287

** unduplicated clients served are individuals that received therapy and case management, individuals reached includes all other individuals that participated in peer groups, youth and older adult services, trainings, outreach and events.*

Program Outcomes

Data Collection Methods

- Child and Adolescent Needs and Strengths (CANS)
- Adult Needs and Strengths Assessment (ANSA)
- Clinical client survey

Outcome Highlights

A majority of clinical clients demonstrated improvements in mental health symptoms of depression and anxiety as well as protective factors.

- Of clinical clients for whom follow-up assessments were available, most had improved or maintained their depression and anxiety scores (CANS/ANSA Depression subscale scores improved or remained the same for at least 80% of clients in all years; anxiety subscales improved or remained the same for at least 80% of clients in all but FY 2021-22).
- Of clients who completed the clinical self-assessment at discharge, most reported improvements in their general behavioral health and ability to cope with stress (at least 87% in all years).
- CANS/ANSA scales for interpersonal/social connectedness and community connection/support improved for at least 73% of clients in each year.

After receiving clinical services, a majority of clients experienced greater comfort speaking about their gender identity and sexual orientation and had a greater sense of empowerment in their life.

Outcome Indicators

Domain	Indicators/Questions	2021-22	2022-23	2023-24
General behavioral health	CANS + ANSA* Depression subscales* (Population: Therapy Services) - improved/ remained the same	85% (41 of 48)	87% (43 of 49)	86% (30 of 35)
	CANS + ANSA Anxiety subscales* (Population: Therapy Services) - improved/remained the same	54% (26 of 48)	80% (39 of 49)	86% (30 of 35)
	Number of clients who reported an improvement in their mental health as measured by: *"How would you rate your mental health in the last 30 days?"* (Population: Therapy Services) - improved/remained	*Data not available*	91% (43 of 47)	83% (29 of 35)
	Number of clients who reported an improvement in their ability to cope with stress as measured by the following "*How would you rate your ability to cope with stress in the last 30 days?"* (Population: Therapy Services) - improved/remained the same	*Data not available*	87% (41 of 47)	74% (26 of 35)
Improved knowledge, skills, and/or abilities	ANSA Interpersonal/Social Connectedness + CANS Interpersonal subscales (Population: Therapy Services) - improved/ remained the same	73% (35 of 48)	80% (39 of 49)	74% (25 of 34)
Connection and Support	ANSA Natural Supports + CANS Community Connection subscales (Population: Therapy Services) - improved/ remained the same	75% (36 of 48)	80% (39 of 49)	76% (30 of 35)
Self-Empowerment	Number of clients who reported improved self-empowerment as measured by the following: "*I am confident I can affect my life through the decisions I make."* (Population: Therapy Services) - improved/ remained the same	*Data not available*	66% (12 of 18)	74% (26 of 35)

Stigma Reduction	Number of clients who reported reduced self-stigma as measured by the following: *"I feel comfortable talking about my sexual orientation."* (Population: Therapy Services) - improved/ remained the same	*Data not available*	83% (15 of 18)	80% (28 of 35)
	Number of clients who reported reduced self-stigma as measured by the following: *"I feel comfortable talking about my gender identity."* (Population: Therapy Services) - improved/ remained the same	*Data not available*	77% (14 of 18)	87% (30 of 35)

**The DEPRESSION and ANXIETY subscales of the CANS and ANSA assessments are considered "Needs" and scored between 0-3. A score of "0" indicates no need is present, whereas a "3" demonstrates high need. The INTERPERSONAL and NATURAL SUPPORTS subscales are considered "Strengths" and also scored between 0-3. For strengths, a score of "0" indicates a positive core strength and a score of "3" indicates no strength is identified.*

Quotes from Clients

"The Pride Center has been very helpful in building self-esteem, affirming my efforts during COVID and in-general and helping me learn computer literacy skills and directing me to resources that are available in the community."

"I just wanted to say thank you again, I finally got my [name and gender change] papers back from the courts and I really wouldn't have even gotten through that step without you guys and the workshop."

"I've really enjoyed working with [clinician] and am so grateful for all the counseling services I've received at the Pride Center. It has been an amazing resource for me!"

Photos: SMC Pride Celebration and Parade 2024

RAVENSWOOD FAMILY HEALTH CENTER

Ravenswood Family Health Center is a community based Federally Qualified Health Center (FQHC) that serves East Palo Alto residents. Ravenswood outreach and engagement services are funded at 40% under CSS and the remaining 60% is funded through PEI. Ravenswood provides outreach and engagement services and identifies individuals presenting for healthcare services that have significant needs for behavioral health services. An MHSA-funded mental health clinician takes referrals from primary care providers at Ravenswood, and if more intensive care is needed then the clinician links the client to BHRS. The intent of the collaboration with Ravenswood FQHC is to identify patients presenting for healthcare services that have significant needs for mental health services. Many of the diverse populations that are now un-served will more likely appear in a general healthcare setting. Therefore, Ravenswood FQHC provides a means of identification of and referral for the underserved residents of East Palo Alto to primary care-based mental health services or to specialty mental health at BHRS.

Numbers Served

Ravenswood	FY 2021-22	FY 2022-23	FY 2023-24
Total clients served	450	386	386
Total cost per client	$57	$47	$47

Program Outcomes

All clients served represent referrals from primary care based providers at Ravenswood FQHC to behavioral health services including to specialty mental health services at BHRS.

SAN MATEO MENTAL HEALTH AND REFERRAL TEAM (SMART)

The San Mateo Mental Health and Referral Team (SMART) provides San Mateo County residents with a comprehensive assessment in the field and offer an alternative to Psychiatric Emergency Services (PES) when appropriate; or if needed to write a hold status and provide secure transportation to the hospital. The SMART contract with American Medical Response (AMR) has been providing 5150 evaluation and transport services since 2005. SMART is staffed by AMR paramedics who are also trained in Crisis Intervention Training (CIT) and is activated only by law enforcement officers. SMART serve any resident in psychiatric crisis regardless of age as identified by law enforcement. Primary program activities include consultation to law enforcement on scene. SMART can write a 5150 hold if needed and transport the person. If the individual does not meet the 5150 criteria the SMART medic can provide support and transportation to an alternate destination, i.e., crisis residential facility, doctor's office, detox, shelter, home, etc.

Numbers Served

SMART	FY 2021-22	FY 2022-23	FY 2023-24
Total calls received	577	286	245
Total cost per client	$56	$522	$549

Program Outcomes

The SMART program has two goals and measures, which are measured on a quarterly basis.

- Divert 10% of calls from PES admission where a 5150 was not already placed
- Respond to 75% of appropriate calls for service

For the most part, the SMART program exceeded both goals in all years and quarters.

- The only two quarters in which a program goal was not met was the percent of calls responded to in Q1 and Q2 of 2021-22 (in red text). The 2021-22 fiscal year generally had lower numbers than the subsequent years.
- In FY 2022-23, both goals were exceeded in all quarters.
- In FY 2023-24, the program exceeded its goal of 10% of calls diverted in Q1-Q3 and met the goal in Q4.

SMART	FY 2021-22	FY 2022-23	FY 2023-24
Percent of calls diverted	Q1: 29.2% Q2: 28.3% Q3: 25.5% Q4: 39.1%	Q1: 46.7% Q2: 41.4% Q3: 47.1% Q4: 32.1%	Q1: 41.4% Q2: 38.1% Q3: 34.6% Q4: 10.0%
Percent of calls responded to	Q1: 55.9% Q2: 47.8% Q3: 82.5% Q4: 94.2%	Q1: 92.5% Q2: 88.6% Q3: 84.3% Q4: 89.3%	Q1: 92.9% Q2: 87.9% Q3: 86.7% Q4: 89.5%

APPENDIX A. ODE KEY INDICATORS/SURVEY QUESTIONS

Indicator 1: Self-Empowerment

1. Due to my participation in this program/training/event, I am more confident in my ability to advocate for the mental health and/or substance use needs of myself and/or my child/ren and/or another family member.
    a. Strongly Agree
    b. Agree
    c. Neither Agree nor Disagree
    d. Disagree
    e. Strongly Disagree

Indicator 2: Community Advocacy (or Community Empowerment)

1. Due to my participation in this program/training/event, I feel more confident in my ability to create change in my community around mental health and substance use conditions. a. Strongly Agree
    b. Agree
    c. Neither Agree nor Disagree
    d. Disagree
    e. Strongly Disagree

Indicator 3: Cultural Humility/Identity

1. Due to my participation this program/training/event, I have a better understanding of how mental health and substance use challenges affect different cultures.
    a. Strongly Agree
    b. Agree
    c. Neither Agree nor Disagree
    d. Disagree
    e. Strongly Disagree
2. I feel like my identity, cultural background, and experiences (race, ethnicity, gender, sexuality, religion, etc.) were affirmed by this program/training/event.
    a. Strongly Agree
    b. Agree
    c. Neither Agree nor Disagree
    d. Disagree
    e. Strongly Disagree

Indicator 4: Access to Treatment/Prevention Programs (Reducing Barriers)

1. Through my participation in this event/program/training, I have learned knowledge and skills that I can use to access mental health and substance use health services.
    a. Strongly Agree
    b. Agree
    c. Neither Agree nor Disagree
    d. Disagree
    e. Strongly Disagree

Indicator 5: Stigma Discrimination Reduction

1. Due to this program/training/event, I feel more comfortable talking about my mental health and/or substance use (*self/internal*).
    a. Strongly Agree
    b. Agree
    c. Neither Agree nor Disagree
    d. Disagree
    e. Strongly Disagree

2. This program/training/event affirmed that people with mental health or substance use conditions are capable and able to make positive contributions to society.
    a. Strongly Agree
    b. Agree
    c. Neither Agree nor Disagree
    d. Disagree
    e. Strongly Disagree

APPENDIX 8. OUTREACH COLLABORATIVE ANNUAL REPORT FOR FY 2023–24

San Mateo County Behavioral Health and Recovery Services Provider Outreach Annual Report

Fiscal Year 2023–2024

Koray Caglayan, PhD; Brooke Shearon, MPP

December 2024

American Institutes for Research® | AIR.ORG

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Executive Summary

In 2004, California voters approved Proposition 63, the Mental Health Services Act, which provides funding to counties for mental health services by imposing a 1% tax on individuals with personal income in excess of $1 million. The Community Services and Supports component of the act was created to provide direct services to individuals with severe mental illness. The component includes outreach and engagement activities.

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) funds the North County Outreach Collaborative (NCOC) and the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO). These organizations provide outreach and engagement activities to residents of San Mateo County. Each collaborative also has providers who provide direct services to the populations they serve.

This report summarizes self-reported data from attendees at individual and group outreach events that occurred in fiscal year (FY) 2023–2024 (July 1, 2023–June 30, 2024). Appendices A through H show data for five providers participating in NCOC and three providers participating in EPAPHMO. We also present self-reported data from these outreach events since FY2019–2020 to show how attendance has changed over time.

Total Attendance

For FY2023–2024, SMC BHRS providers reported that there were 8,928 attendees at all outreach events, which reflects a 62% increase in total attendance compared to FY2022–2023 (which saw 5,519 attendees). The main cause of the increase in overall attendance was the increase in the attendance at group events. During FY2023–2024, SMC providers reached 7,920 attendees across 155 group outreach events, while during FY2022–2023, providers reached 4,601 attendees across 179 group outreach events. The attendance at group outreach events increased by 72% between FY2022–2023 and FY2023–2024. The attendance at individual outreach events showed a modest increase of 10%, with an additional 90 attendees served in FY2023–2024 than in FY2022–2023.

Demographic Characteristics of Outreach Attendees

NCOC

There were 8,322 attendees at NCOC outreach events. Among attendees at NCOC outreach events, the most common age group was adults (31%). A little less than half the attendees were female (44%). The three largest racial/ethnic groups (after declined to state) were multiracial (16%), White or Caucasian (13%), or Samoan (7%). 34 percent of attendees declined to state

their race or ethnicity. Of those reporting special population status (e.g., homeless, at risk for homelessness, vision impaired, hearing impaired, veterans), 43% of attendees reported being a veteran, 24% reported being at risk for homelessness, and 7% of attendees reported having another disability.

EPAPMHO

There were 606 attendees at EPAPMHO outreach events. Most attendees were adults (60%) and females (54.8%). The greatest proportion of attendees by race/ethnicity were Black or African-American (29%), followed by Mexican/Chicano (27%). Of those reporting special population status, 51% were homeless and 26% were at risk of being homeless.

Outreach Event Characteristics

NCOC

NCOC individual outreach events ranged from 1 minute to a little over 2 hours and averaged 42 minutes. Most individual outreach events took place in schools (33%) and over the phone (31%).

NCOC group outreach events ranged from 15 minutes to 7 hours and averaged 87 minutes. Of the 155 group outreach events, most were conducted in schools (43%) or at an unspecified location (24%).

NCOC individual outreach events resulted in mental health referrals (21%) and substance use referrals (3%). Providers made 542 social service referrals for 402 NCOC individual outreach attendees. Among social services referrals, the top five types of referrals were in other referrals (30.4%), cultural services (14.9%), food (11.6%), legal (11%), and other medical care (9%) (see Exhibit 5a).

EPAPMHO

EPAPMHO individual outreach events lasted from 5 minutes to 3 hours and averaged 35 minutes. Most outreach events took place in an office (56%) or at an unspecified location (28%).

There were no EPAPMHO group outreach events in FY 2023-24.

EPAPMHO individual outreach events resulted in mental health referrals (15%) and substance use referrals (53%). Providers made 991 social services referrals for 606 individual outreach attendees. The top five types of other social services referrals made for individual outreach attendees were for housing (21.2%), food (13.1%), other referrals (11.4%), medical care (10.9%), and legal (9.5%).

Recommendations

We have the following recommendations based on FY2023–2024 data. These recommendations fall under two umbrellas: those aimed at enhancing outreach and those intended to improve data collection.

Providing outreach in different languages and offering non-office visits and virtual appointments may have resulted in modest increases in the number of participants attending individual outreach events this year.

Continue to offer non-office locations for group and individual outreach events. Data show that many outreach events were conducted in communities and in nontraditional locations, such as over the phone and through telehealth services. Although this may have originally been in response to the COVID-19 pandemic, the county should consider continuing to provide alternative locations or venues, including a virtual option. This will give county residents multiple options to avail themselves of the services offered through the program.

Provide social service referrals to attendees at group outreach events as well. The county provides referrals to social services like housing and form assistance to those who attend individual outreach events. The county could consider offering similar referrals to social services during group outreach events as this will help to address attendees' needs and improve their overall health and well-being.

Introduction

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), which provides funding to counties for mental health services by imposing a 1% tax on personal income of more than $1 million. Activities funded by MHSA are grouped into various components. The Community Services and Supports (CSS) component was created to provide direct services to individuals with severe mental illness. CSS is allotted 80% of MHSA funding for services focused on recovery and resilience while providing clients and families with an integrated service experience. CSS has three service categories: (a) Full-Service Partnerships, (b) General Systems Development Funds, and (c) Outreach and Engagement.

The San Mateo County Behavioral Health and Recovery Service (SMC BHRS) MHSA Outreach and Engagement strategy aims to increase access and improve linkages to behavioral health services for underserved communities. Strategies include community outreach collaboratives,

pre-crisis response, and primary care-based efforts. SMC BHRS has seen a consistent increase in the representation of underserved communities in its system since the strategies were deployed.

Community outreach collaboratives funded by MHSA include the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) and the North County Outreach Collaborative (NCOC). EPAPMHO caters to transition-age youth and adults; Latino, African American, and Pacific Islander communities; and people who identify as lesbian, gay, bisexual, transgender, and questioning in East Palo Alto. NCOC caters to rural and/or ethnic communities (Chinese, Filipino, Latino, Pacific Islander) and lesbian, gay, bisexual, transgender, and questioning communities in the North County region, including Pacifica. These collaboratives provide advocacy, systems change, resident engagement, expansion of local resources, and education and outreach to decrease stigma related to mental illness and substance use. They work to increase awareness of and access and linkages to culturally and linguistically competent services for behavioral health, Medi-Cal and other public health services, and social services. They participate in a referral process to ensure that those in need receive appropriate services such as food, housing, and medical care. Finally, they promote and facilitate resident input into the development of MHSA-funded services and other BHRS program initiatives.

The American Institutes for Research® (AIR®) has supported SMC BHRS in reporting findings from the county's outreach activities since fiscal year (FY) 2014–2015. This annual report provides details on outreach activities conducted by providers in FY2023–2024 (July 1, 2023–June 30, 2024). Providers collected outreach data using an electronic form (SurveyMonkey®) that gathers self-reported information from attendees. AIR created this form based on interviews with San Mateo County staff and focus groups with providers. After data are entered, AIR cleans them and calculates aggregated counts and percentages to describe outreach activities.

This report focuses on EPAPMHO and NCOC outreach events that occurred during FY2023–2024. We also present historical data from FY2014–2015 to FY2022–2023 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.

Overall Outreach

During FY2023–2024, there were 8,929 attendees at outreach events—1,008 attendees at individual outreach events and 7,920 attendees across 155 group outreach events. An

individual outreach event included a single attendee, while group outreach events included multiple attendees. As stated earlier in this document, the count of attendees is not necessarily unique because a person may have been a part of multiple individual or group outreach events.

Exhibit 1 shows the number of outreach attendees by collaborative, provider, and event type (i.e., individual or group), for FY2023–2024.

Exhibit 1. Outreach Attendees, by Collaborative, Provider, and Event Type, FY2023–2024

Provider organization	Number of individual outreach attendees	Number of attendees at group outreach events	Total attendees reported across all events
NCOC			
Asian American Recovery Services	98	1,062	1,160
Daly City Peninsula Partnership Collaborative	200	1,860	2,060
Daly City Youth Health Center	49	2,909	2,958
Pacifica Collaborative	8	2,089	2,097
StarVista	47	0	47
NCOC total	402	7,920	8,322
EPAPMHO			
Anamatangi Polynesian Voices*	61	0	61
El Concilio	98	0	98
Free At Last	447	0	447
EPAPMHO total	606	0	606
NCOC and EPAPMHO total	1,008	7,920	8,928

Note. NCOC = North County Outreach Collaborative; EPAPMHO = East Palo Alto Partnership for Mental Health Outreach; FY = fiscal year.

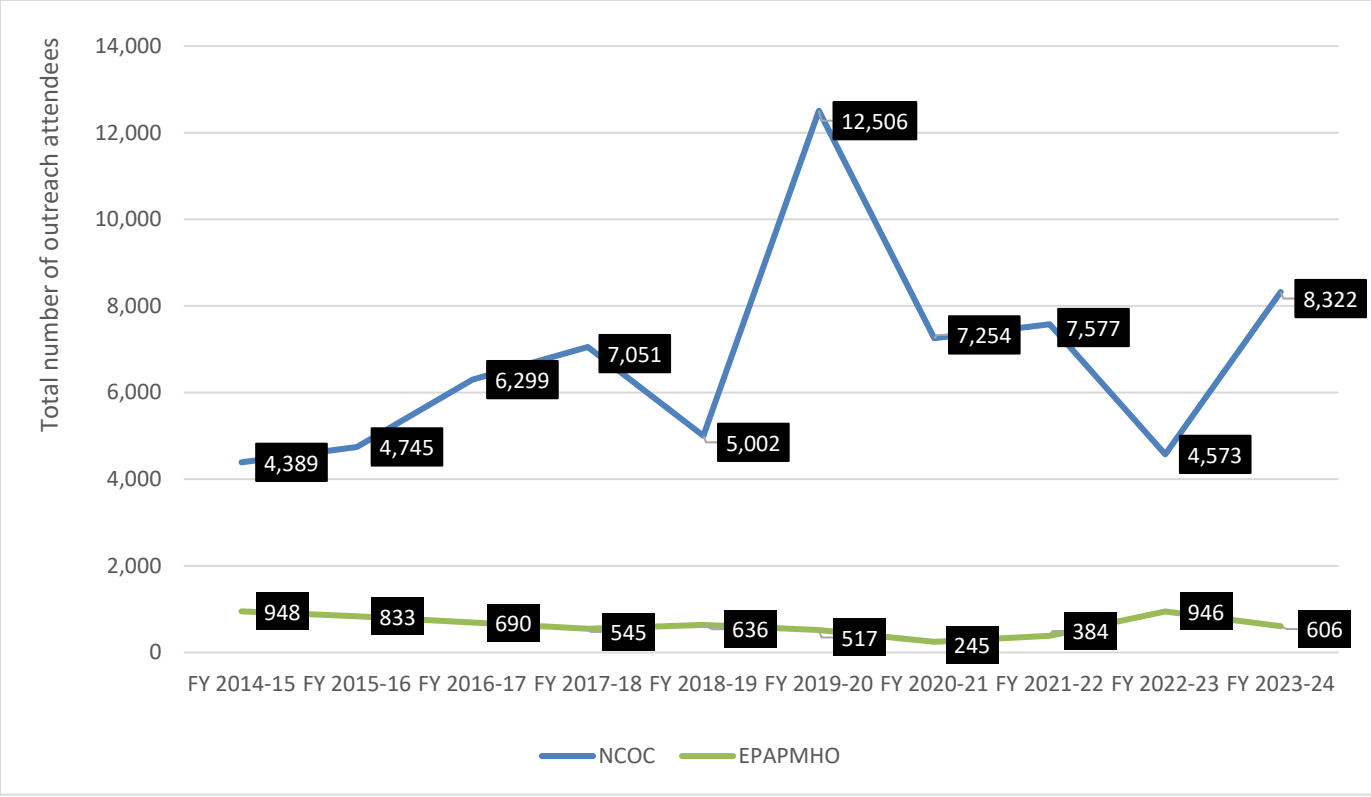
*Multicultural Counseling and Education Services of the Bay Area changed its name to Anamatangi Polynesian voices.

The NCOC is expected to serve a larger proportion of the outreach collaborative effort because it serves the entire northern region of San Mateo County (estimated population = 139,919), including the cities of Colma, Daly City, and Pacifica. The population of these cities is five times the population of the city of East Palo Alto, which is served by EPAPMHO. The north region also spans a much wider geographical area, making group events (vs. individual outreach), such as community-wide fairs, more feasible. In contrast, East Palo Alto spans 2.5 square miles, making an individual approach to outreach more achievable.

Exhibit 2 shows the trends in the number of outreach attendees over the years for both collaboratives. In FY 2019–2020, the number of NCOC attendees increased significantly, likely because more individuals sought mental health services during the COVID-19 pandemic[1]. The COVID-19 regional stay-at-home order was issued on March 16, 2020. Services provided from March 2020 to June 2020 showed an increase in outreach because many more residents were likely seeking mental health services in response to the pandemic. Events sponsored by the Daly City Peninsula Partnership Collaborative and the Daly City Youth Health Center also addressed food security during the pandemic (FY2019–2020) by distributing food during the events. A higher attendance at these events may contribute to an overall increase seen in FY2019–2020. While there was a sharp decrease in attendance from FY2021–2022 to FY2022–2023, there was a sharp increase in FY 2023-2024.

The number of EPAPMHO outreach attendees decreased from FY2014 to FY2021 but increased from FY2020 to FY2023. The number of attendees decreased this year, in FY2023-24.

Exhibit 2. Total Outreach Attendees by Collaborative, FY2014–2024

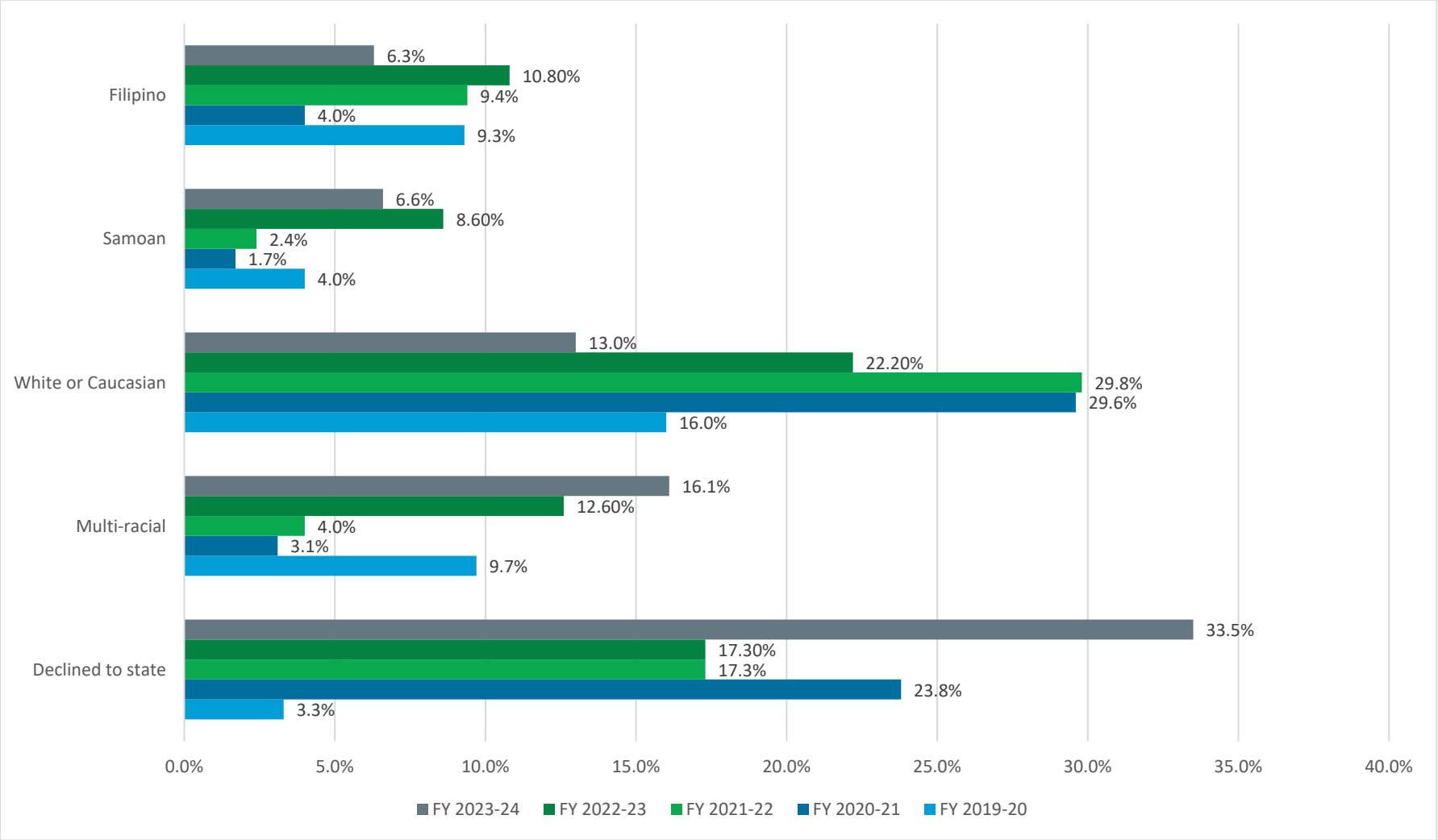


[1] Demand for mental health treatment continues to increase, say psychologists

Note. FY = fiscal year; NCOC = North County Outreach Collaborative; EPAPMHO = East Palo Alto Partnership for Mental Health Outreach. The number of attendees from previous fiscal years is slightly higher than the number reported in the previous reports because some outreach data were reported after that fiscal year.

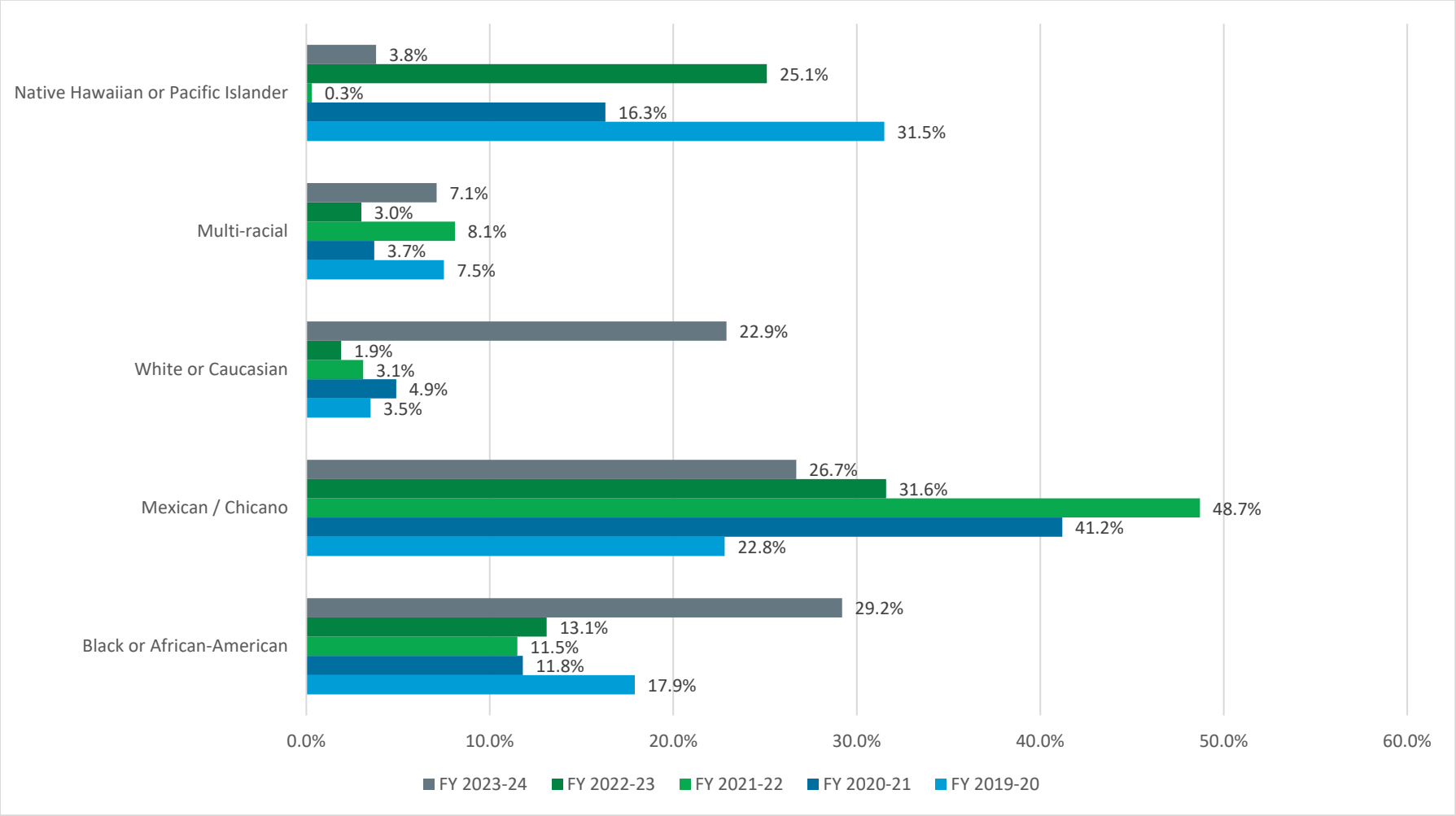
Exhibits 3a and 3b present the proportion of the top five racial/ethnic groups served by individual and group outreach in FY2023–2024 and trends over the past 4 fiscal years (i.e., FY2019–2020, FY2020–2021, FY2021–2022, and FY2022-2023), within each collaborative. A table with the entire breakdown of racial/ethnic groups from FY2019–2020 to FY2023–2024 is presented in Appendix I.

Exhibit 3a. Percentage of the Top Five Racial/Ethnic Groups Served by NCOC in FY2023–2024 and Trends in Prior Years, FY2019–2020 to FY2023–2024



Note. NCOC = North County Outreach Collaborative; FY = fiscal year.

Exhibit 3b. Percentage of the Top Five Racial/Ethnic Groups Served by EPAPMHO in FY2023–2024 and Trends in Prior Years, FY2019–2020 to FY2023–2024



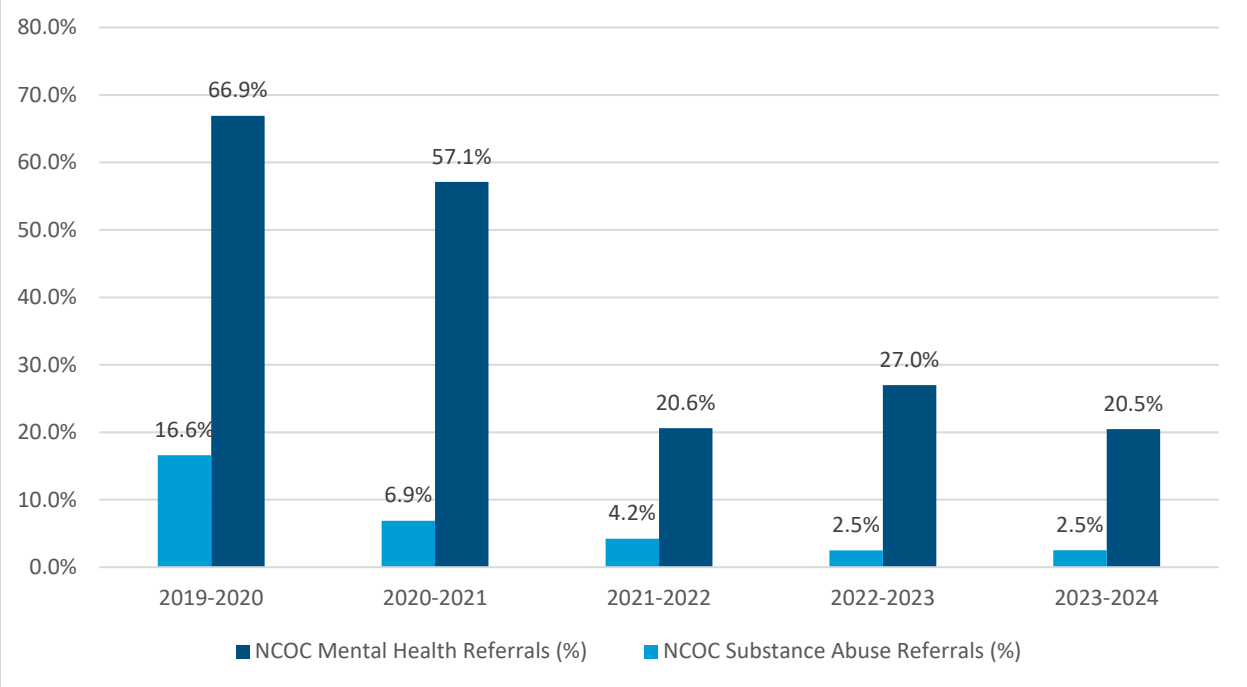
Note. EPAPMHO = East Palo Alto Partnership for Mental Health Outreach; FY = fiscal year.

The NCOC has seen significantly increased outreach numbers this year (FY2023-2024) compared to FY2022–2023 (see **Exhibit 2**), with a few key differences in the racial/ethnic demographics of the outreach attendees. For example, the proportion of White or Caucasian attendees decreased in FY2023–2024 compared to past fiscal years.

The EPAPMHO has seen decreased outreach numbers this year compared to FY2022–2023 (see **Exhibit 2**), with a few key differences in the racial/ethnic demographics of the outreach attendees. For example, the proportion of White or Caucasian attendees as well as Black or African-American attendees both significantly increased in FY2023–2024 compared to past fiscal years, while the proportion of Mexican/Chicano and Native Hawaiian or Pacific Islander attendees decreased.

Exhibit 4a presents the percentages of mental health and substance use referrals by NCOC from FY2019–2020 through FY2023–2024. Compared to FY2022–2023, the percentage of mental health referrals decreased by 6.5 percentage points from FY2022–2023, but the substance abuse referrals remained the same.

Exhibit 4a. Percentage of Mental Health/Substance Use Referrals by NCOC, FY2019–2020 to FY2023–2024

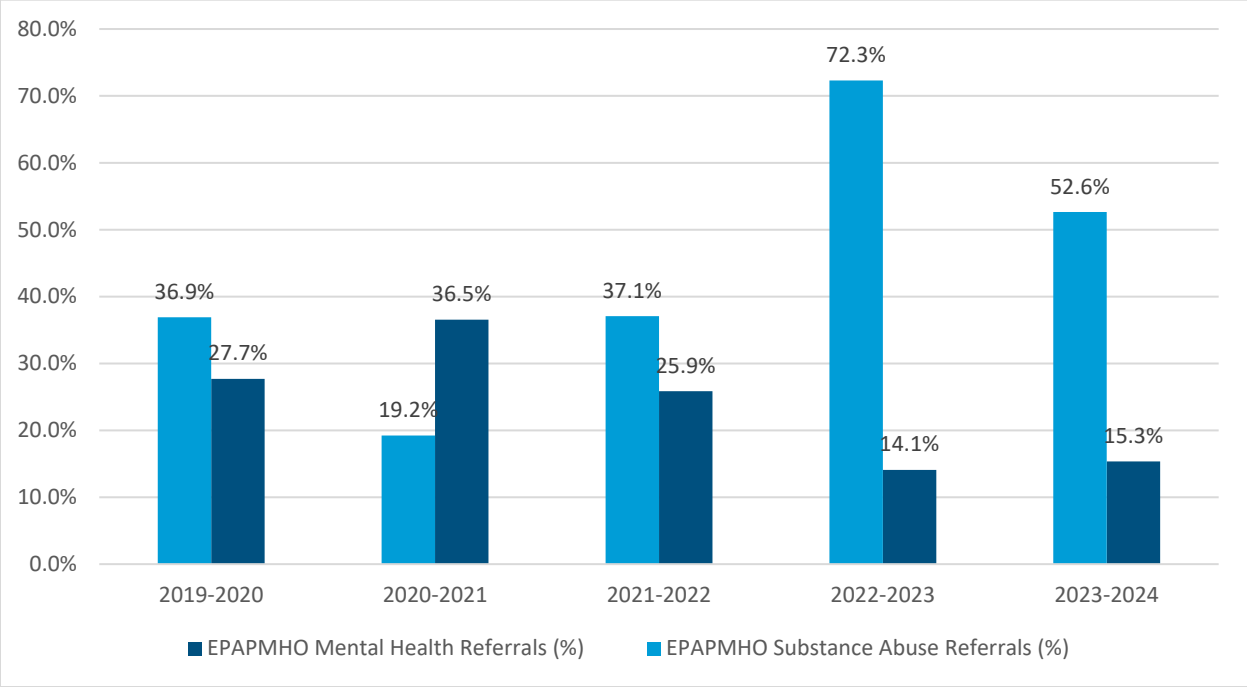


Note. NCOC = North County Outreach Collaborative; FY = fiscal year.

Exhibit 4b presents the percentages of mental health and substance use referrals by EPAPMHO from FY2019–2020 through FY2023–2024. Compared to FY2022–2023, the percentage of

mental health referrals stayed about the same from FY2022–2023. The percentage of substance abuse declined by close to 20 percentage points in FY2023–2024 compared to FY2022-2023.

Exhibit 4b. Percentage of Mental Health/Substance Use Referrals by EPAPMHO, FY2019–2020 to FY2023–2024



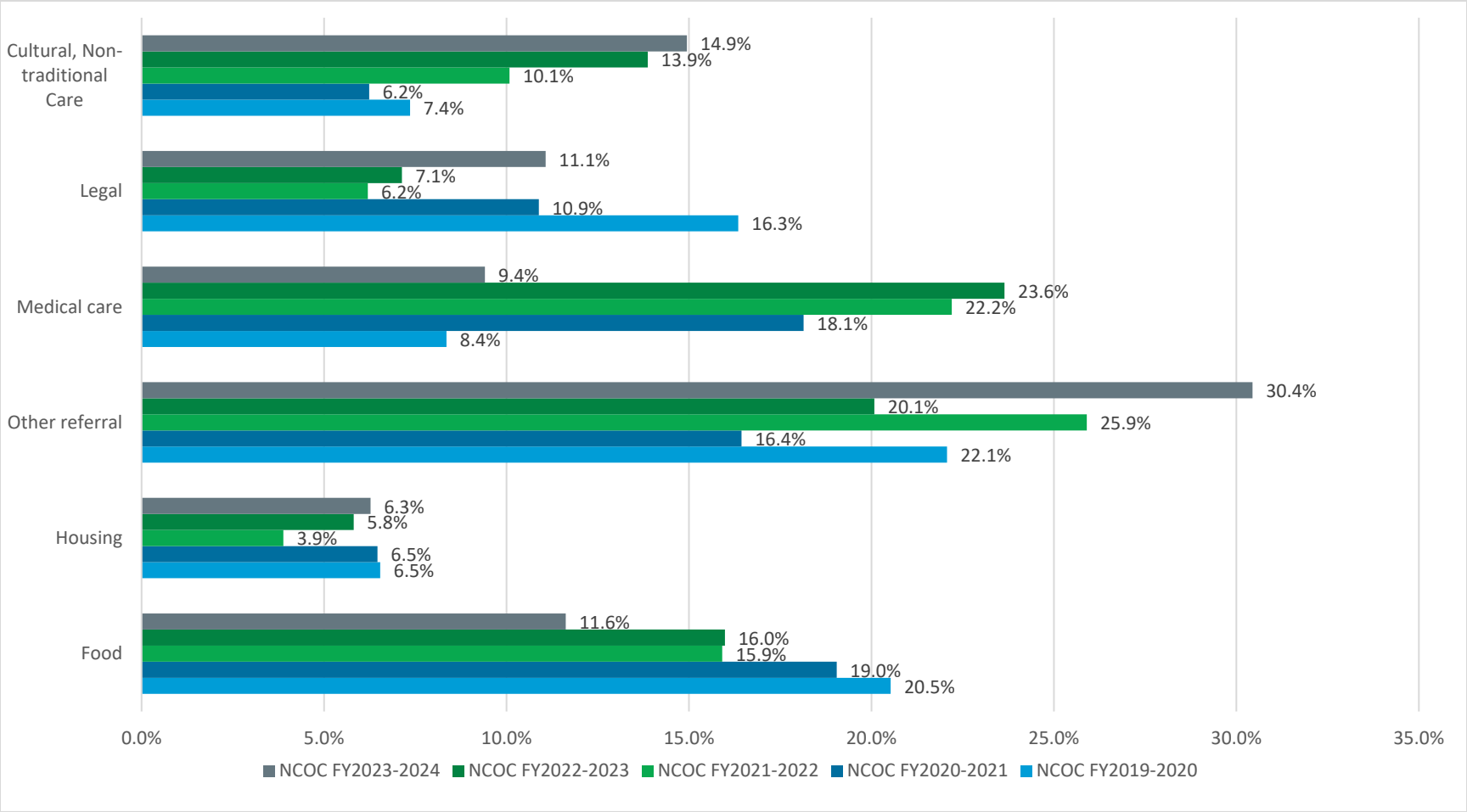
Note. EPAPMHO = East Palo Alto Partnership for Mental Health Outreach; FY = fiscal year.

Of the 8,322 individuals who attended NCOC events in FY2023–2024, 6.5% had referrals to social services. The percentage of referrals to social services decreased over FY2023–2024: of the 4,573 individuals who attended NCOC events in FY2022–2023, 16.5% had referrals to social services. Of the 606 individuals who attended EPAPMHO events in FY2023–2024, there were 991 referrals to social services. The number of referrals to social services decreased from FY2023–2024: of the 946 individuals who attended EPAPMHO events in FY2022–2023, there were 1,096 referrals. **Exhibits 5a and 5b** present the shares of the top five social services to which individual outreach event attendees were referred to in FY2023–2024 and the previous four fiscal years (FY2022-2023, FY2021–2022, FY2020–2021, FY2019–2020).

- In FY2023–2024, NCOC saw increases in the proportion of legal, cultural care, and other referrals with the prior year. On the other hand, the percentage of referrals for financial assistance, medical care, and food decreased in FY2023–2024 compared to the previous year.

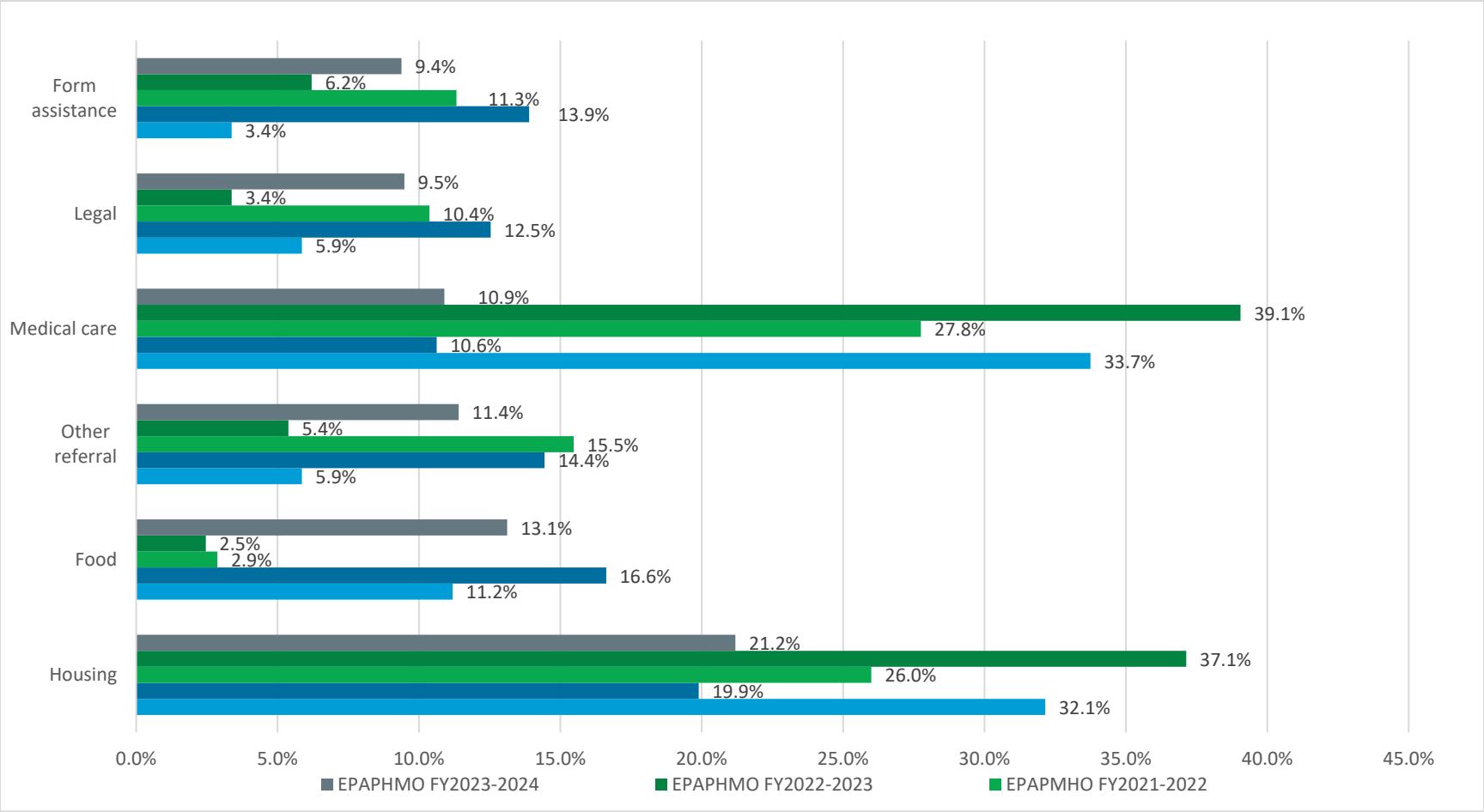
- In FY2023-2024, EPAPMHO saw increases in the proportion of referrals for form assistance, legal, other referrals, and food. On the other hand, the percentage of referrals for medical care and housing decreased in FY2023–2024 compared to the previous year.

Exhibit 5a. Referrals to Social Services Made by NCOC, FY2019–2020 to FY2023–2024



Note. NCOC = North County Outreach Collaborative; FY = fiscal year. Social service referrals not included in the graph include housing (6.3% in FY2023–2024), form assistance (3.5% in FY 2023-2024), emergency/protective services (3.1% in FY2023–2024), transportation (1.5% in FY2023–2024), and health insurance (1.1% in FY2023–2024). Referrals categorized as other social services represented 30.4% of all social service referrals in FY2023–2024 and included services related to COVID-19 testing and vaccinations, EOM Parent Project, the Home Energy Assistance Program, and mental health.

Exhibit 5b. Referrals to Social Services Made by EPAPMHO, FY2019–2020 to FY2023–2024



Note. EPAPMHO = East Palo Alto Partnership for Mental Health Outreach; FY = fiscal year. Social service referrals not included in the graph include health insurance (6.3% in FY2023–2024), financial (5.8% in FY2023–2024), transportation (5.5% in FY2023–2024), cultural services (4.6% in FY2023-24), and emergency/protective services (2.3% in FY2023–2024). Referrals categorized as other social services represented 11.4% of all social service referrals FY2023–2024 and included services related to COVID-19 testing and vaccinations, EOM Parent Project, the Home Energy Assistance Program, and mental health.

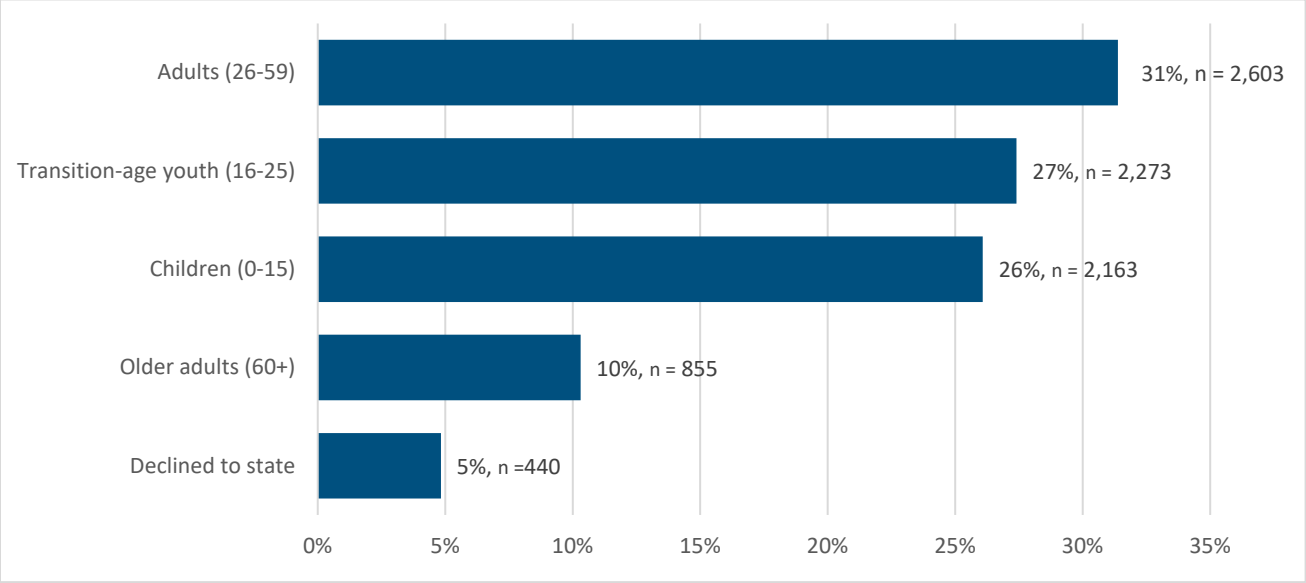
North County Outreach Collaborative (NCOC)

This section provides details about 8,322 attendees at NCOC group and individual outreach events across the five provider organizations in FY2023–2024.

Demographics

Age: Attendees across NCOC outreach events were adults (26–59 years of age; 31%), transition-age youth (16-25 years of age; 27%), children (0–15 years of age; 26%), and older adults (60 years of age and older; 10%) in FY2023–2024. Five percent of attendees declined to state their age. See **Exhibit 6** for the number and percentage of total outreach attendees representing each reported age group.

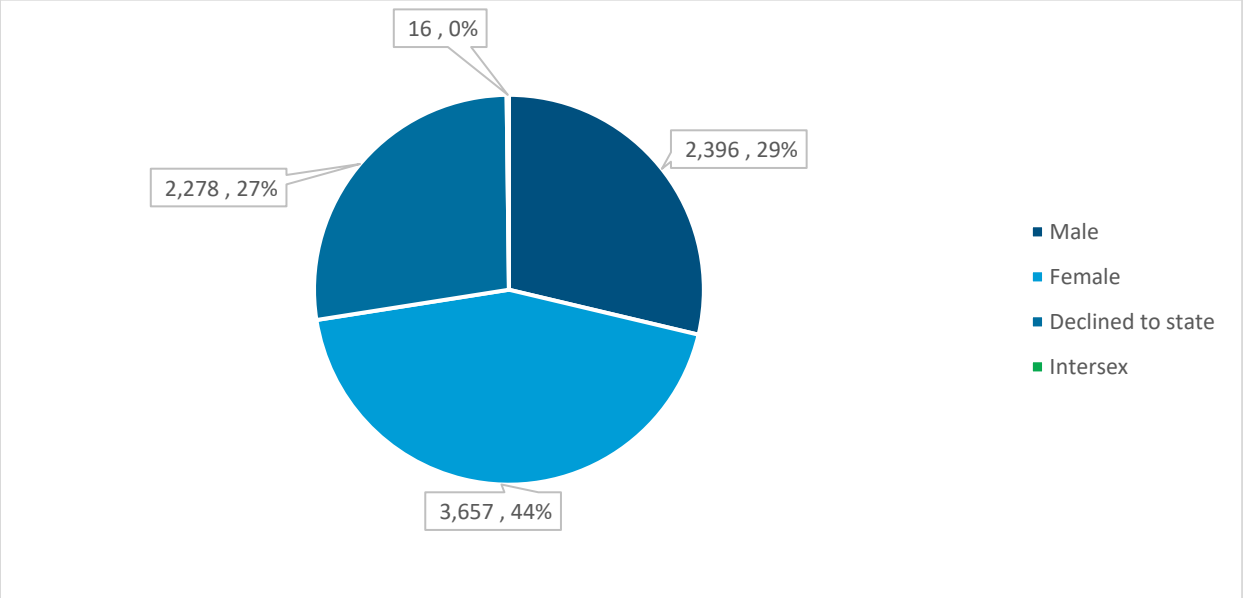
Exhibit 6. Age of Total Outreach Attendees Served by NCOC, FY2023–2024



Note. NCOC = North County Outreach Collaborative; FY = fiscal year. The total count for age reported may exceed the total number of attendees because some providers may have reported individuals in two or more age groups, leading to extra counts in some cases for the group outreach attendees. Therefore, the percentages may add up to more than 100%.

Sex at birth: Exhibit 7 shows the sex at birth of attendees across NCOC group and individual outreach events for FY2023–2024. Attendees indicated their sex at birth as female (44%), male (29%), or intersex (27%). Some declined to state their sex at birth (0.2%).

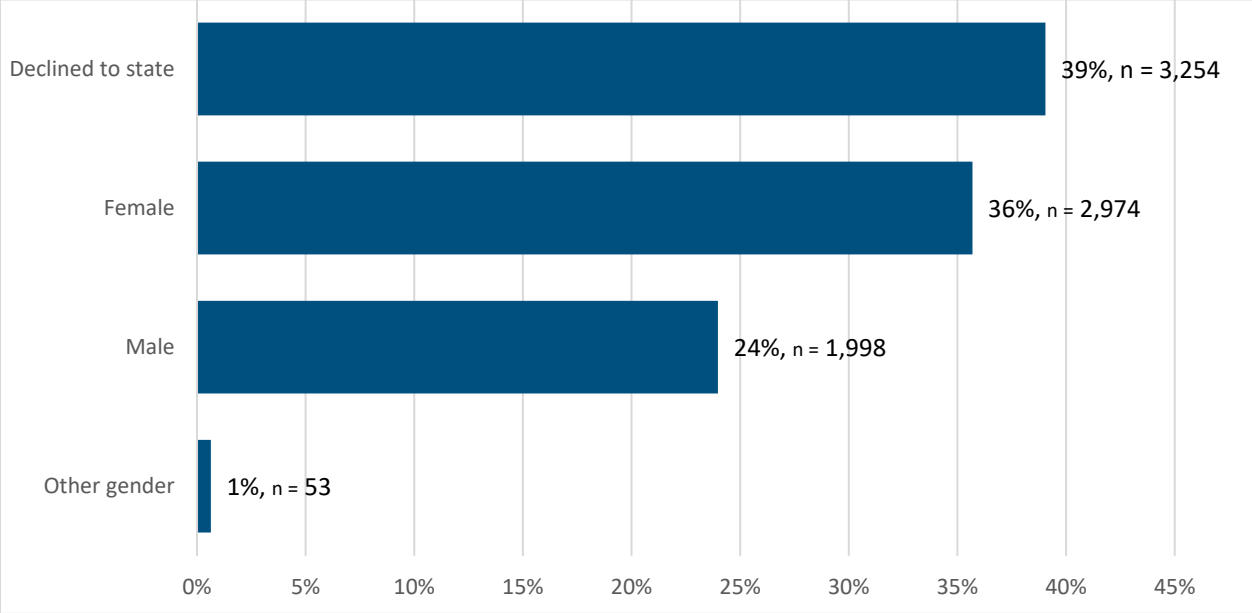
Exhibit 7. Sex at Birth of Outreach Attendees Served By NCOC, FY2023–2024



Note. NCOC = North County Outreach Collaborative; FY = fiscal year. Percentages may not sum to 100% because of rounding. The 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.

Gender: Exhibit 8 shows the gender of attendees across NCOC group and individual outreach events for FY2023–2024. After those that declined to state (39%), attendees identified as female (36%), male (24%), and other gender (1%). Other gender identities, which are not displayed in Exhibit 8 due to the small sample size, were genderqueer (*n*=21), female-to-male transgender (*n* = 18), male-to-female transgender (*n* = 10), and Indigenous gender identity (*n* = 5).

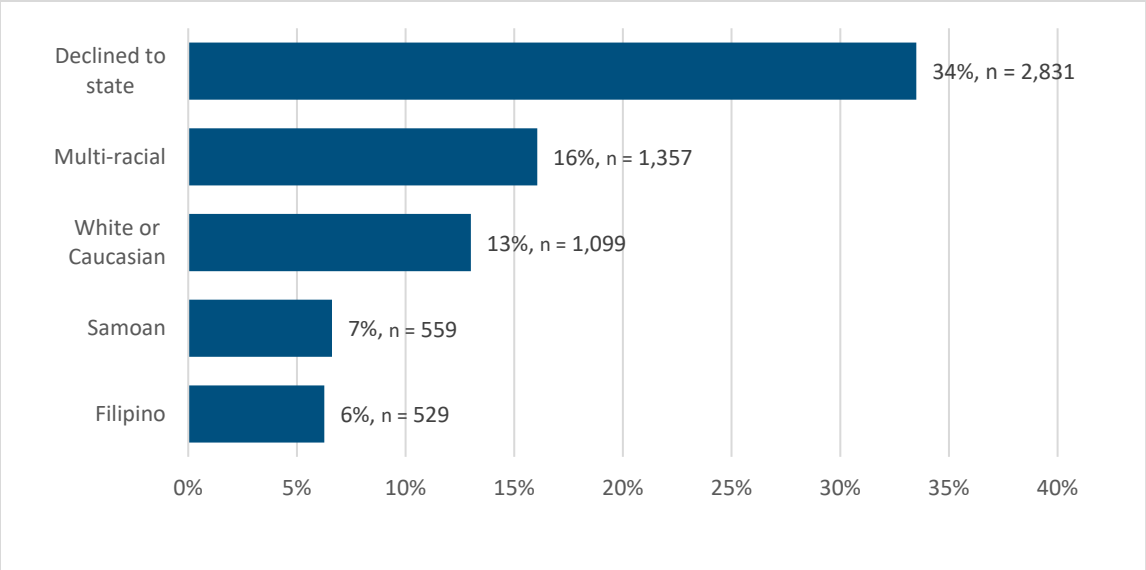
Exhibit 8. Gender of Outreach Attendees Served By NCOC, FY2023–2024



Note. NCOC = North County Outreach Collaborative; FY = fiscal year.

Race and ethnicity: In FY2023–2024, after declined to state (34%), the three largest racial/ethnic groups represented by all NCOC attendees were multiracial (16%), White or Caucasian (13%), and Samoan (7%). See **Exhibit 9** for the number of attendees representing each reported racial/ethnic group. A table with the entire breakdown of racial/ethnic groups from FY2019–2020 to FY2023–2024 is presented in Appendix I.

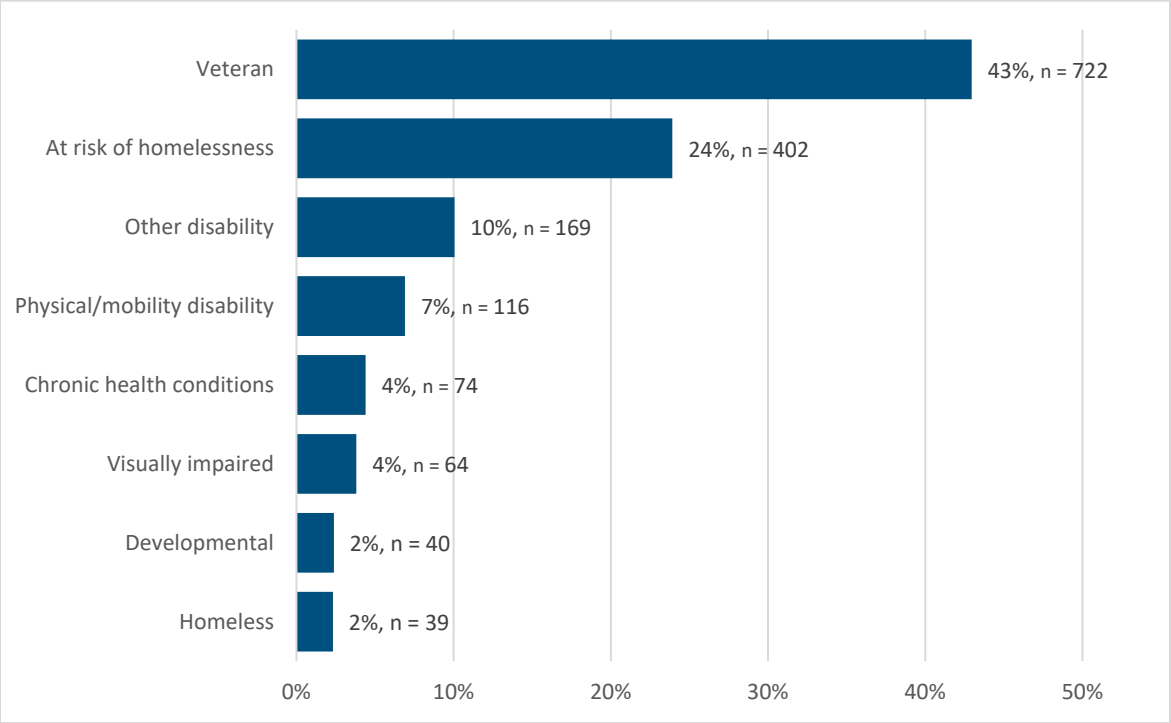
Exhibit 9. Race and Ethnicity of Outreach Attendees Served By NCOC, FY2023–2024



Note. NCOC = North County Outreach Collaborative; FY = fiscal year. The graph does not display 2,075 attendees belonging to various race/ethnicity groups due to small n within each group. The total count for race/ethnicity reported may exceed the total number of attendees because some providers may have reported individuals in two or more race/ethnicity groups, leading to extra counts in some cases for the group outreach attendees. Therefore, the percentages may add up to more than 100%.

Special populations: Of those reporting special population status, 43% reported being a veteran, 24% reported being at risk of homelessness, and 10% reported an other disability as one of the special needs they had. Please refer to **Exhibit 10** for the number of attendees representing each special population in FY2023–2024.

Exhibit 10. Special Populations Served By NCOC, FY2023–2024



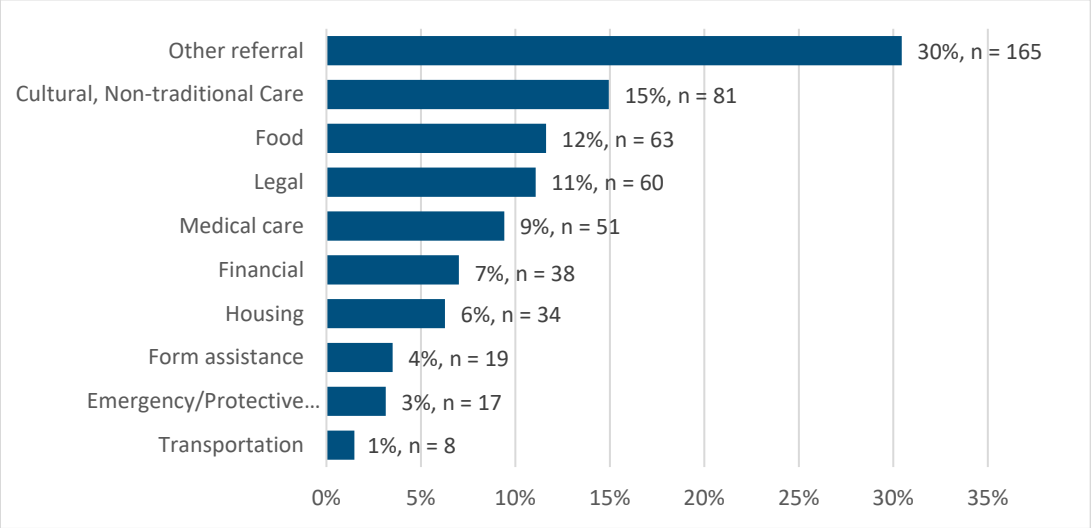
Note. NCOC = North County Outreach Collaborative; FY = fiscal year. Attendees could be included in more than one special population. Percentages may not sum to 100% because of rounding.

Additional Outreach Characteristics (Individual Outreach Events Only)

Mental health/substance use referrals: NCOC individual outreach events resulted in mental health referrals (21%) and substance use referrals (2.5%) in FY2023–2024.

Referrals to social services: Providers made 542 referrals to 402 people who attended NCOC individual outreach events. Out of the 402 people who attended individual NCOC events, 30% were referred to an other referral, such as COVID-19 testing and vaccination, EOM Parent Project, the Home Energy Assistance Program (HEAP), and mental health services; 15% were referred to cultural services; and 12% were referred to food services. **Exhibit 11** summarizes the number and percentage of attendees receiving a given type of referral in FY2023–2024.

Exhibit 11. Referrals to Social Services, FY2023–2024

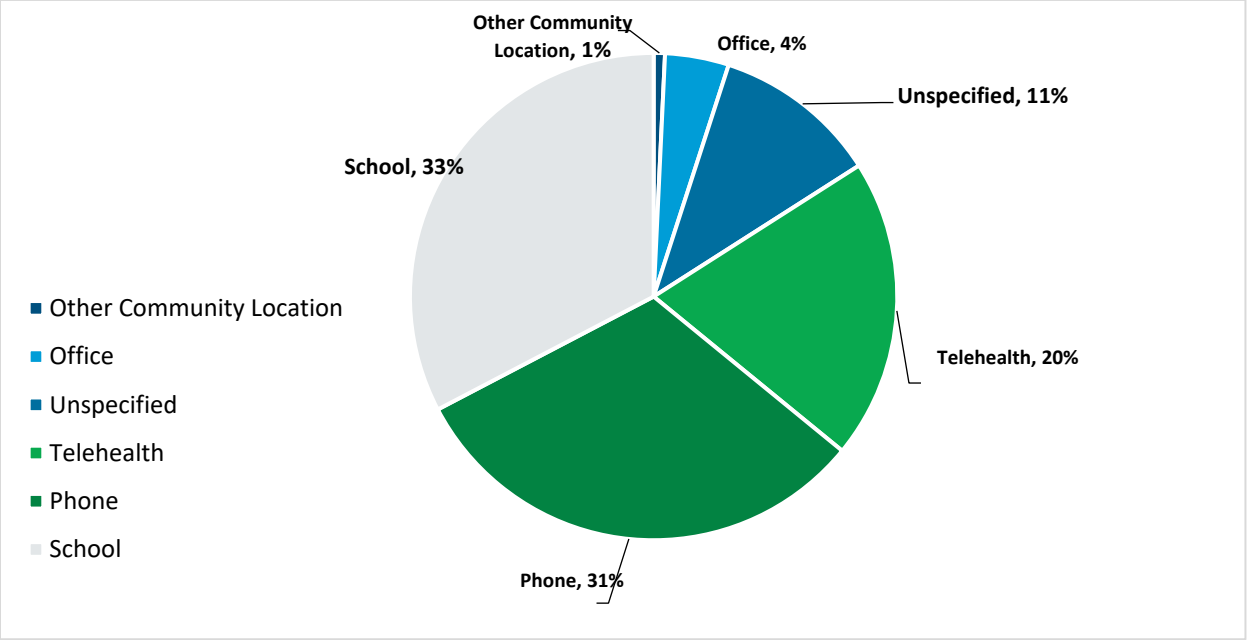


Notes. FY = fiscal year. Only individual outreach events (*n* = 402) offer service referrals. Individual outreach events may refer an attendee to multiple social services. Therefore, the percentages may add up to more than 100%. Other referrals include services related to COVID-19 testing and vaccination, EOM Parent Project, the Home Energy Assistance Program, and mental health services.

Event Characteristics

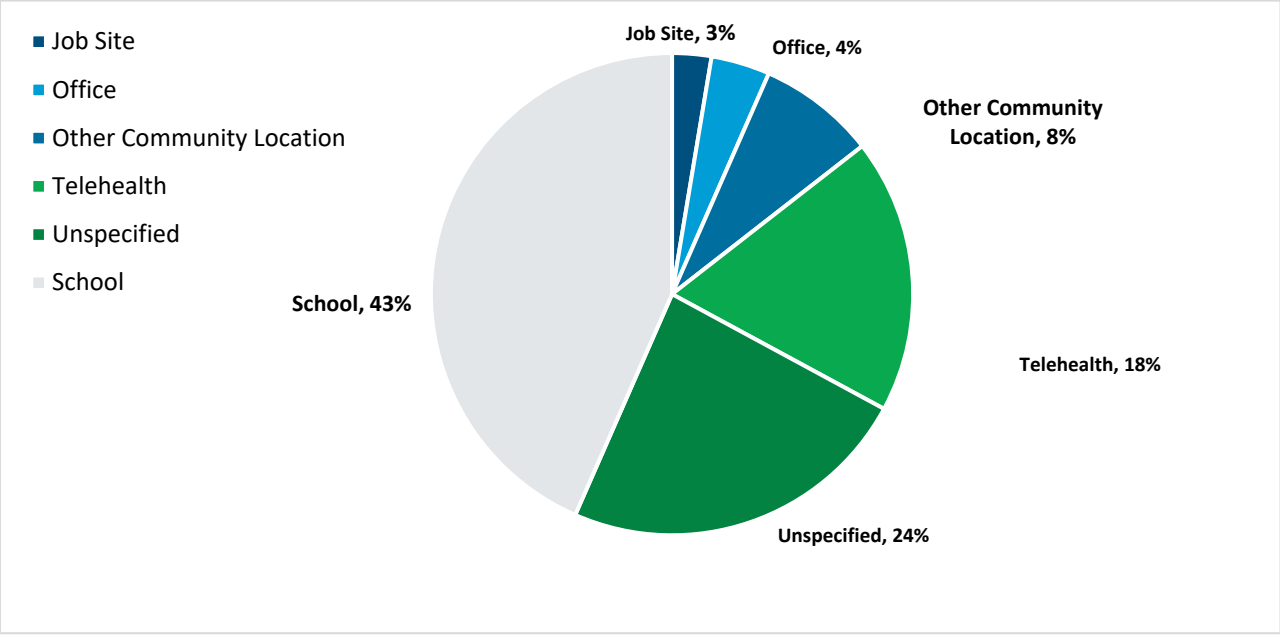
Location: Exhibits 12 and 13 present the locations for individual and group outreach events in FY2023–2024. NCOC individual outreach events occurred primarily at school (33%) or over the phone (31%) in FY2023–2024. Group outreach events occurred primarily at school (43%), at an unspecified location (24%), via telehealth (18%), and at other community locations (8%). Other community locations included places such as Boys & Girls Clubs, community centers, the Daly City Youth Health Center, health fairs, fairgrounds, malls, and public parks.

Exhibit 12. Locations of NCOC Individual Outreach Events, FY2023–2024



Note. NCOC = North County Outreach Collaborative; FY = fiscal year. Percentages may not sum to 100% because of rounding.

Exhibit 13. Locations of NCOC Group Outreach Events, FY2023–2024

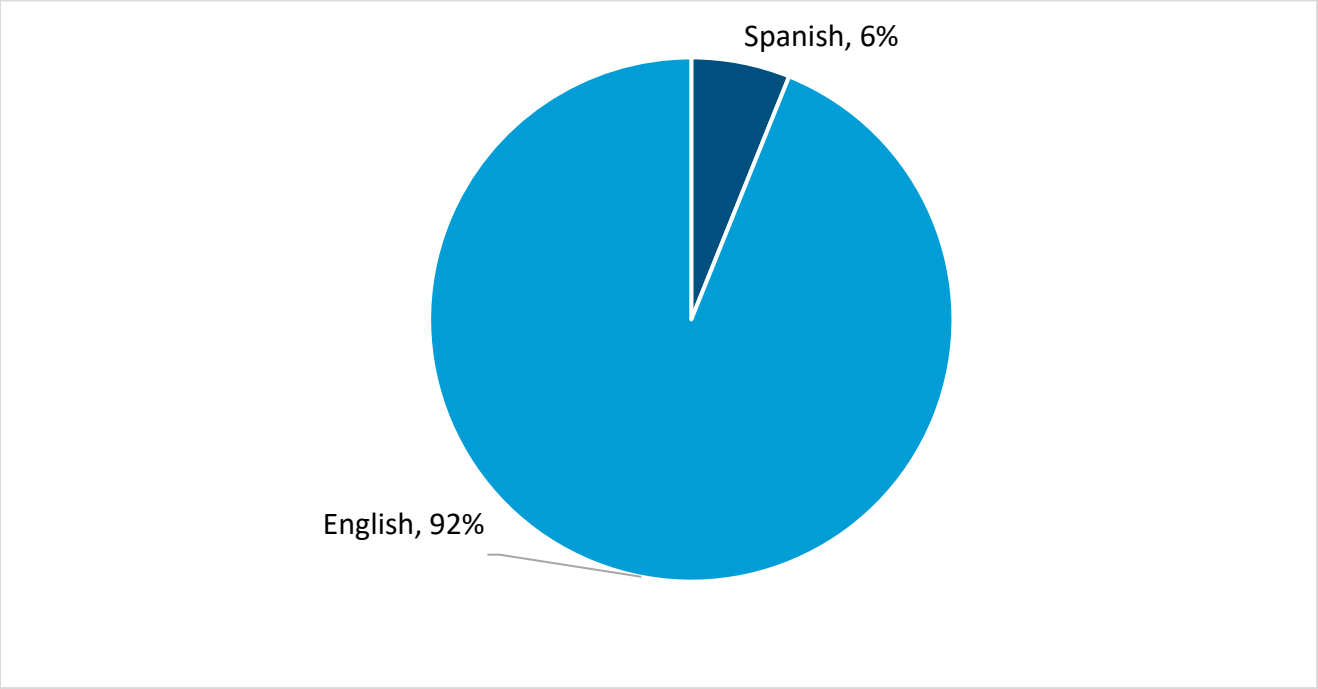


Note. NCOC = North County Outreach Collaborative; FY = fiscal year. Percentages may not sum to 100% because of rounding.

Length of contact: For FY2023-24, the NCOC individual outreach events ranged from 1 minute to a little over 2 hours and averaged 42 minutes. NCOC group outreach events ranged from 15 minutes to 7 hours and averaged 87 minutes.

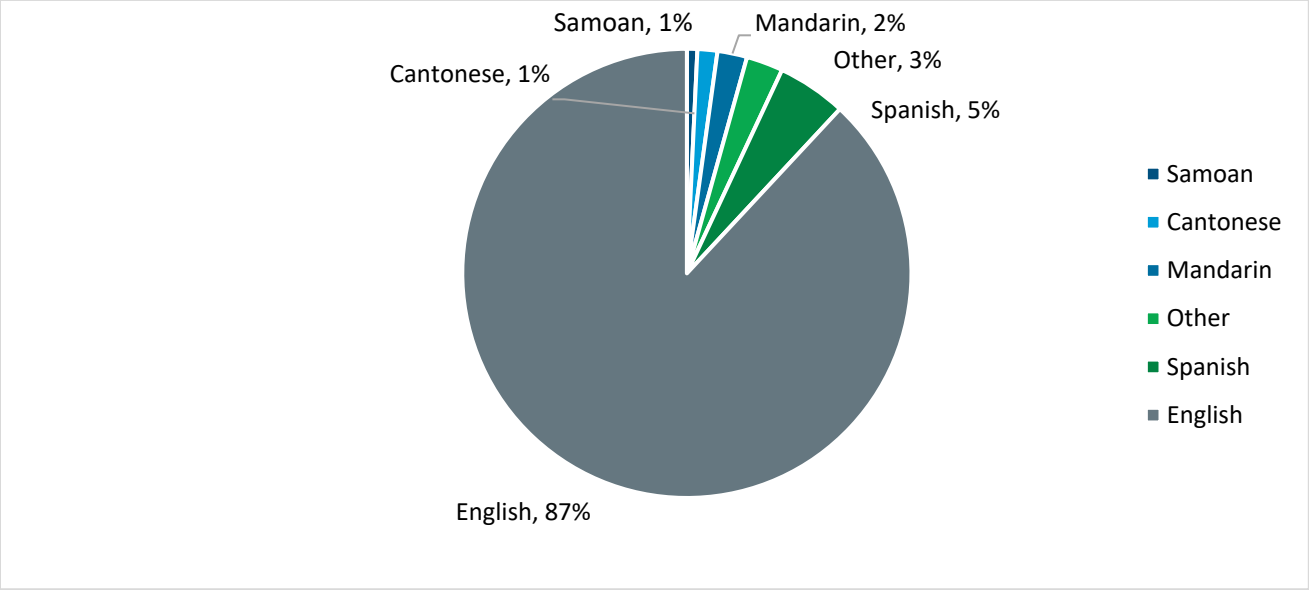
Preferred language: Exhibits 14 and 15 present breakdowns of the preferred languages at individual and group outreach events in FY2023–2024. NCOC individual outreach attendees preferred English (92%) and Spanish (6%). NCOC group outreach attendees preferred English (87%), Spanish (5%), other languages (3%), Mandarin (2%), Cantonese (1%), and Samoan (1%).

Exhibit 14. Preferred Languages of NCOC Individual Outreach Attendees, FY2023–2024



Note. NCOC = North County Outreach Collaborative; FY = fiscal year.

Exhibit 15. Preferred Languages of NCOC Group Outreach Attendees, FY2023–2024



Note. NCOC = North County Outreach Collaborative; FY = fiscal year. Percentages may not sum to 100% because of rounding.

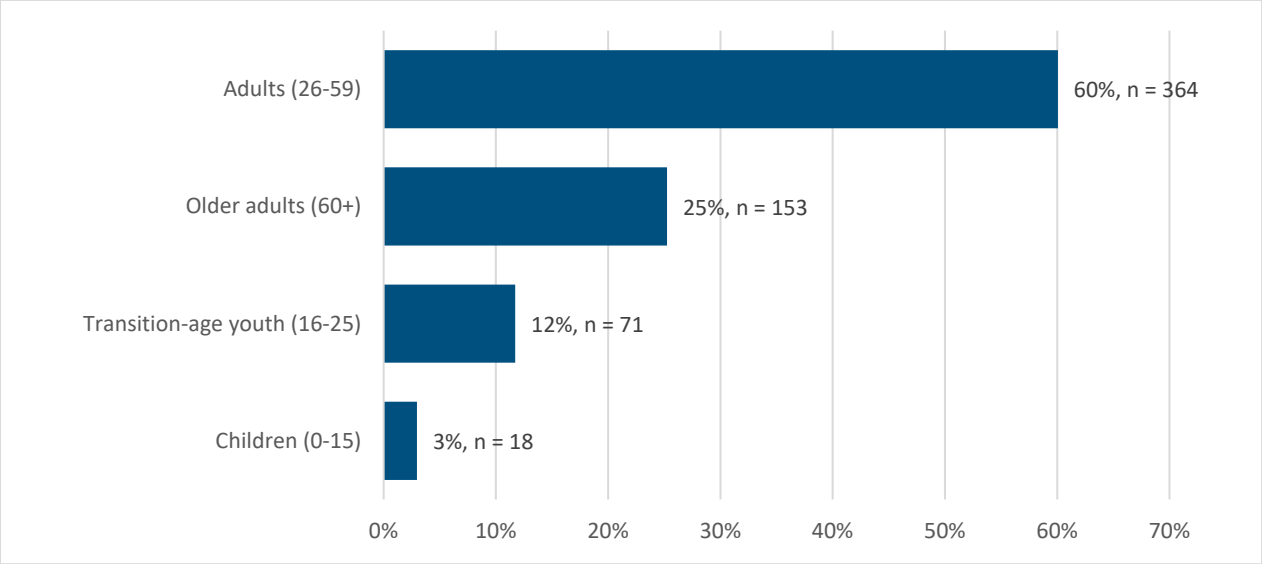
East Palo Alto Partnership for Mental Health Outreach (EPAPMHO)

This section provides details about 606 attendees at EPAPMHO individual outreach events across three provider organizations in FY2023–2024. There were no EPAPMHO group outreach events in FY 2023-2024.

Demographics

Age: Of the EPAPMHO FY2023–2024 individual outreach attendees, 60% were adults (26–59 years of age), 35% were older adults (60+ years of age and older), 12% were transition-age youth (16–25 years of age), and 3% were children (0–15 years of age). See **Exhibit 16** for the number and percentage of outreach attendees representing each reported age group.

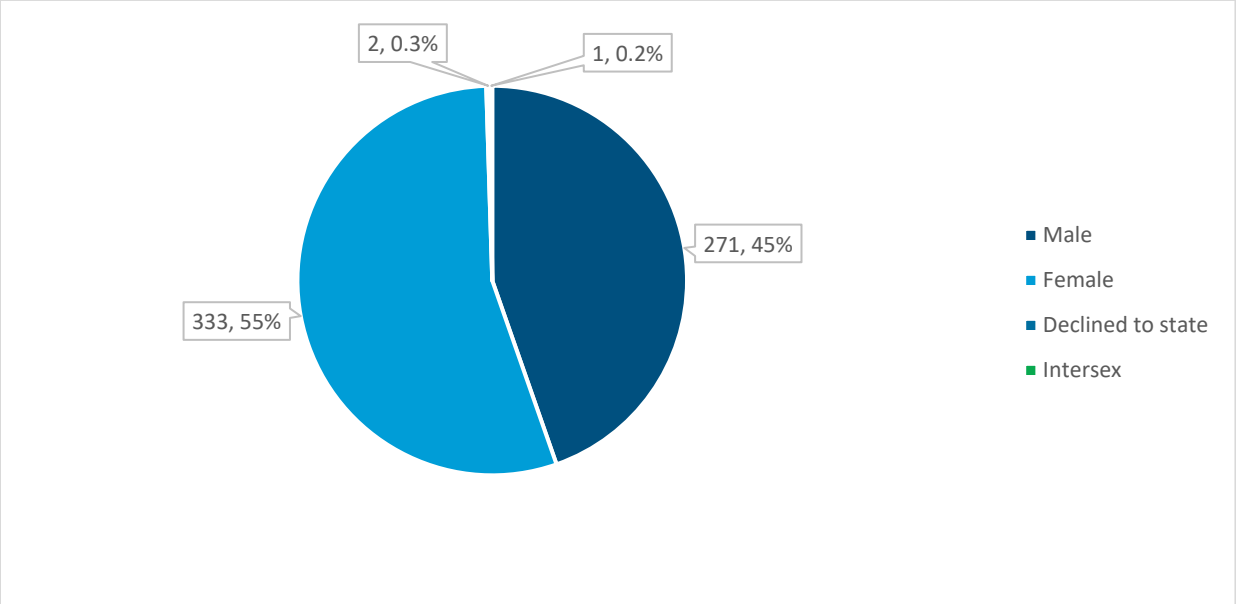
Exhibit 16. Age of Outreach Attendees Served By EPAPMHO, FY2023–2024



Note. EPAPMHO = East Palo Alto Partnership for Mental Health Outreach; FY = fiscal year. The total count for age reported may exceed the total number of attendees because some providers may have reported individuals in two or more age groups, leading to extra counts in some cases for the group outreach attendees. Therefore, the percentages may add up to more than 100%.

Sex at birth: Attendees across EPAPMHO outreach events indicated their sex at birth as female (55%), male (47%), or intersex (0.2%). Two clients declined to state their sex at birth (0.3%). See **Exhibit 17** for the number and percentage of outreach attendees reporting sex at birth.

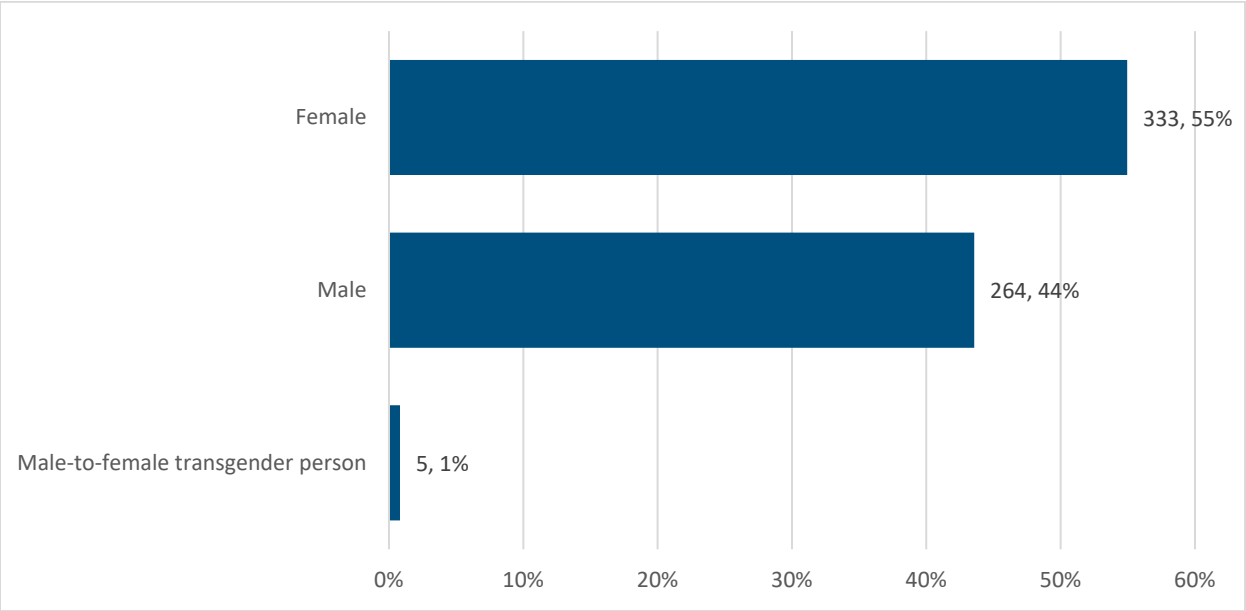
Exhibit 17. Sex at Birth of Outreach Attendees Served By EPAPMHO, FY2023–2024



Note. EPAPMHO = East Palo Alto Partnership for Mental Health Outreach; FY = fiscal year. Percentages may not sum to 100% because of rounding. The 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.

Gender: Attendees across EPAPMHO outreach events identified themselves as female (55%), male (44%), or male-to-female transgender (1%). One client declined to state their gender. See **Exhibit 18** for the number and percentage of outreach attendees representing each reported gender.

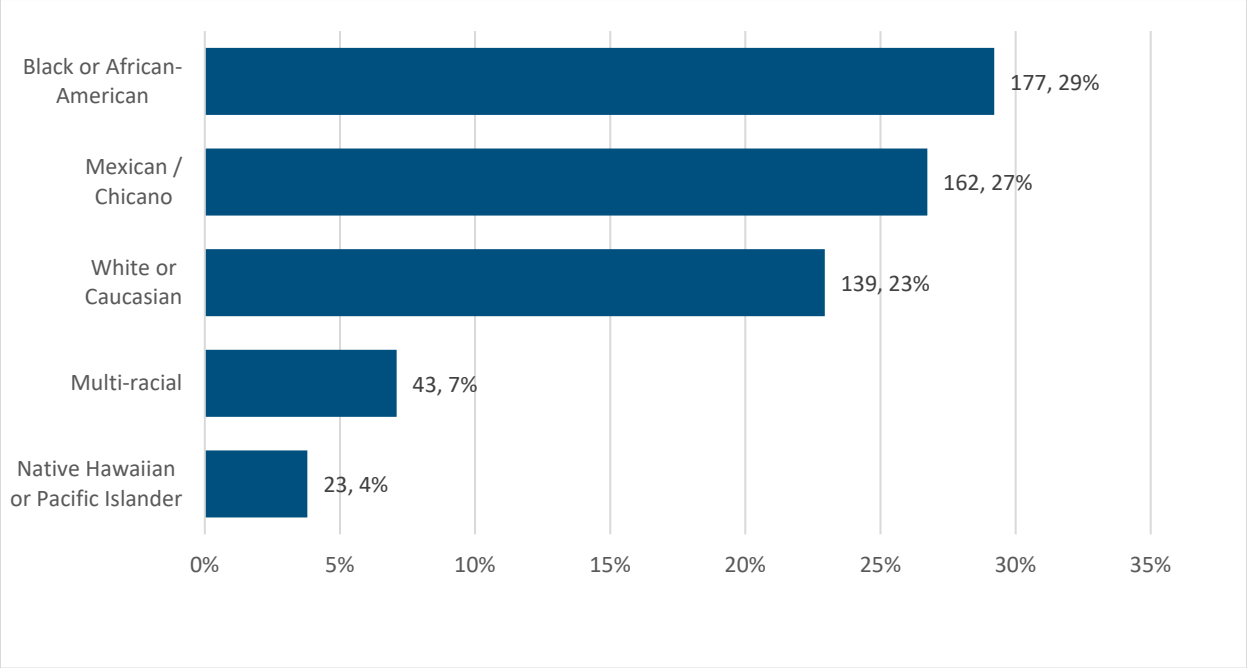
Exhibit 18. Gender of Outreach Attendees Served By EPAPMHO, FY2023–2024



Note. EPAPMHO = East Palo Alto Partnership for Mental Health Outreach; FY = fiscal year.

Race and ethnicity: In FY2023–2024, the four largest racial/ethnic groups represented by all EPAPMHO attendees were Black or African-American (29%), Mexican/Chicano (27%), White or Caucasian (23%), multiracial (7%). See **Exhibit 19** for the number and percentage of attendees representing each reported racial/ethnic group.

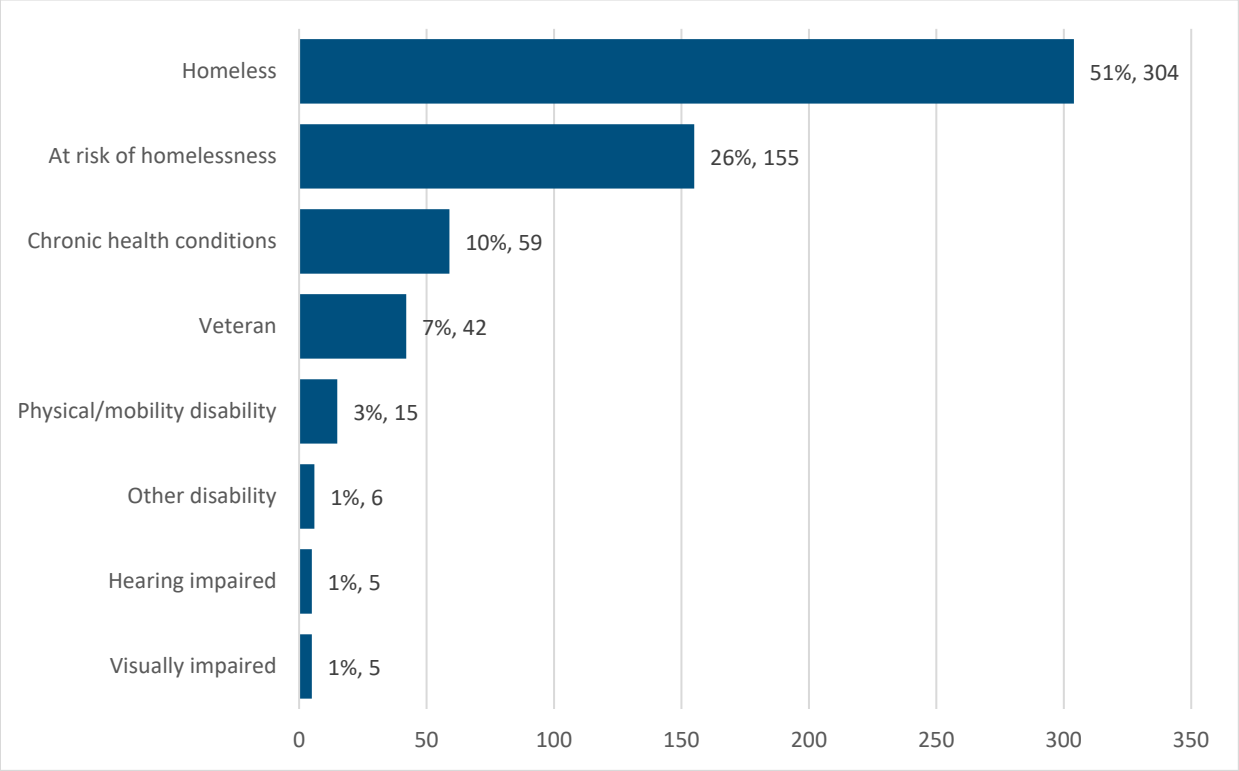
Exhibit 19. Race and Ethnicity of Outreach Attendees Served By EPAPMHO, FY2023–2024



Note. EPAPMHO = East Palo Alto Partnership for Mental Health Outreach; FY = fiscal year. The graph does not display 62 attendees belonging to various race/ethnicity groups due to small n within each group. The total count for race/ethnicity reported may exceed the total number of attendees because some providers may have reported individuals in two or more race/ethnicity groups, leading to extra counts in some cases for the group outreach attendees. Therefore, the percentages may add up to more than 100%.

Special populations: Of those that reported special population status, 51% reported being homeless, 26% reported being at risk of homelessness, 10% reported chronic health conditions, 7% reported being a veteran, and 3% reported a physical/mobility disability. Refer to **Exhibit 20** for the number and proportion of attendees representing each special population in FY2023–2024.

Exhibit 20. Special Populations Served by EPAPMHO, FY2023–2024



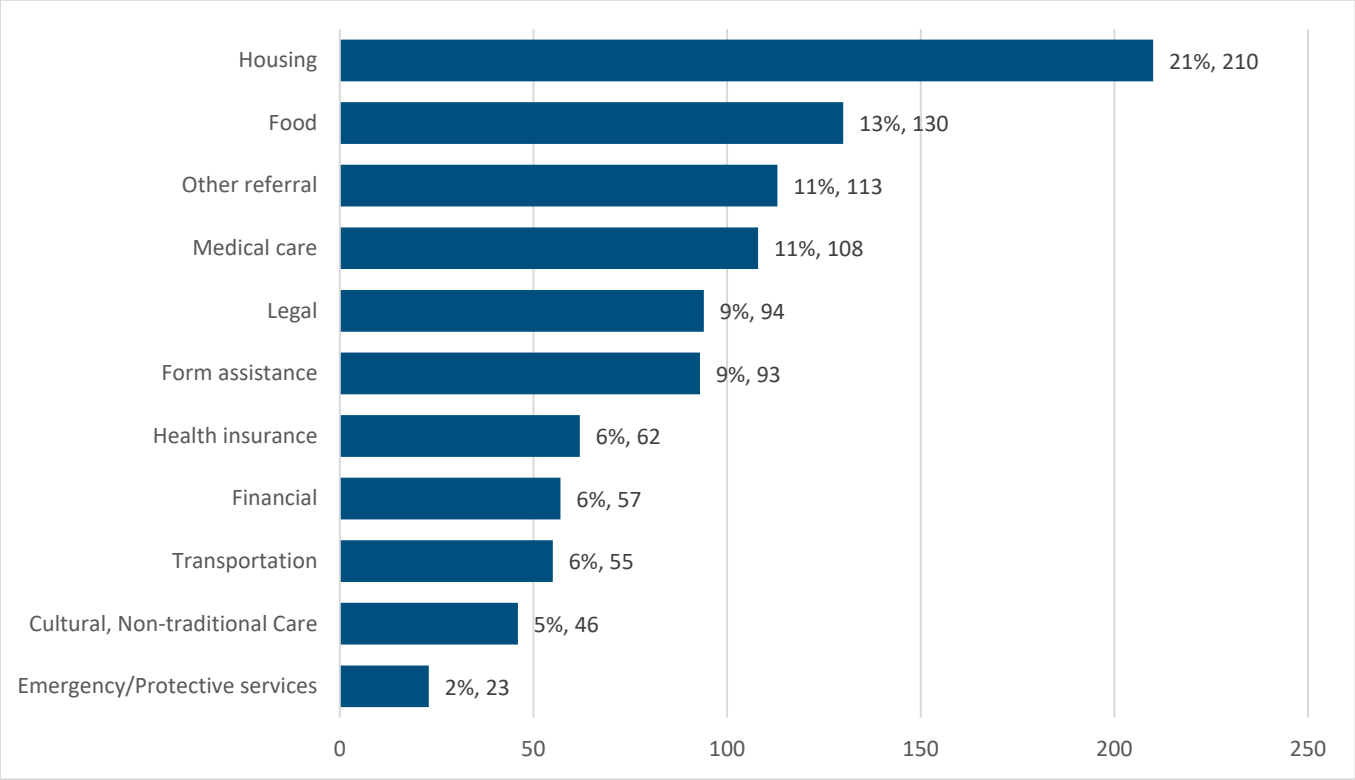
Note. EPAPMHO = East Palo Alto Partnership for Mental Health Outreach; FY = fiscal year. Attendees could select more than one special population, and therefore the percentages may add up to more than 100%.

Additional Outreach Characteristics (Individual Outreach Events Only)

Mental health/substance use referrals: EPAPMHO individual outreach events resulted in mental health referrals (15.3%) and substance use referrals (52.6%) in FY2023–2024.

Referrals to social services: Providers made 991 referrals to 606 EPAPMHO individual outreach attendees. The top five types of other social services referrals made for individual outreach attendees were for housing (21.2%), food (13.1%), other referrals (11.4%), medical care (10.9%), and legal (9.5%). Other services include things such as COVID-19 testing and vaccination, EOM Parent Project, the Home Energy Assistance Program, and mental health services. **Exhibit 21** summarizes the number of attendees receiving a given type of referral.

Exhibit 21. Referrals to Social Services, FY2023–2024

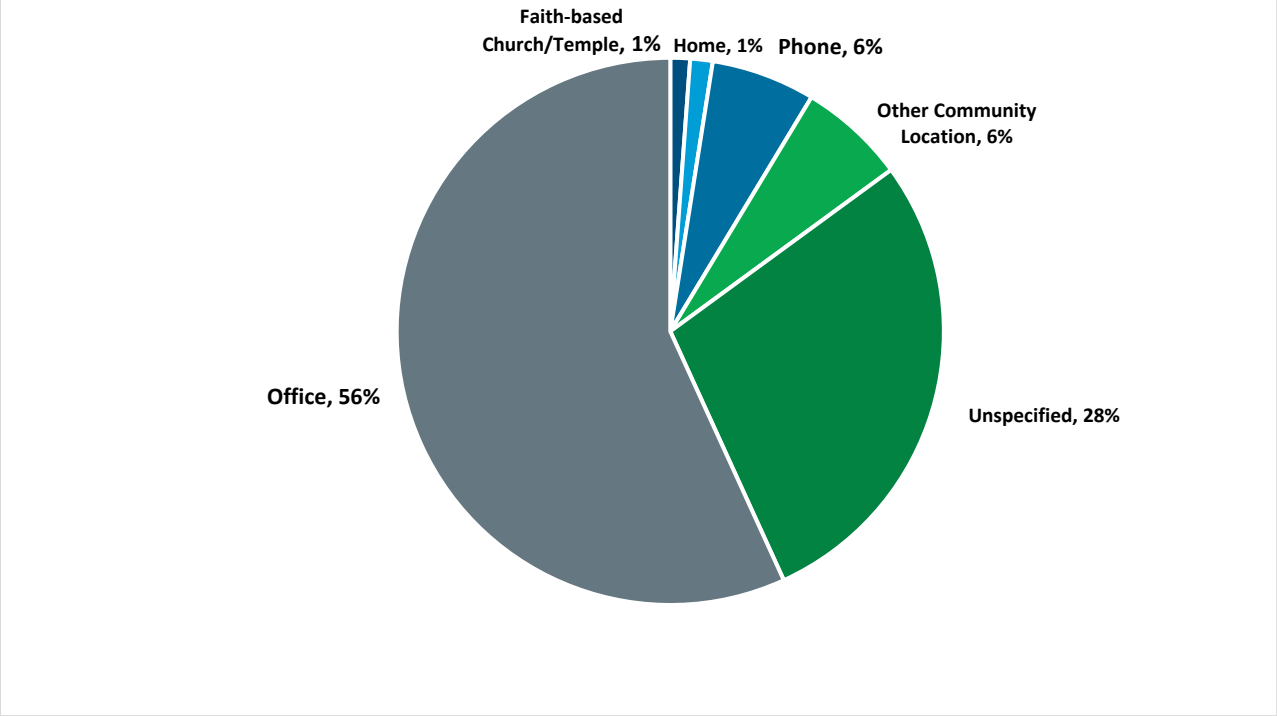


Notes. FY = fiscal year. Only individual outreach events (*n* = 552) offer service referrals. Individual outreach events may refer an attendee to multiple social services. Therefore, the percentages may add up to more than 100%. Other referrals include services related to COVID-19 testing and vaccination, EOM Parent Project, the Home Energy Assistance Program, and mental health services.

Event Characteristics

Location: EPAPMHO individual outreach events occurred in offices (56%), at an unspecified location (28%), or at other community locations (6%). **Exhibit 22** presents individual outreach event locations.

Exhibit 22. Location of EPAPMHO Individual Outreach Events, FY2023–2024

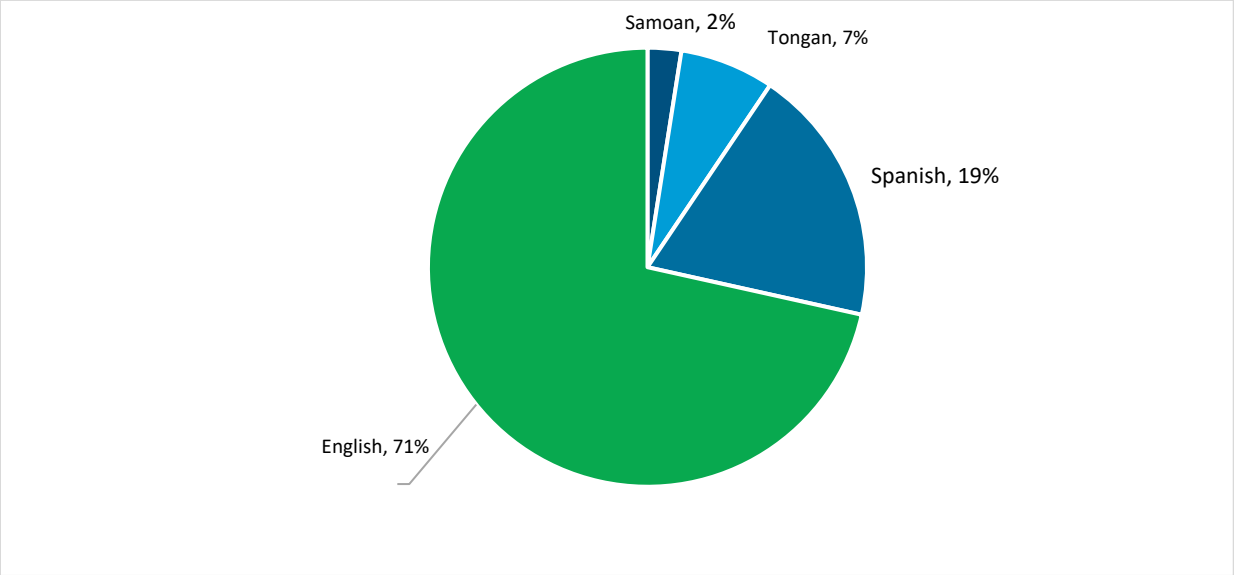


Note. EPAPMHO = East Palo Alto Partnership for Mental Health Outreach; FY = fiscal year.

Length of contact: In FY 2023-2024, EPAPMHO individual outreach events lasted from 5 minutes to 3 hours and averaged 35 minutes.

Preferred language: EPAPMHO individual outreach attendees preferred English (71%), Spanish (19%), Tongan (7%), and Samoan (2%). **Exhibit 23** present breakdowns of preferred languages at individual outreach events in FY2023–2024.

Exhibit 23. Preferred Languages of EPAPMHO Individual Outreach Attendees, FY2023–2024



Note. EPAPMHO = East Palo Alto Partnership for Mental Health Outreach; FY = fiscal year.

Appendix A. FY2023–2024 Outreach, Anamatangi Polynesian Voices

For FY2023–2024, Anamatangi Polynesian Voices reported 61 outreach events, which included 61 individual events and 0 group events. There were 61 attendees across all events. The individual events ranged from 30 minutes to 180 minutes and lasted for 126 minutes on average.

Outreach events

- Most frequently took place in an other community location (**62.3%**; *n* = 38). Other locations for events and their respective values are shown in **Exhibit A1.**
- Resulted in 30 mental health referrals and 3 substance use treatment referrals.
- Individual outreach event attendees (n = 24) were referred to legal (**12.7**%; *n* = 52); housing (**11.7%**, *n* = 48); cultural, nontraditional care (**11.2%**, *n* = 46); form assistance (**10.0%**, *n* = 41) health insurance (**9.5%**, *n* = 39); transportation (**9.5%**; *n* = 39); and food (**9.3%**; *n* = 38) services; medical care (**9.0%**; *n* = 37); and financial services (**8.8%**; *n* = 36).

Exhibit A1. Counts and Percentages of Events by Location Type: Anamatangi Polynesian Voices Outreach Events, FY2023–2024

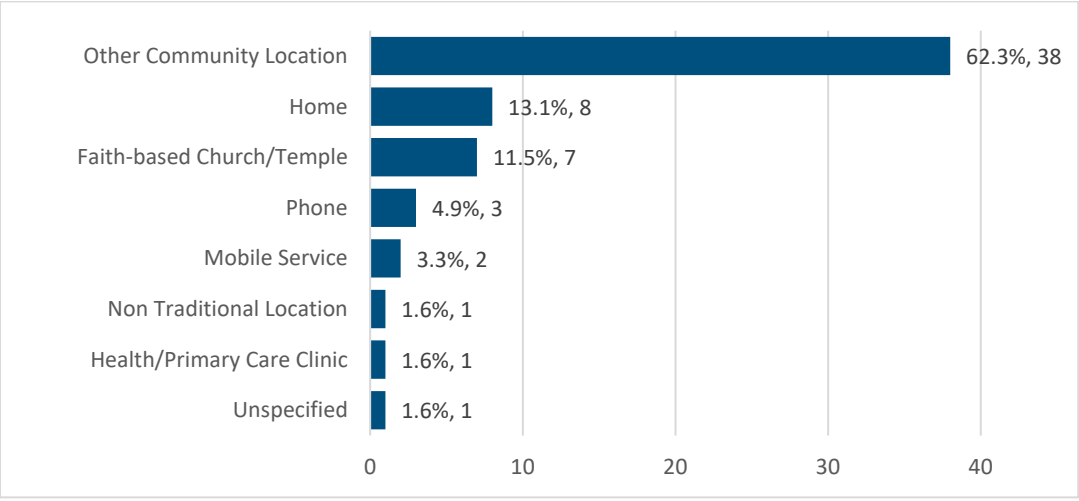
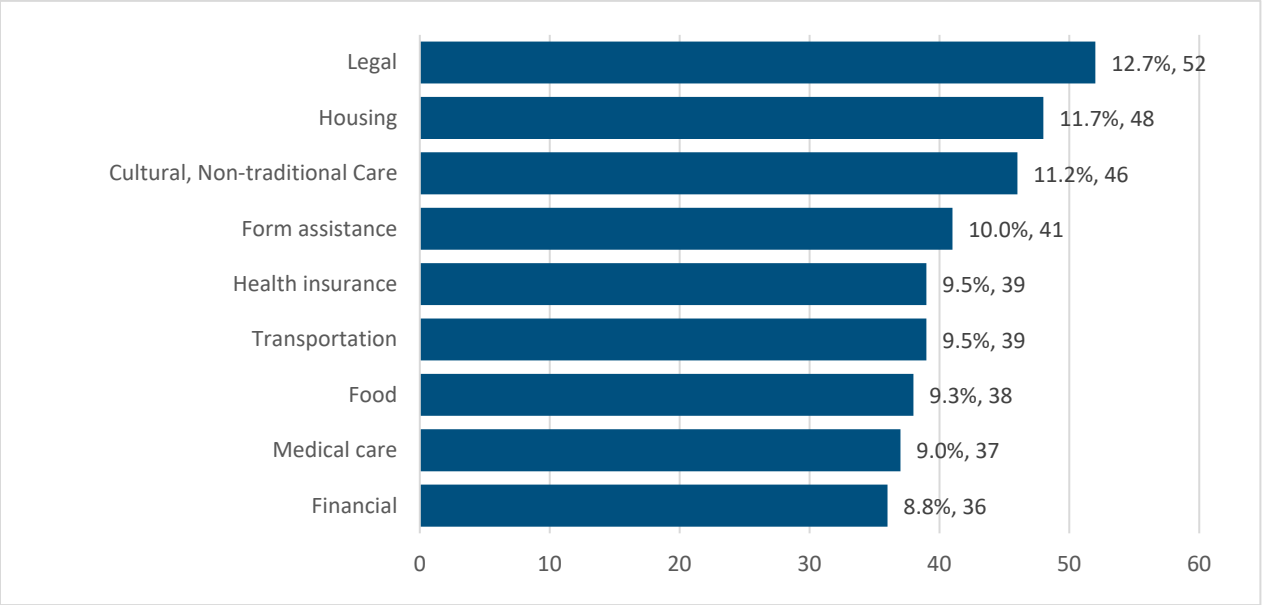


Exhibit A2. Counts and Percentages of Social Services Referrals following Individual Outreach Events: Anamatangi Polynesian Voices, FY2023–2024

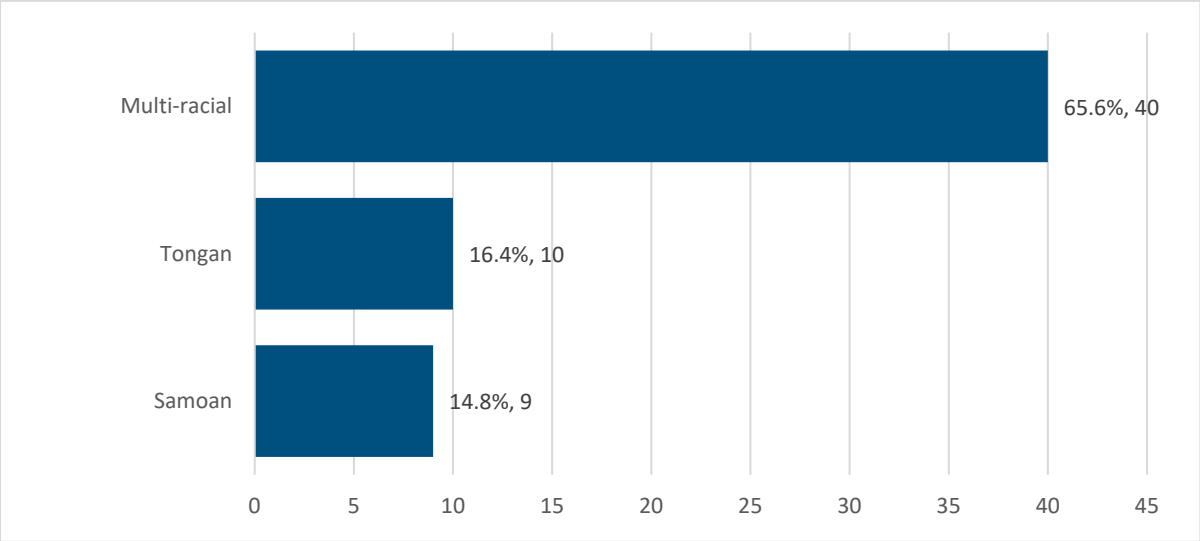


Notes. 1) Only individual outreach events (n = 61) offer service referrals.
2) Individual outreach events may refer an attendee to multiple social services. Therefore, the percentages may add up to more than 100%.
3) These referral types were not displayed in the graph above due to the small n: Emergency/protective services (*n* = 22) and other referral *(n* = 11).

Demographics of Outreach event attendees

- 54% were female (**54%**; *n* = 33); 44% were male (**44.3%**, *n* = 27); 1.6% declined to state (**1.6%**, *n* = 1).
- 59% identified their gender as female (**59%**; *n* = 36); 44% identified as male (**39.3%**; *n* = 24); 1 declined to state (**1.6%**).
- Identified as straight (**85.2%**; *n* = 52) and gay/lesbian (**14.8%**; *n* = 9).
- Included adults (26–59 years of age; **55.6%**; *n* = 35), older adults (60 years of age and older; **27.0%**; *n* = 17), and transition-age youth (16–25 years of age; **17.5%**; *n* = 11).
- Were primarily multiracial (**65.6%**, *n* = 40), Tongan (**16.4%**; *n* = 10), or Samoan (**14.8%;** *n*=9). (See **Exhibit A3.**)

Exhibit A3. Counts and Percentages of Racial/Ethnic Categories: Anamatangi Polynesian Voices Attendees at Outreach Events, FY2023–2024

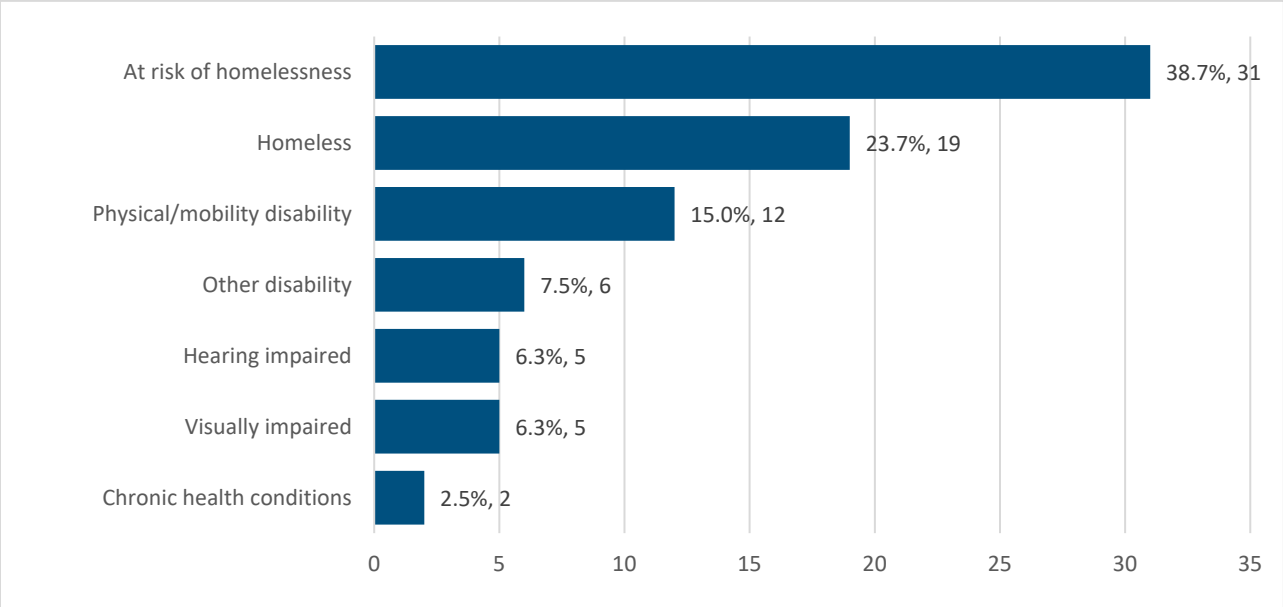


Note. Percentages add to more than 100% because attendees could select more than one race/ethnicity.

In FY2023–2024, out of the 61 people who attended Anamatangi events, 38.7% reported being at risk for homelessness, 23.7% reported being homeless, and 15.0% reported a physical/mobility disability. (See **Exhibit A4 for all categories**.)

Note that special populations are defined as those with special needs in the categories defined in Exhibit A4.

Exhibit A4. Counts and Percentages of Special Populations: Anamatangi Polynesian Voices Attendees at Outreach Events, FY2023–2024



Note. Attendees could select more than one special population, and therefore the percentages may add up to more than 100%.

Appendix B. FY2023–2024 Outreach, Asian American Recovery Services (AARS)

For FY2023–2024, Asian American Recovery Services (AARS) reported 127 outreach events, which included 98 individual events and 29 group events. There were 1,160 attendees. Individual outreach events ranged from 15 to 120 minutes and on average lasted for 43 minutes. The group outreach events ranged from 15 to 240 minutes and lasted for 88 minutes on average.

Outreach events

- Were most often at unspecified locations (**42.7%**, n=88) or at an unspecified location (**42.2%**, *n* = 87). Other locations of events and their respective values are shown in **Exhibit B1**.
- Resulted in 26 mental health referrals and 5 substance use treatment referrals at individual outreach events.
- There were 795 referrals to social services for individuals who attended the individual events. (See **Exhibit B2**.) Individual outreach event attendees (n = 98) were referred to other referrals (**23.3%**; *n* = 185) including services related to COVID-19 testing and vaccinations, EOM Parent Project, the Home Energy Assistance Program (HEAP), and mental health; food (**18.1%**, *n* = 144); medical care (**17.5%**; *n* = 139); and cultural, nontraditional care (**13.7%**, *n* = 109). See Exhibit B2 for the full list of services referred.

Exhibit B1 Counts and Percentages of Events by Location Type: AARS Outreach Events, FY2023–2024

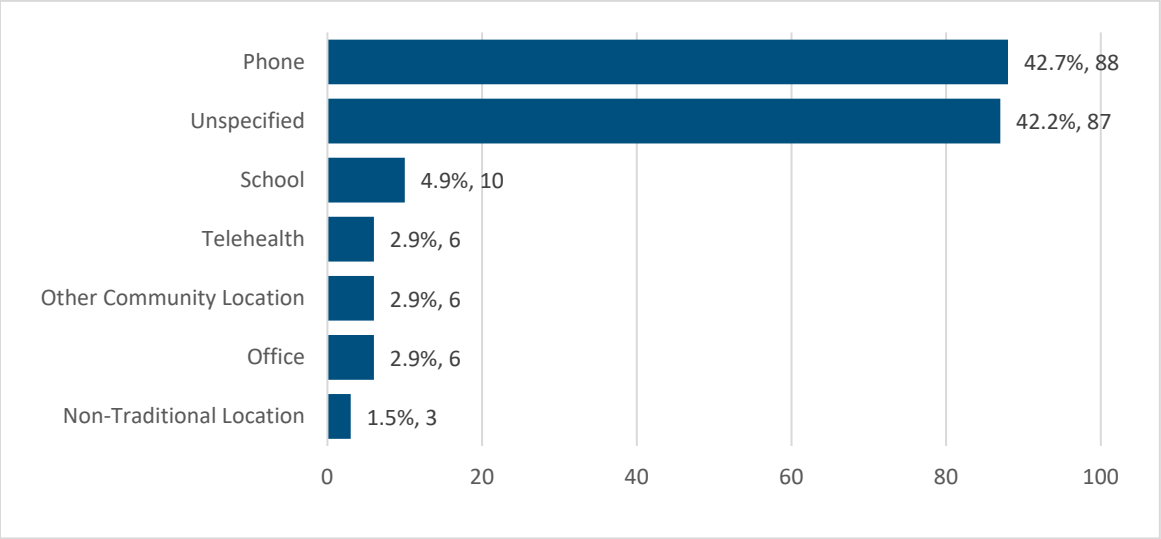
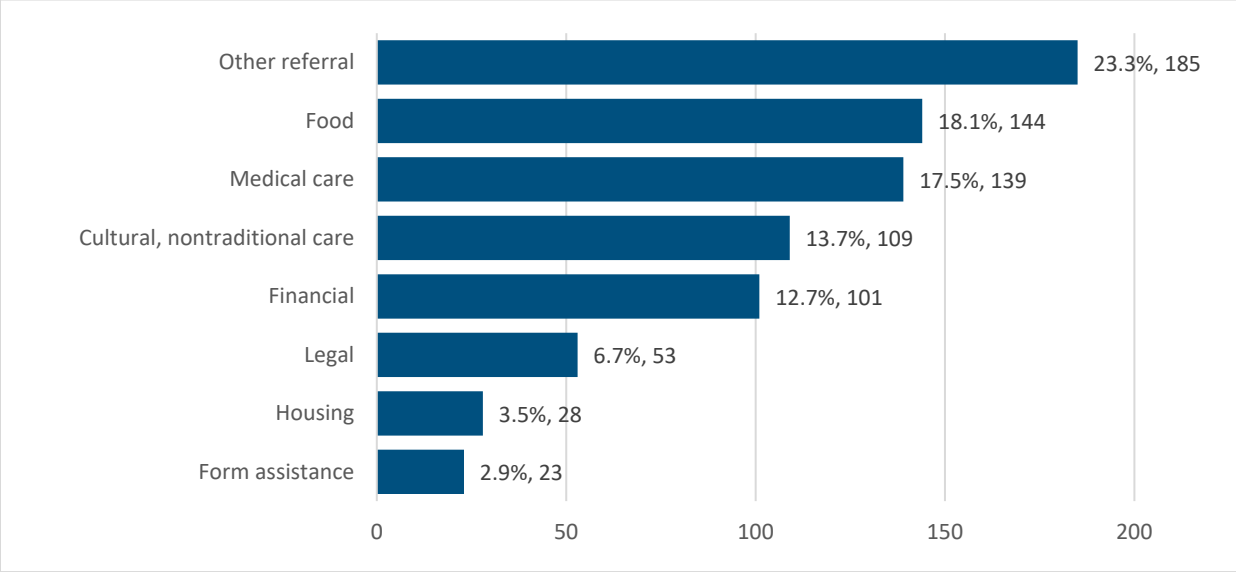


Exhibit B2. Counts and Percentages of Social Services Referrals following Individual Outreach Events: AARS, FY2023–2024

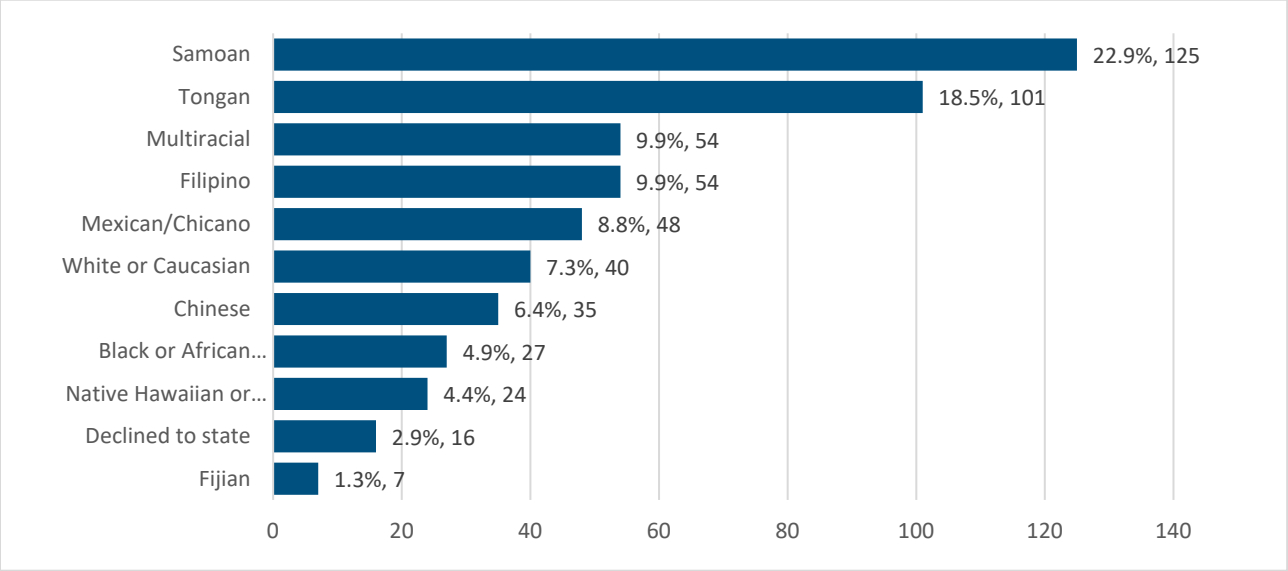


Notes. 1) Only individual outreach events (n = 98) offer service referrals.
2) Individual outreach events may refer an attendee to multiple social services. Therefore, the percentages may add up to more than 100%.
3) These referral types were not displayed in the graph above due to the small n: health insurance *(n* = 5*),* transportation (*n*=5), and emergency/protective services (*n*=3).

Demographics of Outreach event attendees

- Were female (**67.4%;** *n* = 782), male (**31.6%;** *n* = 366), and intersex (**0.9%**; *n*=10). Less than 1% declined to report their sex at birth (**0.2**%; *n* = 2).
- Identified their gender as female (**66.3%;** *n* = 772), male (**46.2%;** *n* = 357); female-to-male transgender (**0.6%;** *n* = 7); male-to-female transgender (**0.5%**; *n*=6); and an Indigenous gender identity (**0.4%;** *n* = 5). 16 attendees declined to state their gender (1.4%).
- Identified as heterosexual (**75.5%;** *n* = 876), gay/lesbian (**4.1%;** *n* = 48), bisexual (**3.1%;** *n* = 36, queer (**1.6%;** *n* = 18), questioning orientation (**1.5%;** *n* = 17); an Indigenous gender identity (**0.9%;** *n* = 11); asexual (**0.04%**; *n*=5); pansexual (**0.03%;** *n* = 3); and other (**8.4%**; *n*=98). The remaining attendees declined to state their sexual orientation (**4.1%;** *n* = 48).
- Included adults (26–59 years of age; **42.7%**; *n* = 495), transition-age youth (16–25 years of age; **22.1%;** *n* = 257), children (15 years of age and younger; **25.3%**; *n* = 294), and older adults (60 years of age and older; **8.9%;** *n* = 104). 10 attendees declined to state their age (**0.9%**).
- Were primarily Samoan (**22.9%;** *n* = 125), Tongan (**18.5%**; *n* = 101), and multiracial (**9.9%**; *n*= 54). (See **Exhibit B3**.)

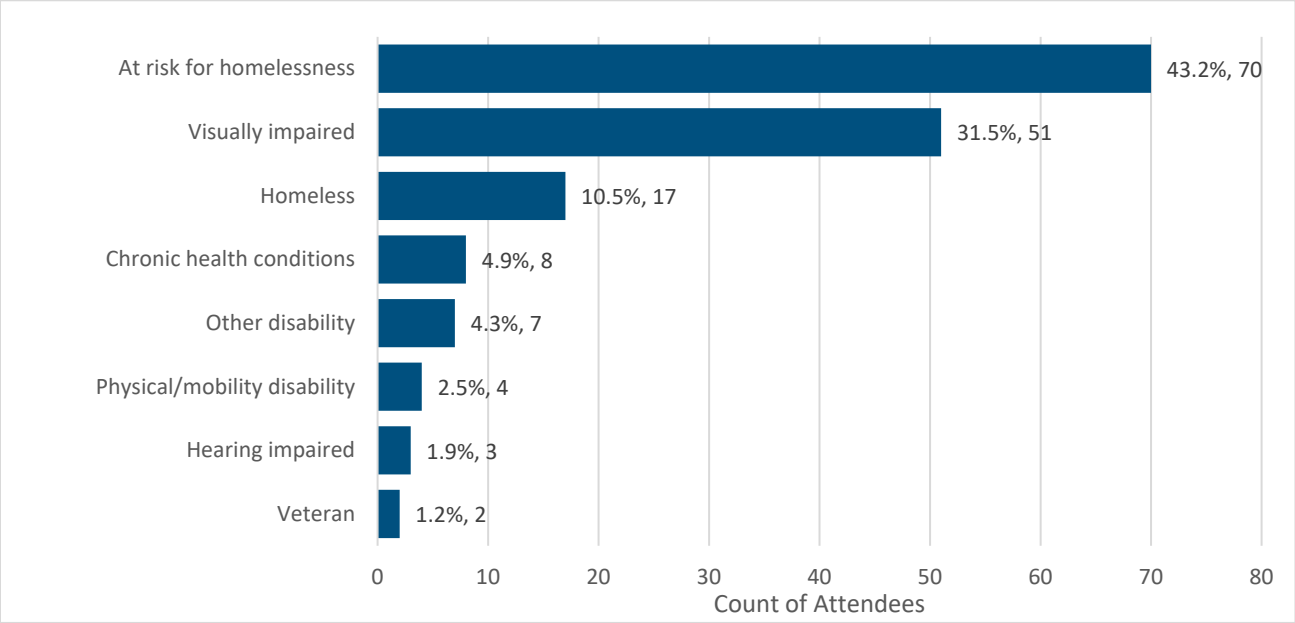
Exhibit B3. Counts and Percentages of Racial/Ethnic Categories: AARS Attendees at Outreach Events, FY2023–2024



Note. Percentages add to more than 100% because attendees could select more than one race/ethnicity. racial/ethnic categories were not displayed in the graph above due to the small n: Central American)n=4), Middle Eastern (n=3), Japanese (n=2), Asian Indian/South Asian (n=2), Asian (n=2), other race (n=1), South American (n=1), and Puerto Rican (n=1).

In FY2023–2024, out of the 1,160 people who reported being part of a special population, 43.2% reported being at risk for homelessness, 31.5% reported visual impairment, and 10.5% reported being homeless. See Exhibit B4 for the full list of special populations reported.

Exhibit B4. Counts and Percentages of Special Populations: AARS Attendees at Outreach Events, FY2023–2024



Note. Attendees could select more than one special population, and therefore the percentages may add up to more than 100%.

Appendix C. FY2023–2024 Outreach, Daly City Peninsula Partnership Collaborative

For FY2023–2024, Daly City Peninsula Partnership Collaborative reported 257 outreach events, including 200 individual events and 57 group events. There were 2,060 attendees at these events. Individual outreach events ranged from 1 to 90 minutes and lasted for 31 minutes on average. The group outreach events ranged from 30 to 420 minutes and lasted for 87 minutes on average.

Outreach events

- Took place via telehealth most often (**62.5%;** *n* = 89). Other locations of events and their respective values are shown in **Exhibit C1.**
- Resulted in 46 mental health referrals and no substance use treatment referrals at the individual outreach events.
- There were 241 referrals to social services for individuals who attended the individual events.

Exhibit C1. Counts and Percentages of Events by Location Type: Daly Center Peninsula Partnership Collaborative Outreach Events, FY2023–2024

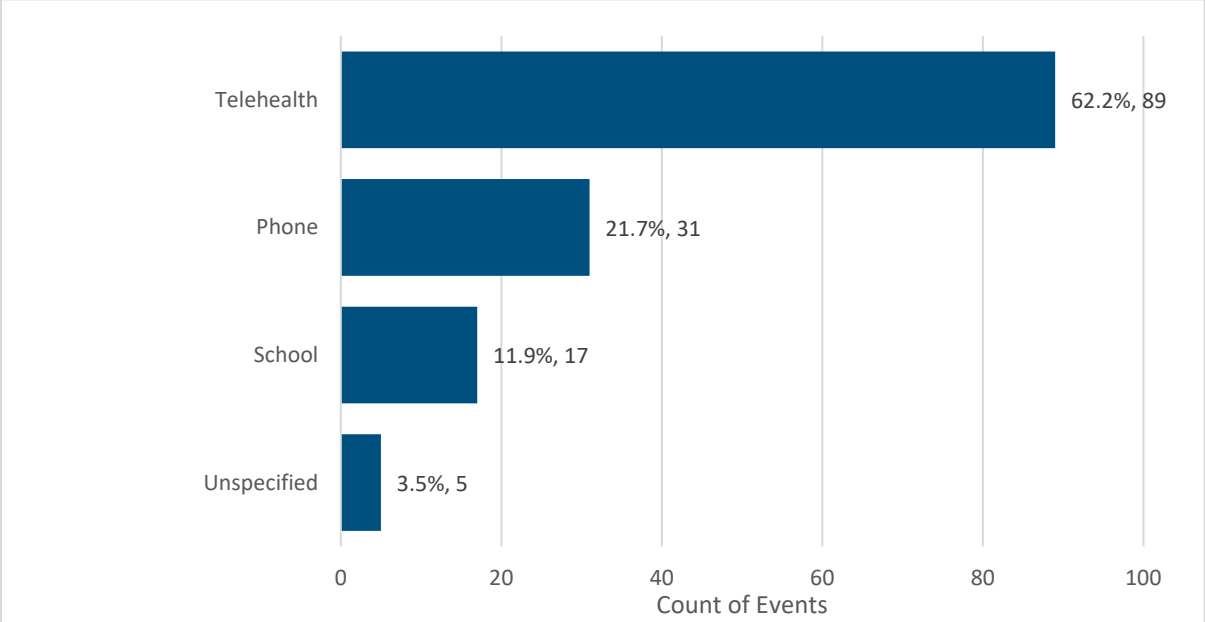
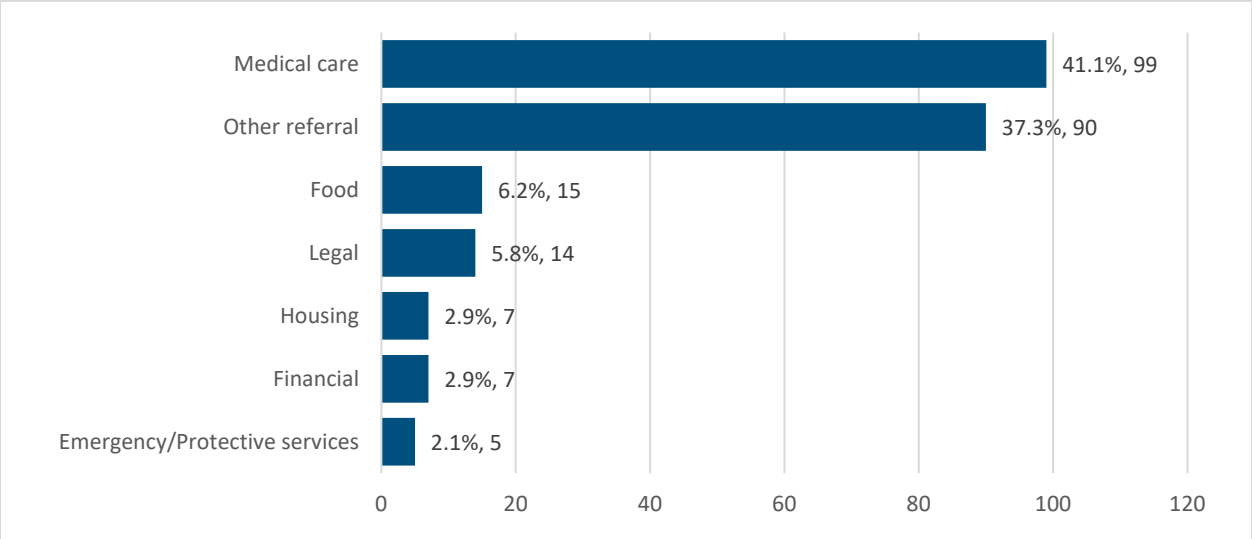


Exhibit C2. Counts and Percentages of Social Services Referrals following Individual Outreach Events: Daly Center Peninsula Partnership Collaborative Outreach Events, FY2023–2024

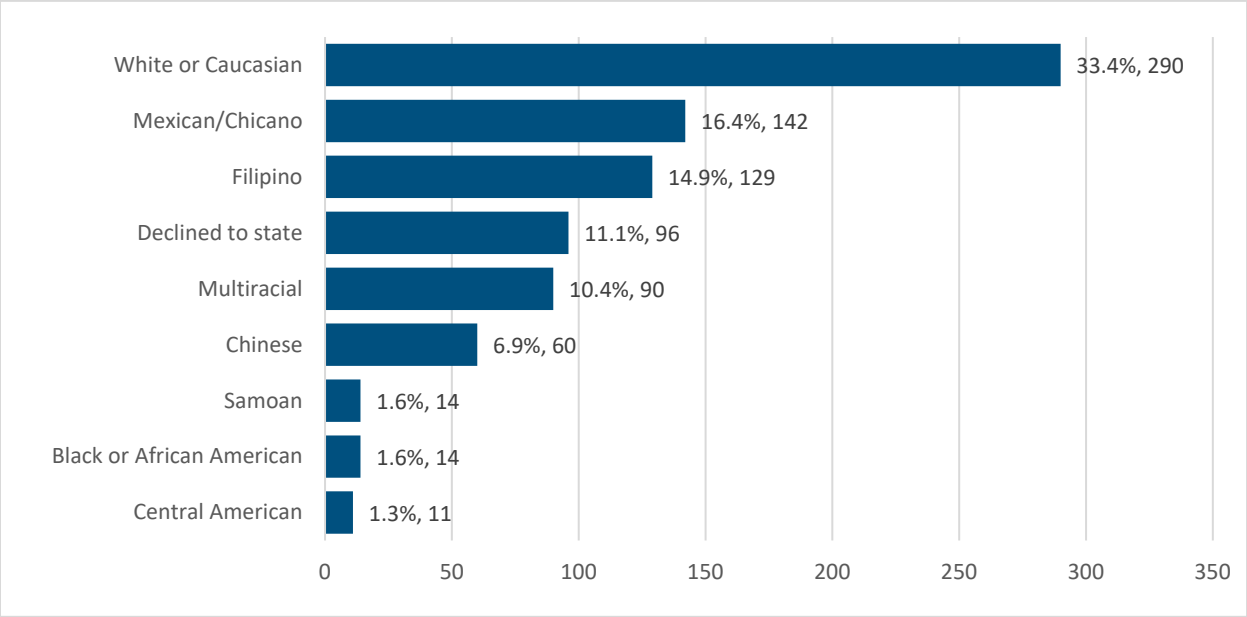


Notes. 1) Only individual outreach events (n = 200) offer service referrals.
2) Individual outreach events may refer an attendee to multiple social services. Therefore, the percentages may add up to more than 100%.
3) These referral types were not displayed in the graph above due to the small n: transportation *(n* = 2) and form assistance (*n*=2).

Outreach event attendees

- Were female (**59.8%;** *n* = 1232), male (**35.8%;** *n* = 738), and intersex (**4.4%**; *n*=91).
- Identified their gender as female (**47%;** *n* = 969), male (**31.8%**; *n* = 653), other gender (**2.4%**; *n*=50), gender queer (**0.1%**; *n*= 3), and female-to-male transgender (**0.05%**; *n*= 1). 384 declined to state their gender (**18.6%**).
- Identified as heterosexual (**48.4%;** *n* = 997), other (**12.1%**; *n*=250), queer (**2.1%;** *n* =42), bisexual (**1.4%**; *n* = 29), gay/lesbian (**0.2%;** *n* = 4), pansexual (**0.09%;** *n* = 2), or questioning (**0.05%,** *n* = 1). 735 attendees declined to state their sexual orientation (**35.6%).**
- Included children (15 years of age and younger; **37.6%;** *n* = 776), adults (26–59 years of age; **33.5%;** *n* = 690), older adults (60 years of age and older; **8.5%**; *n* = 176), and transition-age youth (16–25 years of age; **13.7%;** *n* = 282). **6.6%** (*n* = 136) declined to state their age.
- Were most frequently of White or Caucasian (**33.4%;** *n* = 290), Mexican/Chicano (**16.4%;** *n* = 142), or Filipino (**14.9%;** *n*=129). (See **Exhibit C3**.)

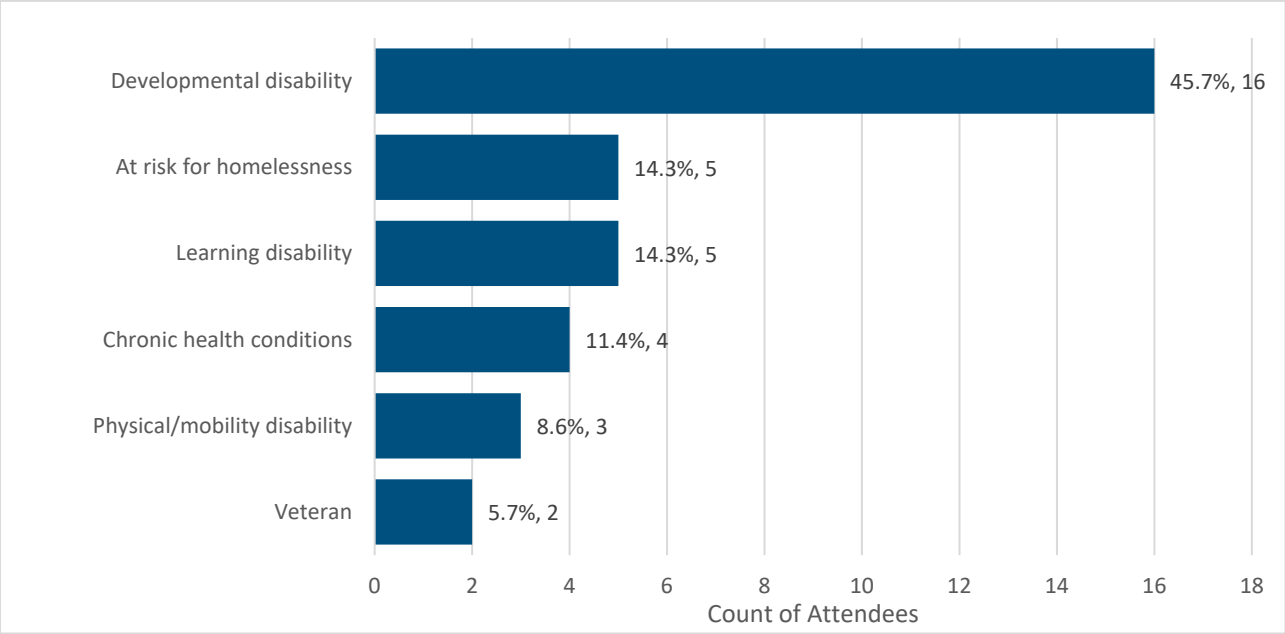
Exhibit C3. Counts and Percentages of Racial/Ethnic Categories: Daly City Peninsula Partnership Collaborative Attendees at Outreach Events, FY2023–2024



Note. Percentages add to more than 100% because attendees could select more than one race/ethnicity. These racial/ethnic categories were not displayed in the graph above due to the small n: Other race (*n* = 6), Asian Indian/South Asian (*n* = 5), Vietnamese (*n* = 1), and Japanese (*n* = 1).

In FY2023–2024, of those that reported being part of a special population, 45.7% reported a developmental disability, 14.3% reported being at risk for homelessness, and 14.3% reported having a learning disability. See **Exhibit C3** for the full list of special populations reported.

Exhibit C3. Counts and Percentages of Special Populations: Daly City Peninsula Partnership Collaborative at Outreach Events, FY2023–2024



Note. Attendees could select more than one special population, and therefore the percentages may add up to more than 100%.

Appendix D. FY2023–2024 Outreach, Daly City Youth Center

For FY2023–2024, Daly City Youth Center reported 108 outreach events, including 49 individual events and 59 group events. There were 2,958 attendees. Individual outreach events ranged from 1 to 135 minutes and lasted for 95 minutes on average. The group outreach events ranged from 15 to 360 minutes and lasted for 82 minutes on average.

Outreach events

- Took place at schools most of the time (**85.7%**, *n* = 203). Other locations for events and their respective values are shown in **Exhibit D1.**
- Resulted in 3 mental health referrals and no substance use treatment referrals at the individual outreach events.
- There were 12 referrals to social services for individuals who attended the individual events. (See **Exhibit D2**). Of those referred to social services, there were five referrals to other services, three to food services, and two to medical services. See Exhibit D2 for the full list of services referred.

Exhibit D1. Daly City Youth Center Locations of Outreach Events, FY2023–2024

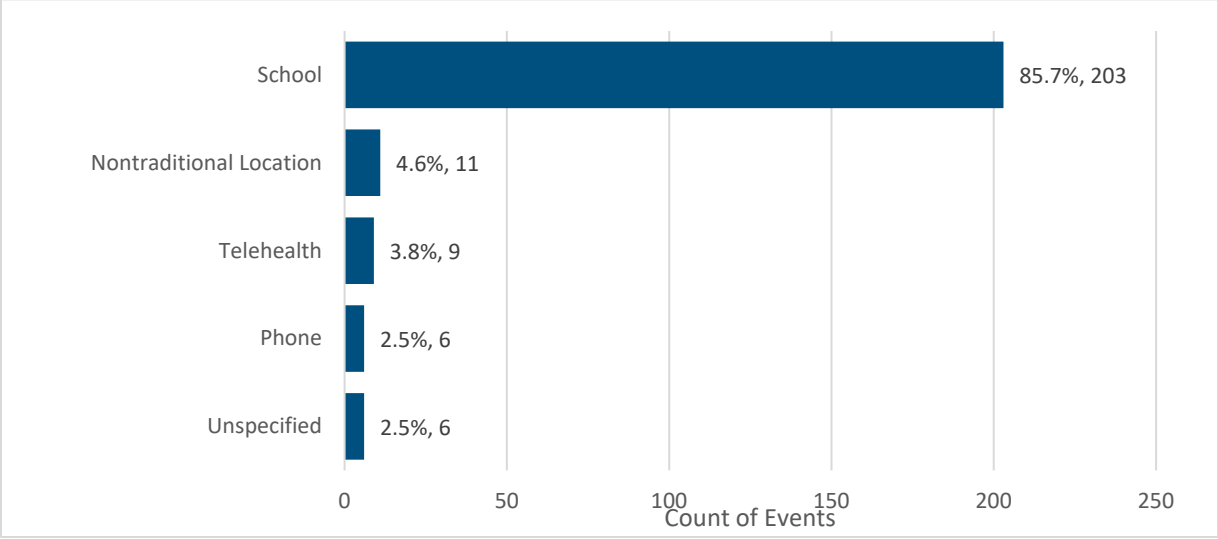
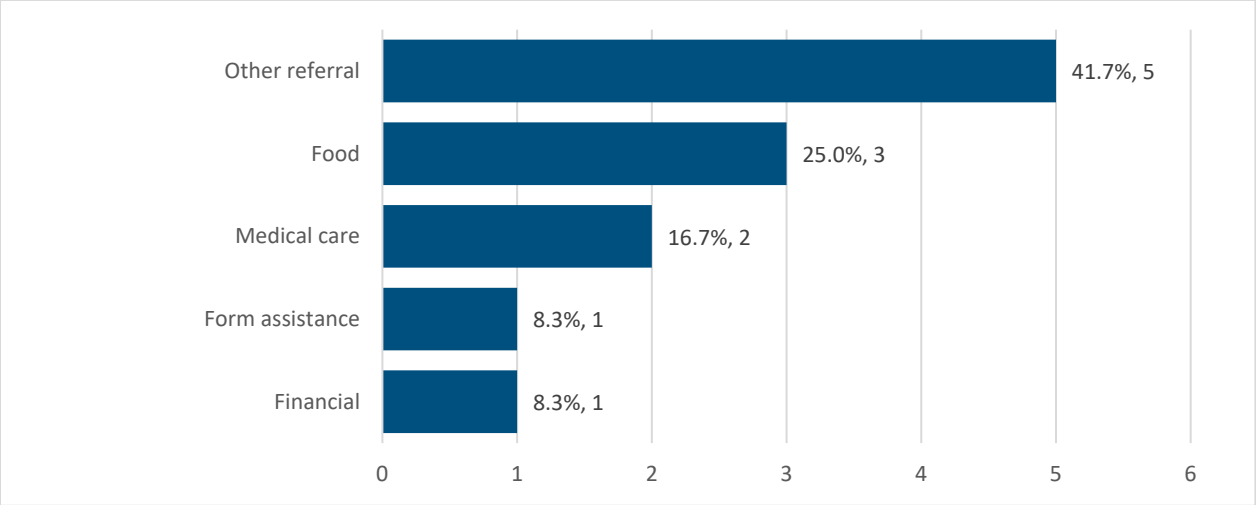


Exhibit D2. Daly City Youth Center Social Services Referrals, FY2023–2024

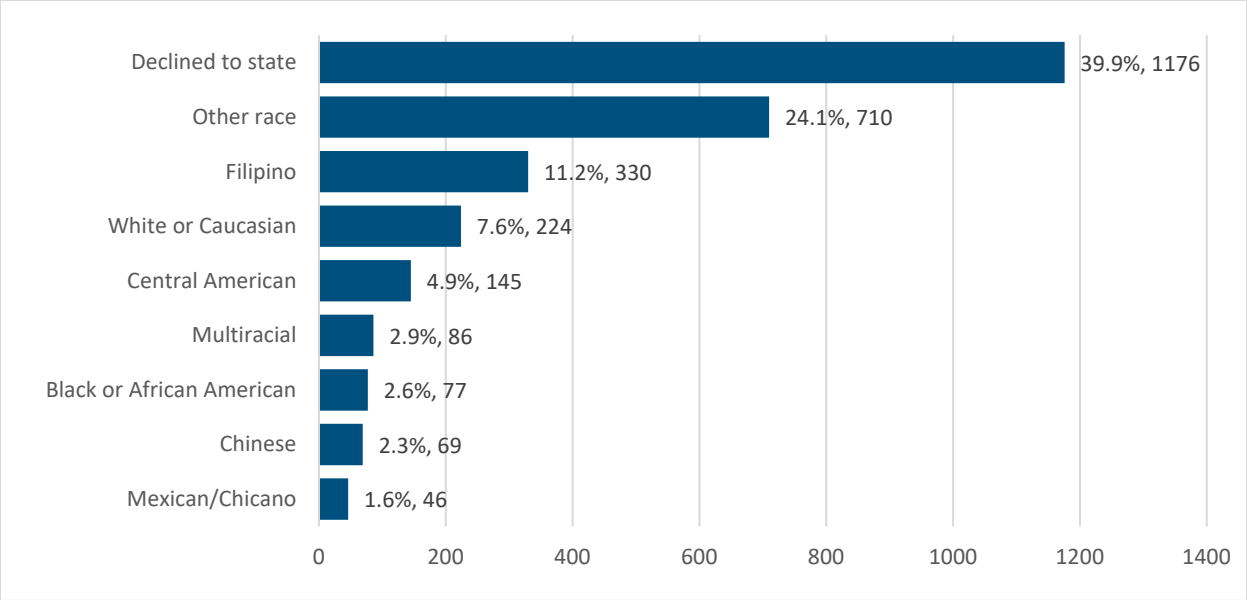


Notes. 1) Only individual outreach events (n = 49) offer service referrals. 2) Individual outreach events may refer an attendee to multiple social services. Therefore, the percentages may add up to more than 100%.

Demographics of Outreach event attendees

- Were female (**16.3%**, *n* = 483) and male (**11.9%**; *n* = 352). Most declined to state their sex at birth (**71.8%;** *n* = 2123).
- Identified their gender as female (**3.2%;** *n* = 96), male (**1.8%**; *n* =53), genderqueer (**0.2%**; *n* =7), female to male transgender (**0.1%**; *n* =3), male to female transgender (**0.1%**; *n* =3). Most declined to state their gender (**97.3%;** *n*=2796).
- Identified as other (**1.8%;** *n* = 53), heterosexual (**0.5%;** *n* = 14), bisexual (**0.2%;** *n* = 6), questioning (**0.2%;** *n* = 5), queer (**0.1%;** *n* = 3), gay/lesbian (**0.08%;** *n* =2), and bisexual (**0.08%;** *n* = 2). Most declined to state their sexual orientation (**98.9%;** *n* = 2879).
- Included transition-age youth (16–25 years of age, **47.8%;** *n* = 1414), children (15 years of age and younger; **28.7%**; *n* = 851), adults (26–59 years of age; **12.8%**; *n* = 379), older adults (older than 60 years of age; **0.8%;** *n*= 25). The remaining attendees (**9.7%;** *n* = 289) declined to state their age.
- Most declined to state their race (**39.9%**; *n* = 1176). The remaining attendees were primarily an other race (**24.1%;** *n* = 710), Filipino (**11.2%;** *n* = 330), or White or Caucasian (**7.6%;** *n* = 224). (See **Exhibit D3**.)

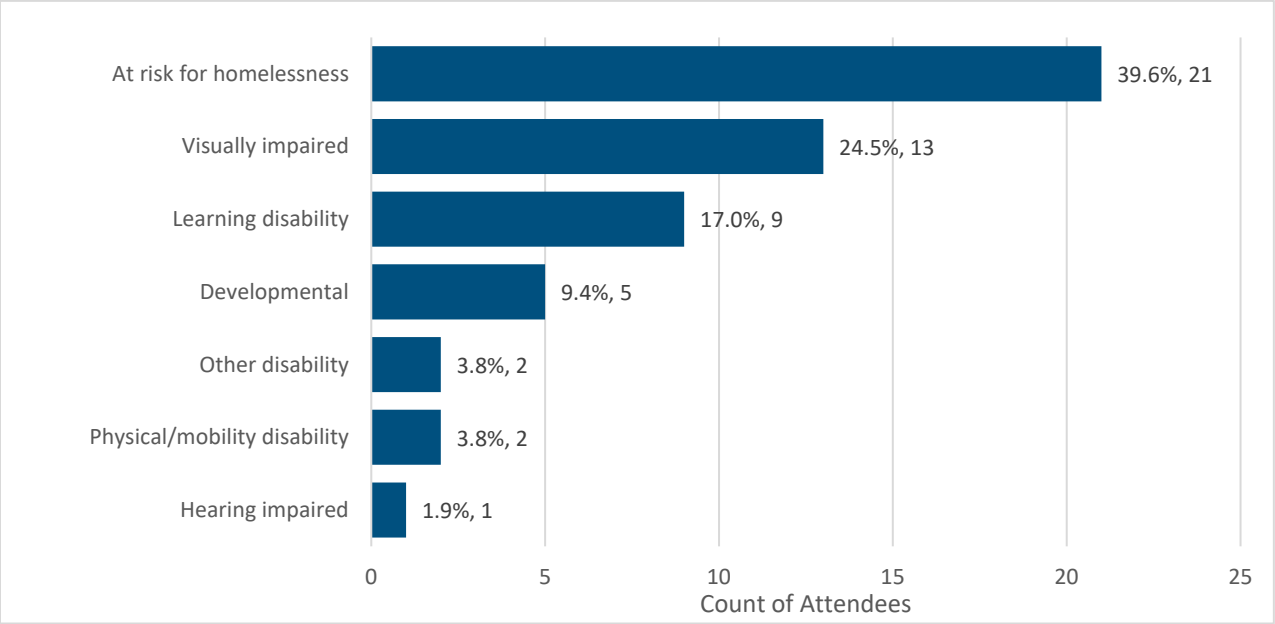
Exhibit D3. Daly City Youth Center Attendees by Top Racial/Ethnic Category, FY2023–2024



Note. Percentages add to more than 100% because attendees could select more than one race/ethnicity. These racial/ethnic categories were not displayed in the graph above due to the small n: Asian Indian/South Asian (n=21), Middle Eastern (n=17), American Indian/Alaskan Native (n=13), Samoan (n=12), Japanese (n=8), South American (n=5), Native Hawaiian or Pacific Islander (n=5), Korean (n=2), European (n=1), Eastern European (n=1), and Puerto Rican (n=1).

In FY2023–2024, of the people that reported being part of a special population, 39.6% reported being at risk for homelessness, 24.5% reported a visual impairment, and 17.0% reported a learning disability. See Exhibit D4 for a full list of special populations reported.

Exhibit D4. Counts and Percentages of Special Populations: Daly City Youth Center Attendees at Outreach Events, FY2023–2024



Note. Attendees could select more than one special population, therefore the percentages may add up to more than 100%.

Appendix E. FY2023–2024 Outreach, El Concilio

For FY2023–2024, El Concilio reported 98 outreach events, all of which were individual events. There were 98 attendees. Individual outreach events ranged from 10 to 45 minutes and lasted for 12 minutes on average.

Outreach events

- Most took place in an office (**51.0%**; n = 76). Other locations of events and their respective values are shown in **Exhibit E1.**
- Resulted in 35 mental health referrals and one substance use treatment referral at the individual outreach events.
- Individual outreach event attendees (n = 98) were referred to other services (**43.7%**; n = 97), form assistance (**26.1%**; n = 58), and legal services (**12.6%**, n = 28). See **Exhibit E2** for the full list of services referred.

Exhibit E1. Counts and Percentages of Events by Location Type: El Concilio Outreach Events, FY2023–2024

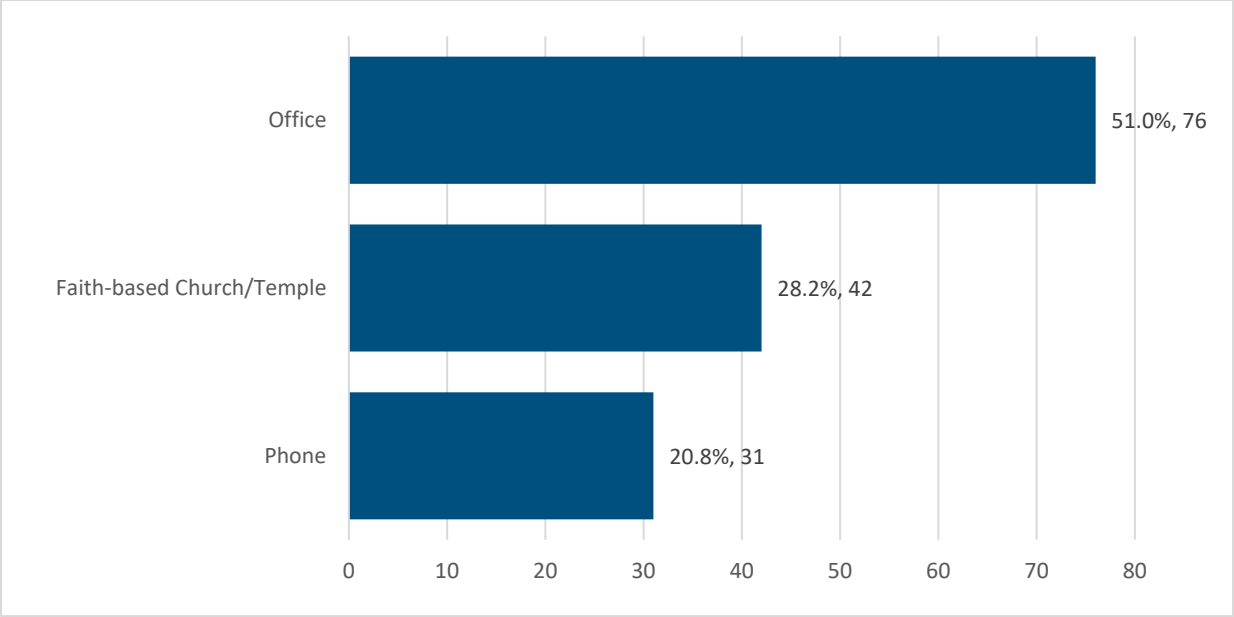
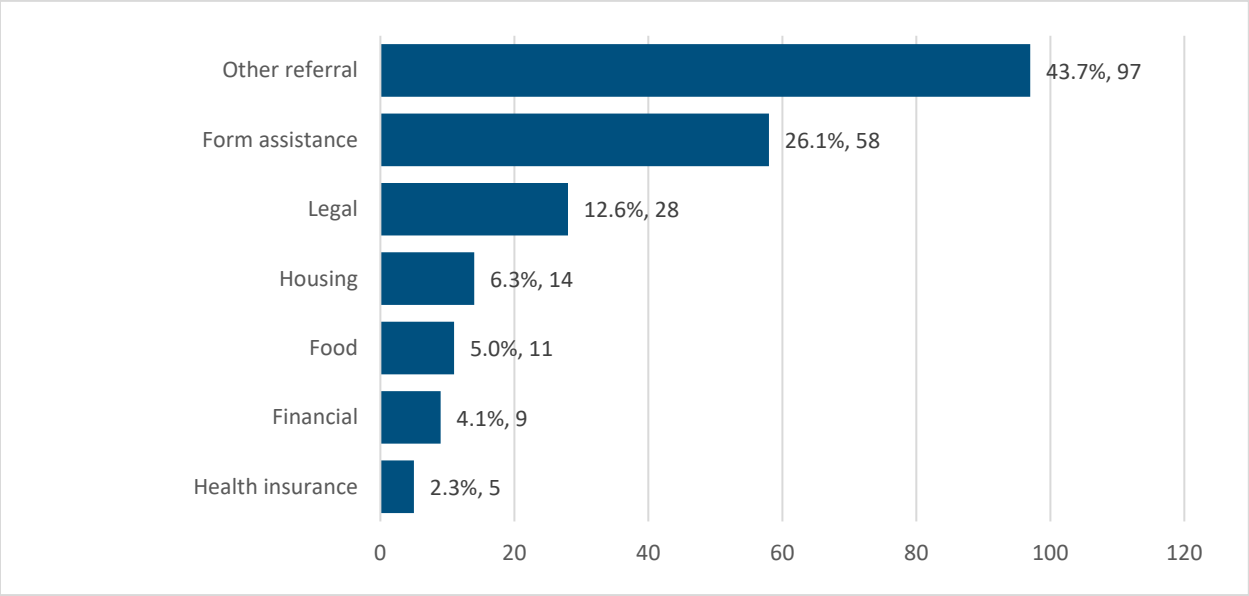


Exhibit E2. Counts and Percentages of Social Services Referrals following Individual Outreach Events: El Concilio, FY2023–2024

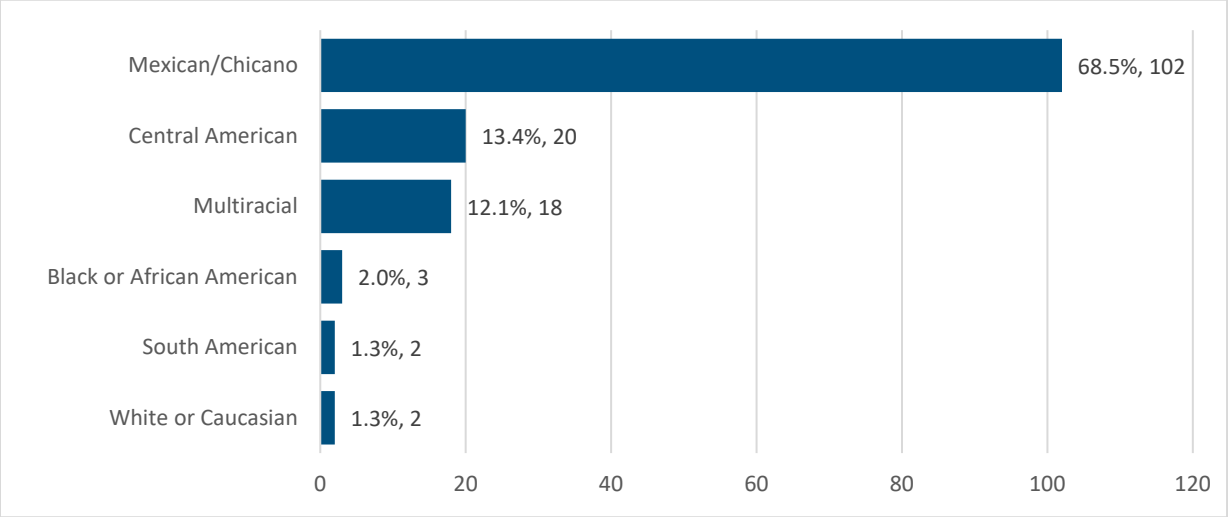


Notes. 1) Only individual outreach events (n = 98) offer service referrals.
2) Individual outreach events may refer an attendee to multiple social services. Therefore, the percentages may add up to more than 100%.

Outreach event attendees

- Attendees were female (**94.6%**; n = 87) or male (**5.4%**; n =11).
- Were heterosexual (**92.9%**; n = 91) and bisexual (**7.1%**; n = 7)
- Included adults (26–59 years of age, **89.8%**; n = 88), and older adults (60 years, **10.2%**; n = 10).
- Race/ethnicities most frequently reported by outreach event attendees were Mexican/Chicano (**68.5%**; n =102), Central American (**13.4%**; n = 20), and multiracial (**12.1%**; n = 18). (See **Exhibit E3.**)

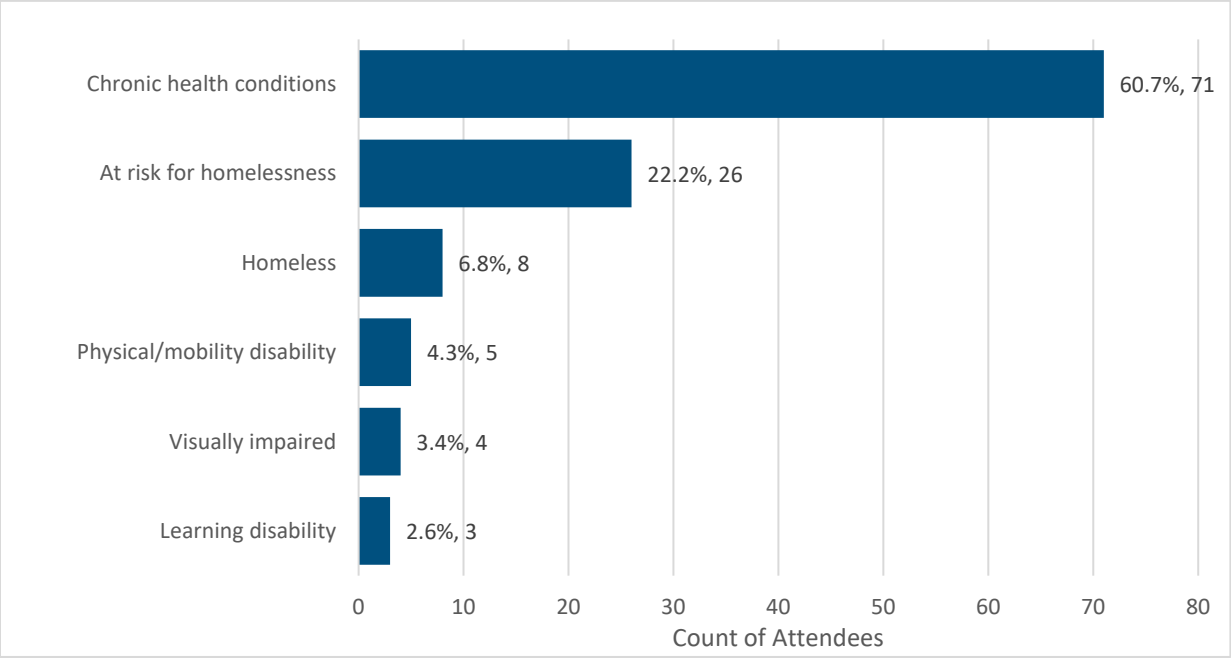
Exhibit E3. Counts and Percentages of Racial/Ethnic Categories: El Concilio Attendees at Outreach Events, FY2023–2024



Note. Percentages add to more than 100% because attendees could select more than one race/ethnicity.

In FY2023–2024, of those that reported being part of a special population, 60.7% had chronic health conditions, 22.2% were at risk for homelessness, 6.8% reported being homeless, and 4.3% reported having a physical/mobility disability. See **Exhibit E4** for the full list of special populations reported.

Exhibit E4. Counts and Percentages of Special Populations: El Concilio Attendees at Outreach Events, FY2023–2024



Note. Attendees could select more than one special population, and therefore the percentages may add up to more than 100%.

Appendix F. FY2023–2024 Outreach, Free At Last

For FY2023–2024, Free At Last reported 447 outreach events, all of which were individual events. There were 447 attendees. The events ranged from 5 to 60 minutes and were for 28 minutes on average.

Outreach events

- Most frequently took place over the phone (**88.9%;** *n* = 152) and in an office (**11.1%;** *n* = 19), as shown in **Exhibit F1.**
- Resulted in 28 mental health referrals and 315 substance use referrals at the individual outreach events.
- There were 330 referrals to social services for individuals who attended the individual events. (See **Exhibit F2**.) Individual outreach event attendees (*n* = 447) were referred to medical care (**50.9%;** *n* = 168), housing (**43.9%;** *n* = 145), and health insurance (**3.0%;** *n* = 10). See Exhibit F2 for the full list of services referred.

Exhibit F1. Counts and Percentages of Events by Location Type: Free at Last Attendees at Outreach Events, FY2023–2024

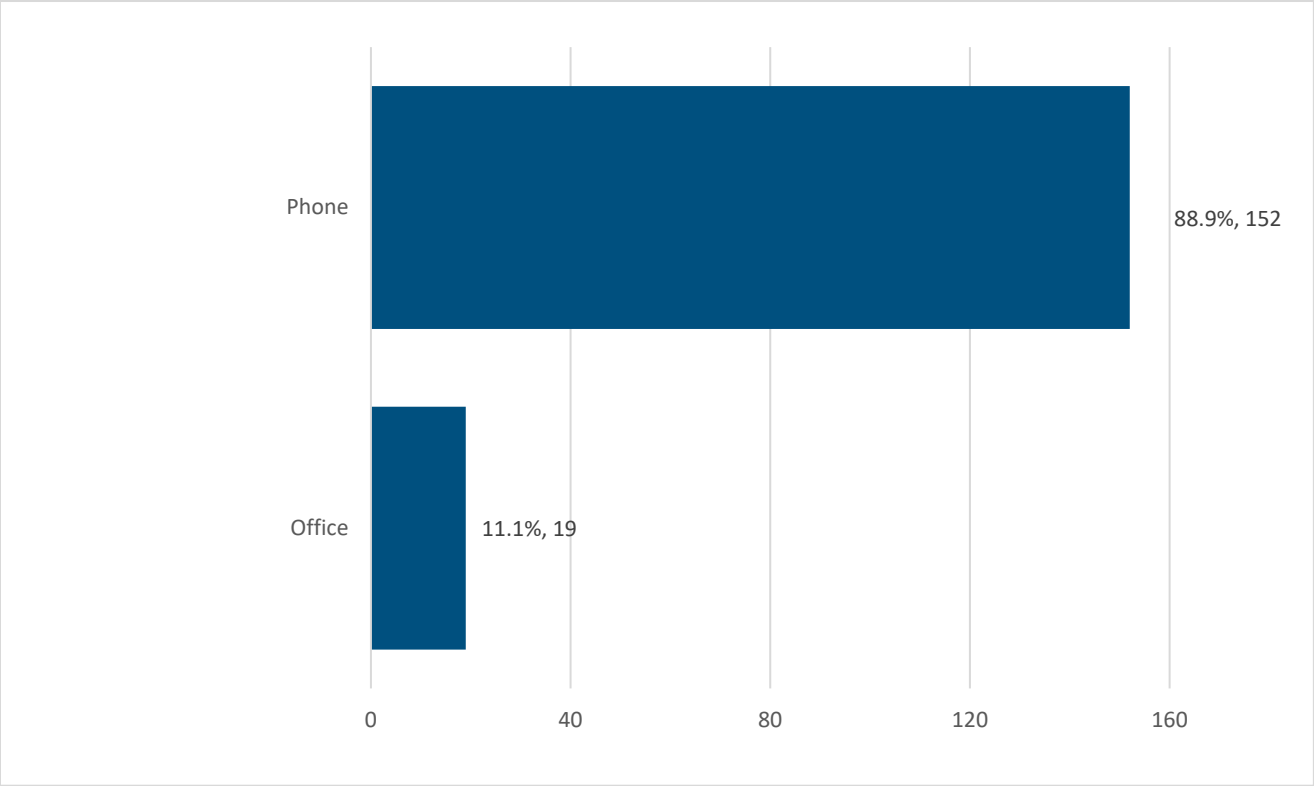
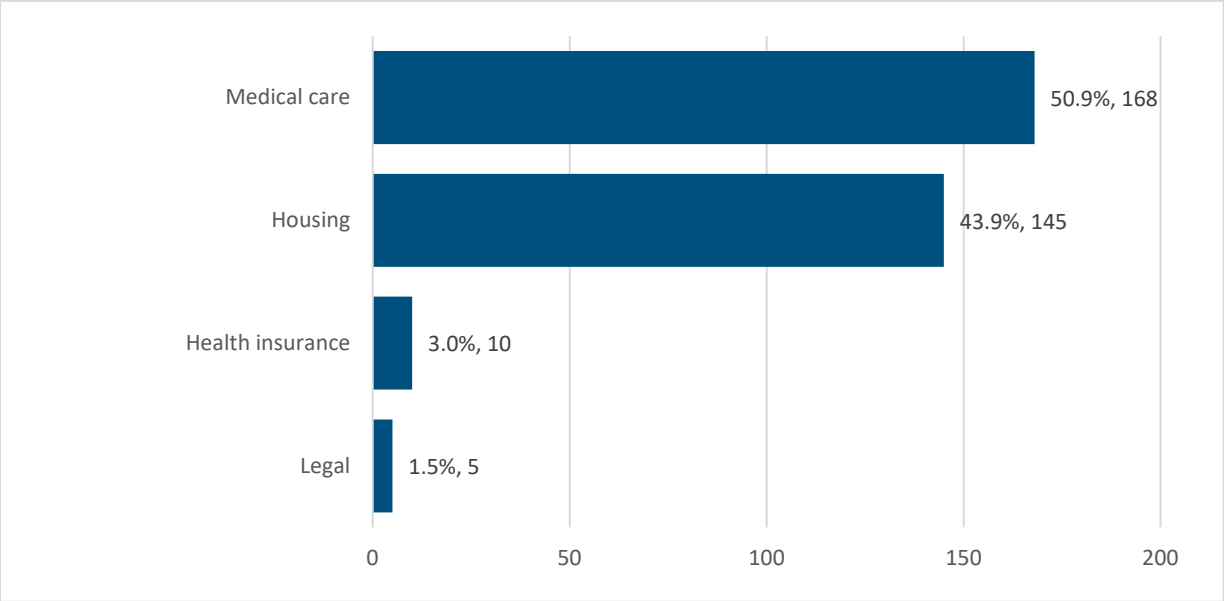


Exhibit F2. Counts and Percentages of Social Services Referrals following Individual Outreach Events: Free at Last, FY2023–2024

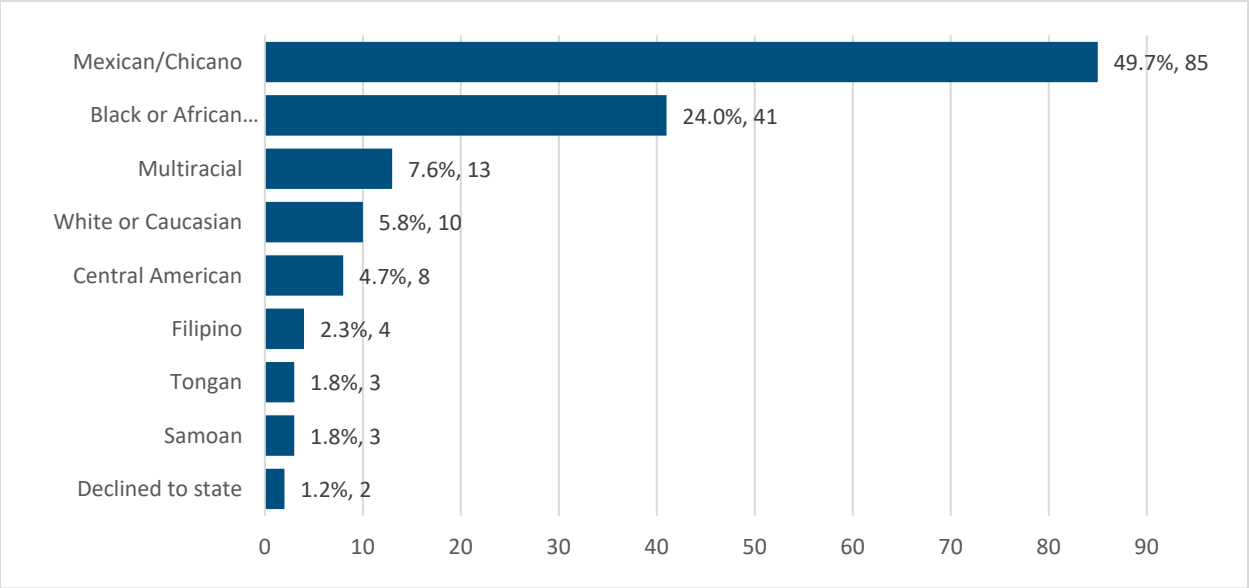


Notes. 1) Only individual outreach events (n = 447) offer service referrals.
2) Individual outreach events may refer an attendee to multiple social services. Therefore, the percentages may add up to more than 100%.
3) These referral types were not displayed in the graph above due to the small n: transportation (*n* = 1) and form assistance (*n* = 1).

Outreach event attendees

- Most often were male (**52.1%;** *n* = 233); 47.9% were female (**47.9%;** *n* = 214).
- Identified their gender as male most of the time (**51.2%;** *n* = 229); identified as female (**47.4%;** *n* = 212); male-to-female transgender (**1.1%,** *n* = 5),or female-to-male transgender (**0.2%,** *n* = 1).
- Identified as heterosexual (**90.3%;** *n* = 404), gay/lesbian (**5.8%;** *n* = 26), bisexual (**3.4%;** *n* = 15), or pansexual (**0.2%**; *n* = 1). One declined to state their sexuality (**0.2%**).
- Included adults (26–59 years of age, **57.7%;** *n* = 258) older adults (60 years or older, **29.5%;** *n*= 132), and transition-age youth (16–25 years of age, **12.5%;** *n* = 57).
- Most frequently self-reported race/ethnicity category as Mexican or Chicano (**49.7%;** *n* = 85), Black or African American (**24%;** *n* = 41), or more than one race (**7.6%;** *n* = 13). (See **Exhibit F3**.)

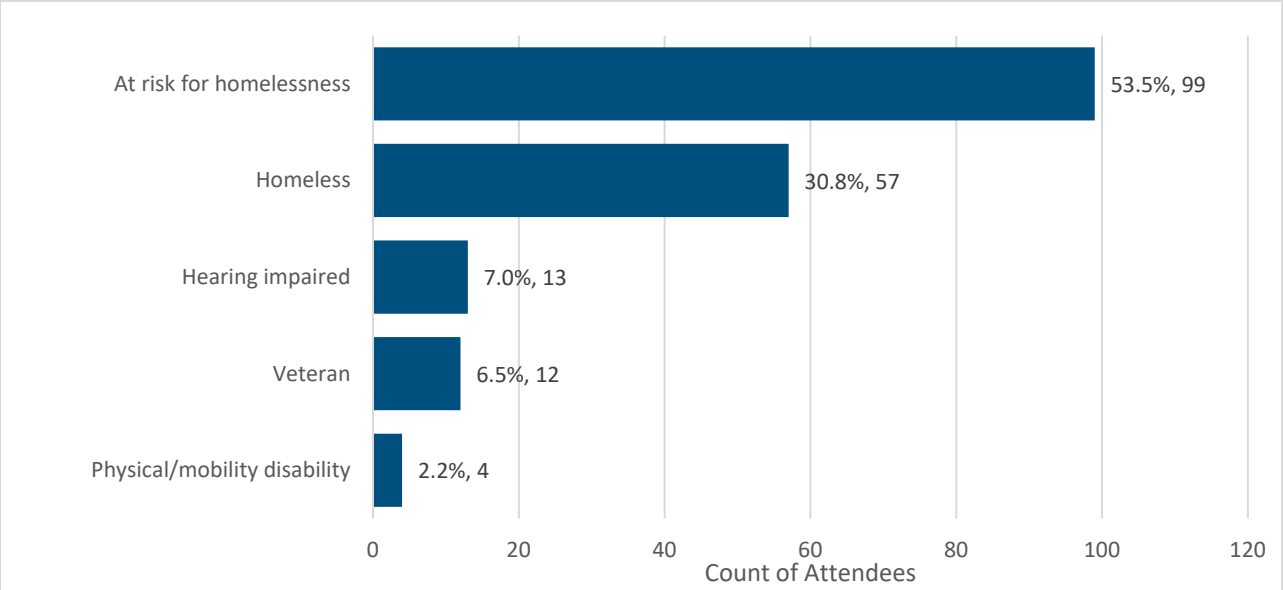
Exhibit F3. Counts and Percentages of Racial/Ethnic Categories: Free at Last Attendees at Outreach Events, FY2023–2024



Note. Percentages add to more than 100% because attendees could select more than one race/ethnicity. These racial/ethnic categories were not displayed in the graph above due to the small n: Korean (*n* = 1) and Native Hawaiian or Pacific Islander (*n* = 1).

In FY2023–2024, of those that reported being part of a special population, 53.5% were at risk for homelessness, 30.8% were homeless, and 7.0% reported having a hearing impairment. See **Exhibit F4** for the full list of special populations reported.

Exhibit F4. Counts and Percentages of Special Populations: Free at Last Attendees at Outreach Events, FY2023–2024



Note. Attendees could select more than one special population, and therefore the percentages may add up to more than 100%.

Appendix G. FY2023–2024 Outreach, Pacifica Collaborative

For FY2023–2024, Pacifica Collaborative reported 18 outreach events, including 8 individual outreach events and 10 group outreach events. There were 2,097 attendees. Individual outreach events lasted for 30 minutes with an average of 30 minutes. Group outreach events ranged from 90 to 180 minutes and lasted an average of 108 minutes.

Outreach events

- Most frequently took place at an other community location (**50.0%;** *n* = 13), school (**23.1%;** *n*=6), and telehealth (**19.2%,** *n*=5). See **Exhibit G1** for the full list of locations.
- Resulted in 8 mental health referrals and 7 substance use treatment referrals.
- There were 33 referrals to social services for individuals who attended the individual events. (See **Exhibit G2**). Individual outreach event attendees (*n*=8) were referred to food (**30.3%;** *n* = 10), housing (**21.2%;** *n* = 7), and transportation (**18.2%;** *n* = 6). See Exhibit G2 for the full list of services referred.

Exhibit G1. Counts and Percentages of Events by Location Type: Pacifica Collaborative Outreach Events, FY2023–2024

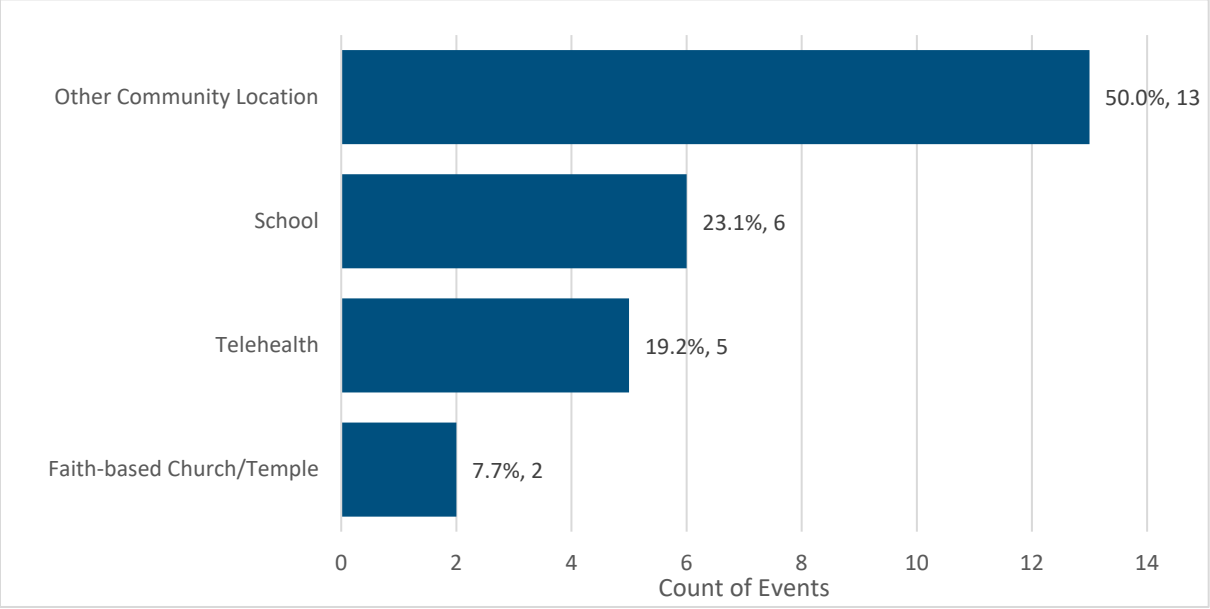
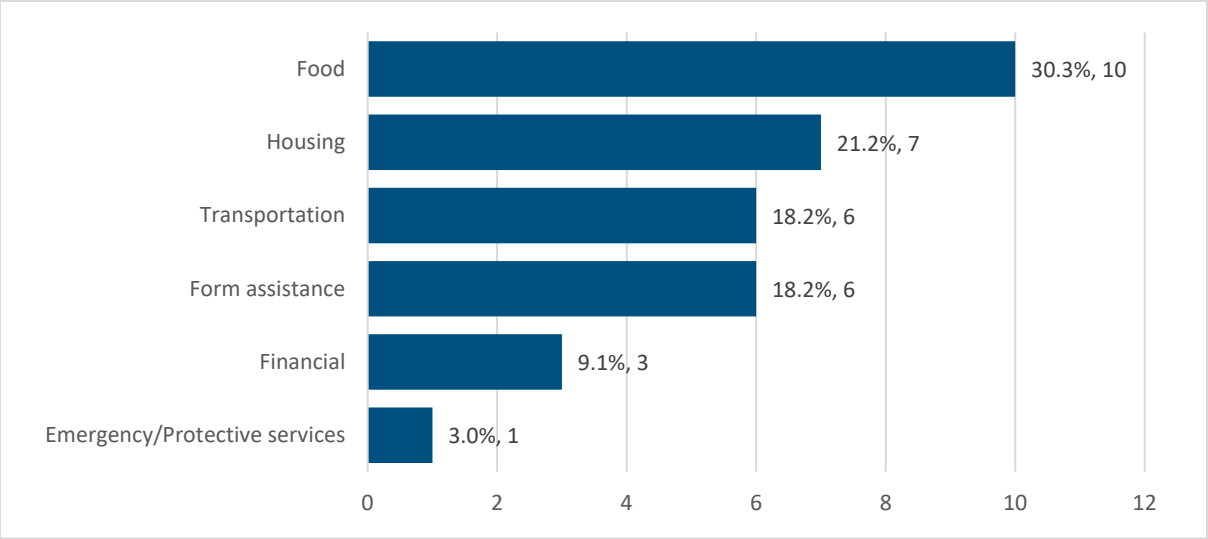


Exhibit G2. Counts and Percentages of Social Services Referrals following Individual Outreach Events: Pacifica Collaborative, FY2022–2023

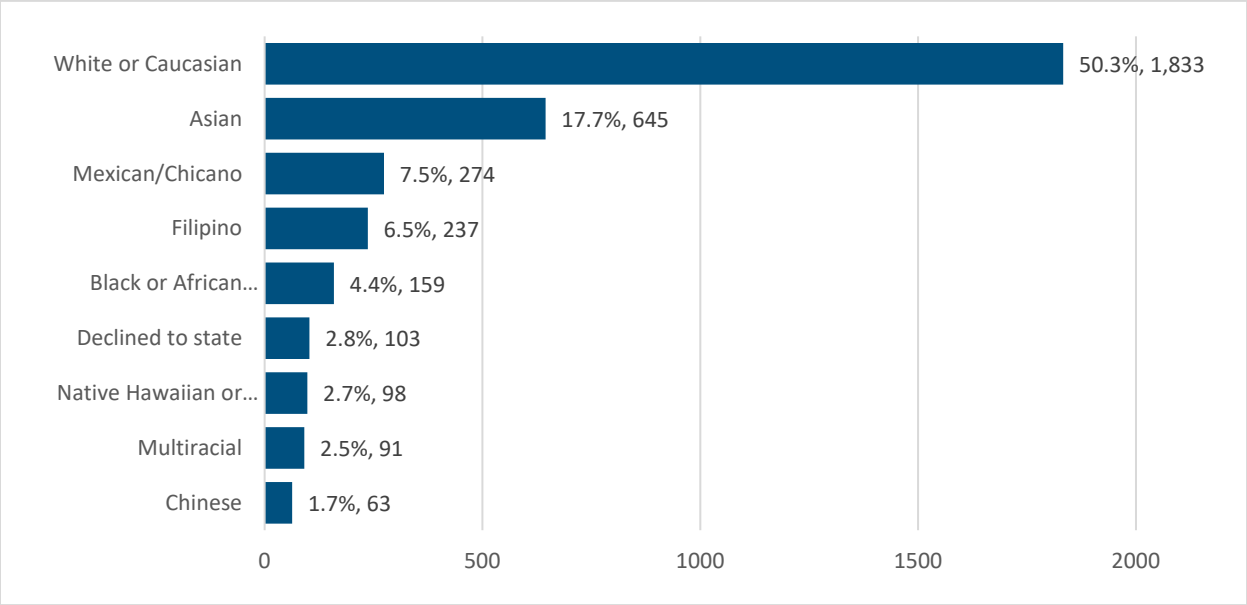


Notes. 1) Only individual outreach events (n = 12) offer service referrals.
2) Individual outreach events may refer an attendee to multiple social services. Therefore, the percentages may add up to more than 100%.

Outreach event attendees

- Were female (**53.6%;** *n* =1123) or male (**44.2%;** *n* = 926). There were 48 (**2.2%**) individuals who declined to state their sex at birth.
- Identified their gender as female (**53%;** *n* = 1111), male (**44%;** *n* = 923), female to male transgender (**0.3%;** *n* = 7), other (**0.1%;** *n* = 3), and male to female transgender (**0.1%;** *n* = 1). There were 53 (**2.5%**) attendees who declined to state their gender.
- Identified as heterosexual (**4.9%;** *n* = 103), gay/lesbian (**2.3%;** *n* = 49), queer (**0.9%;** *n* = 18), or bisexual (**0.4%;** *n* = 9). **91.4%** of attendees (*n* = 1917) declined to state their sexual orientation.
- Included adults (26–59 years of age, **48.6%;** *n* = 1020), older adults (60 years of age and older, **26.2%**; *n* = 550), transition-age youth (16–25 years of age, **14.2%;** *n* = 298), and children and teens (0–15 years of age, **10.6%**; *n* = 225) There were 3 (**0.1%**) attendees who declined to state their age.
- The highest percentages of identified race/ethnicity include White or Caucasian (**50.3%;** *n* = 1833), Asian (**20%;** *n* = 325), Asian (**17.7%;** *n*=645), or Mexican/Chicano (**7.5%;** *n*= 274). See Exhibit G3 for the remaining identified race/ethnicity groups.

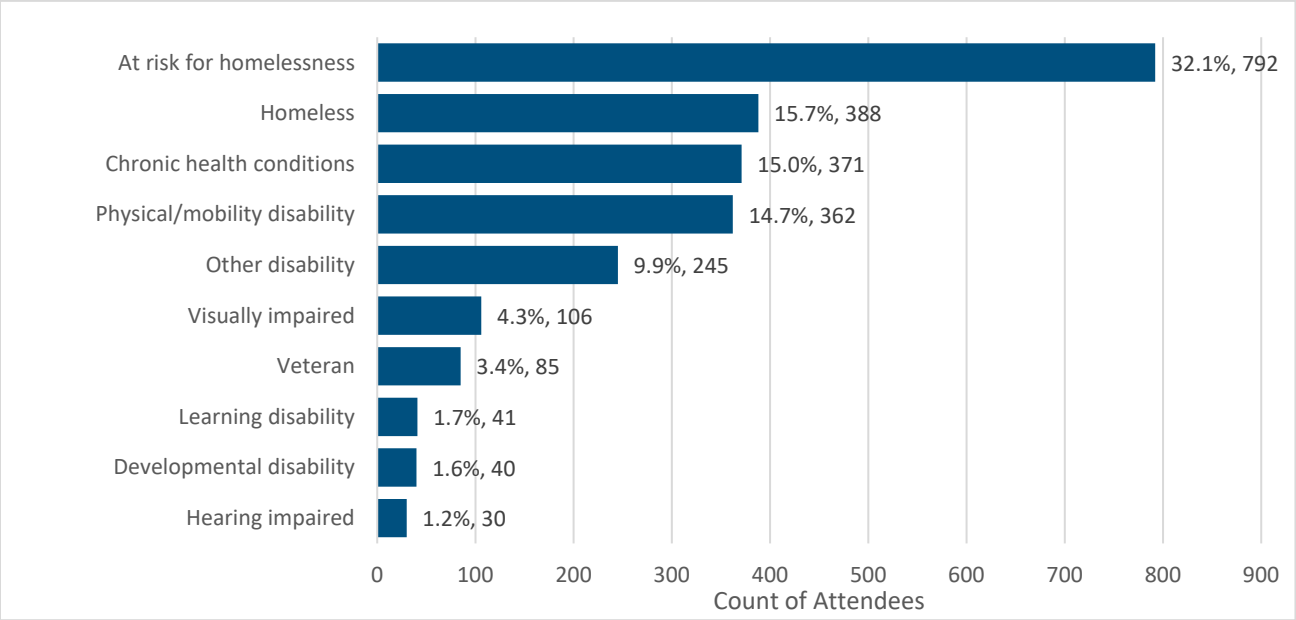
Exhibit G3. Counts and Percentages of Racial/Ethnic Categories: Pacific Collaborative Attendees at Outreach Events, FY2023–2024



Note. Percentages add to more than 100% because attendees could select more than one race/ethnicity. There were 141 clients whose racial/ethnic categories are not displayed in the graph above due to the small n. These racial/ethnic categories were not displayed in the graph above due to the small n: Samoan (*n* = 34), American Indian Alaskan Native, or Indigenous (*n* = 33), Japanese (n=26), Asian Indian/South Asian (*n* = 24), Tongan (*n* = 17), Korean (*n* = 5), other race (*n* = 1), and Fijian (*n* = 1).

In FY2023–2024, of those that reported being part of a special population, 31.2% reported being at risk for homelessness, 15.7% reported being homeless, and 15.0% reported chronic health conditions. See **Exhibit G4** for the full list of special populations reported.

Exhibit G4. Counts and Percentages of Special Populations: Pacifica Collaborative Attendees at Outreach Events, FY2023–2024



Note. Attendees could select more than one special population, and therefore the percentages may add up to more than 100%. These special populations were not displayed in the graph above due to the small n: Dementia (*n* = 7).

Appendix H. FY2023–2024 Outreach, StarVista

For FY2022–2023, StarVista reported 47 events, with all events being individual. There were a total of 47 attendees. Individual outreach events ranged from 15 to 120 minutes and lasted for 34 minutes on average.

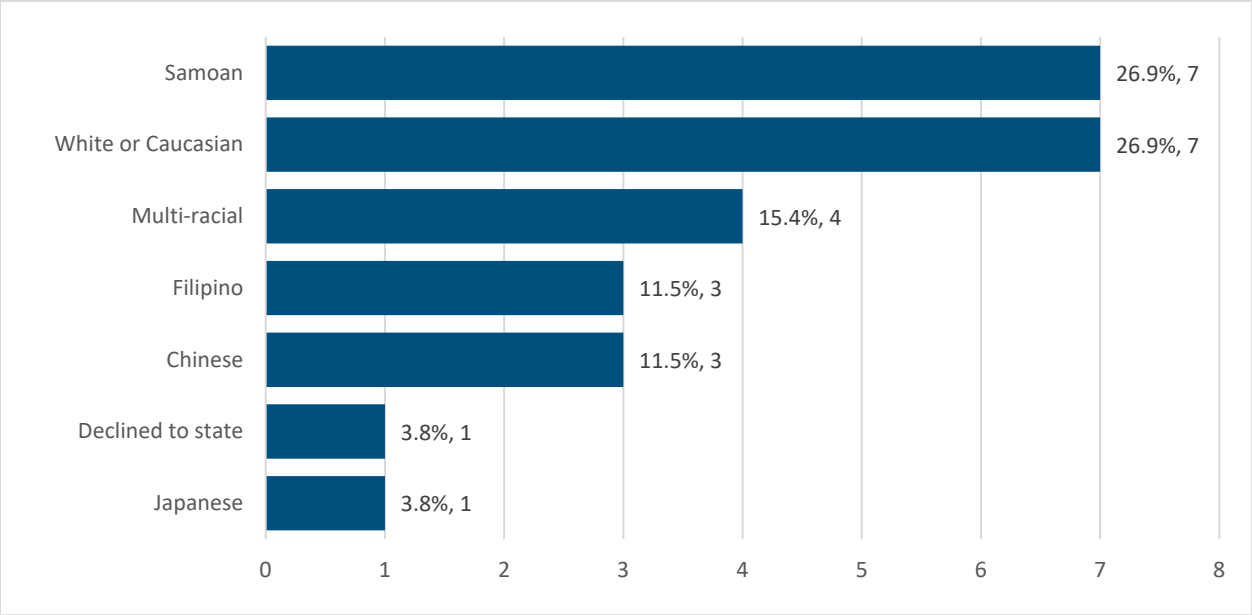
Outreach events

- Took place on via telehealth (**100%;** *n* = 4).
- Resulted in 31 mental health referrals and two substance abuse referrals.
- There were no referrals to social services or attendees who reported being part of a special population.

Outreach event attendees

- Were female (**70.2%;** *n* = 33) or male (**29.8%;** *n* = 14).
- Identified their gender as female (**55.3%**; *n* = 26), male (**25.5%**; *n* = 12), or gender queer (**8.5%**; *n*=4). Five declined to state their gender (**10.6%**).
- Identified as heterosexual (**42.6%;** *n* = 20), bisexual (**4.3%;** *n* = 2), or queer (**2.1%;** *n* = 1). 24 declined to state their sexual orientation (**51.1%;** *n* = 24).
- Were adults (26–59 years of age, **40.4%;** *n* = 19), were under the age of 15 (**36.2%;** *n* = 17), or were between the ages of 16-25 (**23.4%;** *n* = 11).
- Were primarily Samoan (**26.9%;** *n* = 7), White or Caucasian (**26.9%;** *n* = 7), or multi-racial (**15.4%;** *n*= 4). See Exhibit H1 for all other racial/ethnic groups.

Exhibit H1. Counts and Percentages of Racial/Ethnic Categories: StarVista Attendees at Outreach Events, FY2023–2024



Note. Percentages add to more than 100% because attendees could select more than one race/ethnicity.
Attendees by Race/Ethnicity by Collaborative, FY2018–2023

Appendix I. Attendees by Race/Ethnicity by Collaborative, FY2019–2024

Exhibit I1. Attendees by Race/Ethnicity by Collaborative, FY2019-2024

	EPAPMHO					NCOC				
Race/Ethnicity	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**
Black	93 (17.9%)	29 (11.8%)	44 (11.5%)	129 (13.1%)	177 (29.2%)	685 (5.4%)	202 (2.6%)	277 (3.4%)	157 (3.4%)	385 (4.6%)
White	18 (3.5%)	12 (4.9%)	12 (3.1%)	19 (1.9%)	139 (22.9%)	2024 (16%)	2336 (29.6%)	2394 (29.8%)	1015 (22.2%)	1099 (13%)
American Indian	1 (.2%)	0 (0%)	0 (0%)	0 (0%)	1 (.2%)	90 (.7%)	67 (.8%)	46 (.6%)	33 (.7%)	11 (.1%)
Middle Eastern	2 (.4%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	44 (.3%)	30 (.4%)	28 (.3%)	49 (1.1%)	23 (.3%)
Eastern European	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	5 (0%)	1 (0%)	1 (0%)	0 (0%)	3 (0%)
European	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	5 (0%)	3 (0%)	1 (0%)	3 (.1%)	11 (.1%)
Mexican	119 (22.8%)	101 (41.2%)	187 (48.7%)	310 (31.6%)	162 (26.7%)	2302 (18.2%)	1235 (15.6%)	510 (6.3%)	392 (8.6%)	472 (5.6%)
Puerto Rican	2 (.4%)	1 (.4%)	1 (.3%)	0 (0%)	2 (.3%)	44 (.3%)	36 (.5%)	2 (0%)	3 (.1%)	3 (0%)
Cuban	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Central American	19 (3.6%)	15 (6.1%)	28 (7.3%)	27 (2.7%)	15 (2.5%)	127 (1%)	13 (.2%)	160 (2%)	104 (2.3%)	60 (.7%)
South American	0 (0%)	1 (.4%)	2 (.5%)	0 (0%)	0 (0%)	27 (.2%)	67 (.8%)	6 (.1%)	11 (.2%)	27 (.3%)
Caribbean	0 (0%)	0 (0%)	0 (0%)	1 (.1%)	0 (0%)	5 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (0%)
Other Latino	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Asian	1 (.2%)	1 (.4%)	0 (0%)	1 (.1%)	4 (.7%)	873 (6.9%)	604 (7.6%)	647 (8.1%)	388 (8.5%)	393 (4.7%)
Filipino	4 (.8%)	0 (0%)	4 (1%)	7 (.7%)	2 (.3%)	1170 (9.3%)	316 (4%)	753 (9.4%)	494 (10.8%)	529 (6.3%)
Chinese	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	936 (7.4%)	304 (3.8%)	230 (2.9%)	158 (3.4%)	220 (2.6%)
Japanese	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	37 (.3%)	42 (.5%)	38 (.5%)	13 (.3%)	17 (.2%)
Korean	0 (0%)	1 (.4%)	1 (.3%)	0 (0%)	1 (.2%)	39 (.3%)	25 (.3%)	7 (.1%)	6 (.1%)	11 (.1%)
South Asian	1 (.2%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	222 (1.8%)	50 (.6%)	52 (.6%)	30 (.7%)	27 (.3%)
Vietnamese	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	84 (.7%)	4 (.1%)	1 (0%)	2 (0%)	9 (.1%)
Cambodian	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	8 (.1%)	0 (0%)	0 (0%)	1 (0%)	1 (0%)
Laotian	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Mien	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Other Asian	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Tongan	30 (5.8%)	15 (6.1%)	35 (9.1%)	125 (12.7%)	19 (3.1%)	89 (.7%)	88 (1.1%)	118 (1.5%)	111 (2.4%)	98 (1.2%)
Samoan	26 (5%)	19 (7.8%)	31 (8.1%)	67 (6.8%)	16 (2.6%)	503 (4%)	137 (1.7%)	192 (2.4%)	327 (7.1%)	559 (6.6%)
Fijian	1 (.2%)	0 (0%)	4 (1%)	13 (1.3%)	0 (0%)	21 (.2%)	25 (.3%)	8 (.1%)	10 (.2%)	9 (.1%)
Hawaiian	164 (31.5%)	40 (16.3%)	1 (.3%)	246 (25.1%)	23 (3.8%)	1521 (12.1%)	174 (2.2%)	127 (1.6%)	105 (2.3%)	218 (2.6%)
Guamanian	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Multi	39 (7.5%)	9 (3.7%)	31 (8.1%)	29 (3%)	43 (7.1%)	1228 (9.7%)	248 (3.1%)	325 (4%)	576 (12.6%)	1357 (16.1%)
Other Race	0 (0%)	1 (.4%)	0 (0%)	0 (0%)	2 (.3%)	113 (.9%)	5 (.1%)	718 (8.9%)	40 (.9%)	74 (.9%)
Unknown Race	1 (.2%)	0 (0%)	2 (.5%)	8 (.8%)	0 (0%)	412 (3.3%)	1883 (23.8%)	1392 (17.3%)	551 (12%)	2831 (33.5%)
Total	**521**	**245**	**384**	**982**	**606**	**12614**	**7899**	**8033**	**4582**	**8450**

Note. Percentages may not sum to 100% because of rounding. The total count for race/ethnicity reported may exceed the total number of attendees because some providers may have reported individuals who are multiracial as both multiracial and their respective race/ethnicity, leading to extra counts in some cases. The denominator for race/ethnicity percentage is the sum of all race/ethnicity data reported. N/A indicates the category was not available or discontinued during the specific fiscal year.

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APPENDIX 9. KAPWA KULTURAL CENTER INN EVALUATION REPORT, FY 2023–24

Kapwa Kultural Center & Café Evaluation

Mental Health Services Act (MHSA) Innovation (INN) Annual Report: FY23-24

RDA CONSULTING | 40 YEARS of Systems Change | SAN MATEO COUNTY HEALTH BEHAVIORAL HEALTH & RECOVERY SERVICES | KAPWA KULTURAL CENTER

Kapwa Kultural Center & Café

Mental Health Services Act (MHSA) Innovation (INN) Annual Report: FY23-24

This report was developed by RDA Consulting under contract with the County of San Mateo, Behavioral Health and Recovery Services.

RDA Consulting, 2024

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Program Overview

The Kapwa Kultural Center & Café (KKC or program) is an innovative program funded by the Mental Health Services Act (MHSA) Innovation (INN) component. Designed and implemented through a collaborative effort between the County of San Mateo Behavioral Health and Recovery Services (BHRS) Office of Diversity and Equity (ODE), the Filipino Mental Health Initiative (FMHI), and the Daly City Partnership (DCP), the KKC seeks to introduce a new and innovative approach that includes a social enterprise business model to provide culturally responsive mental health and wellness services to Filipino/a/x youth in and around Daly City. Recognizing the unique mental health challenges faced by this community and using a social determinants of health (SDoH) framework, KKC addresses both mental health needs and workforce development opportunities for youth, ages 16-24, through a social enterprise model centered around a café.

Photo 1. Kapwa Care Open Mic Event

The San Francisco Bay Area is home to the second-largest population of Filipino/a/x Americans in the United States, with Daly City, California, standing out as the municipality with the highest concentration, where 33.2% of residents identify as Filipino/a/x. Despite their significant presence, research on the mental health challenges faced by Filipino/a/x individuals remains limited, with even less attention given to culturally responsive practices. This gap underscores the urgent need for resources like KKC, along with related data, which provides culturally informed wellness support, particularly for adolescent youth within the Filipino/a/x community.[1]

Over the past three years, KKC, in partnership with its BRIDGE Advisory Board[2] and Kapwa Youth Advisory (KAYA), has made significant progress toward its mission of becoming a cultural hub for Filipino/a/x youth, offering a safe space for mental health support, entrepreneurship mentorship, and cultural education. The program integrates wellness services, leadership development, and vocational training to holistically support youth, helping them connect with their cultural identity while learning useful and relevant life skills. KKC serves as both a community space and a revenue generator. In addition to hosting workshops and other events, going into its fourth year, KKC will generate revenue through selling boba tea and snacks ("merienda") from local businesses, space rentals for events and meetings, and seminars, further supporting the financial sustainability of the café operations and the youth-focused programming.

At the heart of the KKC's mission is the concept of "Ginhawa," which translates to "total wellness" or "well-being." This approach reflects a Filipino/a/x value of holistic health that encompasses physical, mental, and spiritual dimensions, grounded in the concept of "Kapwa"—the belief that the self is connected to others. By fostering this sense of shared identity and community, KKC

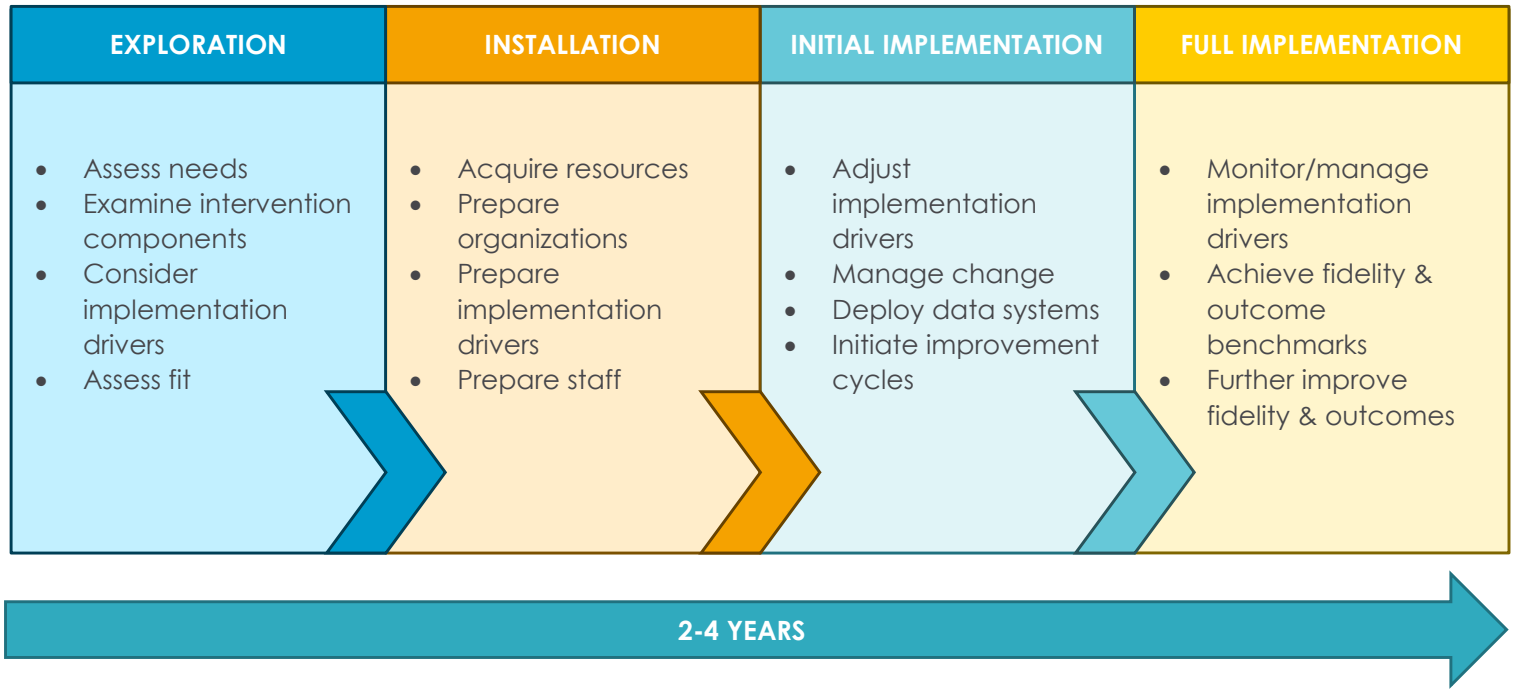
[1] Social Enterprise Café proposal.
[2] This is an advisory board comprised of diverse members who represent the community, target population, and other key interest holders in all KKC planning and programming aspects.

aims to improve mental health outcomes for Filipino/a/x youth, building protective factors and encouraging deeper engagement with culturally relevant services. Through its integrated, community-driven approach, the KKC is working to transform the mental health landscape for Filipino/a/x youth in San Mateo County.

Program Implementation Progress

Program implementation generally progresses through four stages (Figure 1): **exploration**, where needs are identified and solutions are planned; **installation**, which involves building infrastructure, securing funding, and hiring and preparing staff; **initial implementation**, where the program is piloted and early challenges are addressed; and **full implementation**, focused on officially launching the program, refining and sustaining it for long-term success.[3]

Figure 1. Implementation Core Components



In its third year, KKC continued to progress in the initial implementation stage with plans to move into full implementation at the start of its fourth year. Considerable progress was made to reach this point in the initial implementation stage, marking a significant milestone for the program.

Implementation Progress

Exploration Stage (Prior to 2021). KKC leadership team and their partners began exploring the idea of launching a social enterprise. The work that the team did to prepare the MHSA INN grant application set up the team for a successful start on their implementation journey.

Installation Stage (Year 1: 2021-2022). After the MHSA INN award, the KKC leadership team moved forward into the installation phase of implementation and this phase is detailed in the **first annual evaluation report** in 2022.

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[3] Fixsen, D. L., Blase, K. A., Naoom, S. F., & Wallace, F. (2009). Core implementation components. Research on social work practice, 19(5), 531-540. https://www.researchgate.net/publication/240699640_Core_Implementation_Components

Initial Implementation Stage

(Year 2: 2022-2023). KKC initiated the initial implementation phase in year two. The KKC leadership team along with their partners at DCP, the BRIDGE Advisory Board, key interest holders, and KAYA members[4] worked to achieve: (1) the development of a pilot workshop series which was well received by youth; (2) the creation of infrastructure and a business plan, in partnership with a local Filipina restauranteur, that mapped out the staff that need to be hired and their funding sources moving forward; (3) validation of the earned income strategies developed by the KKC Directors with the Harvard Community Service Partners.

(Year 3: 2023-2024). In its third year, KKC has made substantial progress in its initial implementation stage, despite challenges along the way. The program also continued the workshops piloted in the second year, offering valuable opportunities for participants to develop skills in leadership, mental health, and wellness. One of the key accomplishments has been the successful youth retreat and leadership development sessions for KAYA members. These sessions provided an opportunity for youth to reconnect with their roles, reflect on their wellness journeys, and engage in leadership development and self-advocacy training. In this year, KKC leadership also launched its internship program, which saw six interns this year engaged in on-the-job training.

On the operational side, the café's design and construction are progressing well, with major architectural design completed, boba equipment purchased, as well as the replacement of a skylight and windows. The KKC leadership team is finalizing key elements such as outside awning, minor electrical work, refrigeration maintenance, plumbing, security camera system implementation, boba bench installation, and identification/installation of a point-of-sale system. The KKC leadership team actively involved the community in menu planning through boba focus groups, ensuring that the café reflects community needs and preferences.

A crucial aspect of KKC's success in this phase is the involvement of a Business Development Manager from Harvard. This manager has been instrumental in developing a long-term sustainability plan for the café, conducting a 360-degree review with interest holders and providing strategic advice on financial modeling, earned income strategies, and operational processes. The Business Development Manager has also created an executive summary to track progress and outline the path forward for the next several years, with a particular focus on earned income opportunities through café operations, workshops, and space rentals. The leadership is also pursuing additional funding through grant applications and local partnerships and has engaged a public relations agency to develop a marketing strategy for the café's soft launch.

Additionally, staffing turnover among partner organizations has created delays, but the leadership has successfully onboarded a Café Manager and an Operations Coordinator, who will play key roles in supporting the café's daily operations and higher-level strategic planning. In addition, the leadership also recruited and hired a Mental Health Program Services Coordinator, who will oversee program service implementation and tracking of services and resources.

Given the significant progress made during the initial implementation phase, the KKC leadership is set to conduct a soft launch of the café in October 2024, entering its fourth year of

[4] This is a youth advisory board comprised of Filipino/a/x youths who represent the community, target population, and other key interest holders in all KKC planning and programming aspects.

implementation. This positions them to transition into the full implementation stage during the same period.

Sustainability Challenges

Alongside implementation challenges carried over from the previous year (Table 1), the passage of Proposition 1[5] (Behavioral Health Services Act or BHSA) in 2024 adds uncertainty as to how this will impact the use of future BHSA funds, in particular Prevention and Early Intervention programs. As such, the KKC leadership team has had to accelerate efforts to diversify funding sources and secure sustainable financial supports. While this is not an immediate challenge, it is one that may have implications for the future of the program. However, the KKC leadership has been proactive and diligent in exploring and solidifying efforts to maintain program sustainability beyond the scope of MHSA INN funds, including transitioning the café to becoming a standalone 501(c)(3) (non-profit) organization.

Table 1. Implementation Challenges

Implementation Year	Challenge
Year 1 (2021-2022)	• Securing a physical location for the café • KKC leadership balancing the duality of their roles as Daly City Partnership (DCP) staff and KKC leaders • Delays due to the COVID-19 pandemic, which impacted site assessments and project productivity
Year 2 (2022-2023)	• Delays in café construction due to necessary building upgrades, exacerbated by catastrophic weather • Staffing turnover among partner agencies, causing delays in continuity, • Complications in establishing a non-profit partnership with the county, which lacked experience in social enterprise projects, delaying guidance and resources for KKC leadership

[5] California Budget & Policy Center. (n.d.). *Q&A: Understanding California Prop 1*. Retrieved September 19, 2024, from https://calbudgetcenter.org/resources/qa-understanding-california-prop-1/

Implementation Year	Challenge
Year 3 (2023-2024)	• Passage of Proposition 1 and its impact on the use of future BHSA funds, in particular Prevention and Early Intervention programs

Evaluation Overview

In July 2021, BHRS contracted RDA to conduct a multi-year evaluation of the KKC, concluding in June 2026. The evaluation intends to:

1. **Evaluate implementation, outcomes, and impact of the KKC.**
2. **Comply with MHSA INN regulatory requirements, including annual evaluation reports to the Mental Health Services Oversight and Accountability Commission (MHSOAC).**

RDA conceptualizes its role as evaluation partners rather than external researchers. In this approach, RDA collaborates with BHRS and KKC partners to articulate program goals, develop process and outcome measures, and interpret and respond to evaluation findings. RDA incorporates opportunities for stakeholder participation throughout the evaluation process by including BHRS, the KKC, the BRIDGE Advisory Board, and the KAYA in developing the evaluation plan, reviewing evaluation tools, and interpreting evaluation findings.

RDA supports BHRS' KKC program goals through both process and outcome evaluation components. The program evaluation includes assessment of KKC's development and implementation to support continuous program improvement (process evaluation), as well as the program's outcomes to understand the extent to which intended goals of the program are met (outcome evaluation). The evaluation utilizes a mixed methods approach, leveraging both qualitative and quantitative data to explore the research questions.

Evaluation Domains

RDA focused on three domains in KKC's third year of implementation: Leadership, Service Delivery, and Prioritization (

Figure 2), to ensure the program is effective, meets community needs, and stays true to its mission. The Leadership domain looks at how well the KKC leadership team is making decisions, how they are planning for the program's future, and how their efforts are valued by key groups like the BRIDGE Advisory Board and KAYA members. Strong leadership is important for keeping the program running smoothly and ensuring it continues to grow. The Service Delivery domain focuses on the experiences of youth participants and partners who are part of KKC workshops and internships. It examines whether the program is helping youth with their personal and professional growth and whether it is reaching the right people in the community. This area also looks at how partner organizations and facilitators feel about working with KKC and how their feedback can improve future offerings. Lastly, the Prioritization domain ensures that KKC is staying true to its mission of creating a culturally relevant space for Filipino/a/x youth. It checks whether the community understands and feels connected to the center's mission and if the programs reflect the values and goals of the community. These three areas come together to provide a full picture of how KKC can continue serving and uplifting the community. More information on each of the domains is detailed below.

Figure 2. Kapwa Kultural Center & Café Evaluation Domains

Leadership

The Leadership domain in this evaluation focuses on assessing the KKC leadership team's[6] effectiveness, decision-making capacity, interest holder perceptions, and forward planning for the program's sustainability. It aims to understand how well the leadership team is equipped to make decisions on behalf of KKC, and how empowered they feel in doing so. The domain also evaluates how KKC leadership's skills and project management are valued by key interest holders, such as the BRIDGE Advisory Board and KAYA members, shedding light on the leadership team's impact and the recognition of their efforts. Additionally, the domain explores the extent to which KKC leadership has engaged in long-term sustainability planning and how they have included interest holders in these discussions, emphasizing the importance of collaborative and forward-thinking strategies for the program's future.

Service Delivery

The Service Delivery domain focuses on evaluating the experiences of both youth participants and external collaborators, such as partner organizations and workshop facilitators, in the KKC workshops and internship program. It assesses how youth participants engage with and perceive the programs, examining the extent to which these activities contribute to their personal and professional development. Additionally, it seeks to determine whether the program is effectively targeting its intended population, ensuring alignment with its goals. The domain also investigates the experiences of partner organizations and facilitators in collaborating with KKC leadership, exploring how they contributed to the programs and how these interactions might influence future offerings. Through these evaluation questions, this domain provides an understanding of how well the programs are meeting the needs of participants and collaborators, and how the program's implementation and its associated services can be improved moving forward.

[6] The KKC leadership team is comprised of an Director, Associate Director, and Outreach and Engagement Coordinator.

Prioritization

The Prioritization domain focuses on understanding how well the core mission and values of KKC are communicated, understood, and reflected in its operations. It examines the extent to which youth participants, KAYA members, and other interest holders can articulate the purpose and mission of KKC, as well as whether they perceive that the mission is being accomplished. This domain also assesses how effectively the program has prioritized its mandate to create a culturally appropriate space for Filipino/a/x youth, particularly through the lens of its social enterprise model. These evaluation questions explore the alignment between the program's goals and its implementation, offering insight into how well the program's cultural and social aims are being realized and sustained in practice.

Evaluation Questions

Evaluation questions reflect the purpose of the evaluation, help to guide evaluation activities, ensure the collection of appropriate data, and address local priorities. The questions for the evaluation of KKC are grouped into the three domains described above. Although separated to provide structure for the report process, domains and questions are interconnected and build off each other for a cohesive KKC evaluation. As previously mentioned, the evaluation questions for this reporting year were revised to align with the program's evolving direction, ensuring that both process and outcome evaluations were conducted in a way that was responsive to the program's current phase.

Leadership

1. To what extent is the KKC leadership team equipped and empowered to make decisions on behalf of program?
2. To what extent are KKC leadership skills and project management valued by the BRIDGE Advisory Board, KAYA members, and other interest holders?
3. To what extent has KKC leadership engaged in long-term sustainability planning and included interest holder engagement in that planning?

Service Delivery

4. How do youth participants experience the KKC workshops and internship program, and in what ways do these programs or activities impact their personal or professional development? Is the program targeting its intended population?
5. How did partner organizations and youth conference workshop facilitators experience their collaboration with the KKC leadership team, and what was their experience like in participating in and contributing to the workshops and internship program? What impacts, if any, do these experiences have for future offerings?

Prioritization

6. To what extent can youth, KAYA, and interest holders discuss the purpose and mission of Kapwa Café? If so, do they feel as though the mission is being accomplished?
7. How has the program prioritized the mandate to create a culturally appropriate space for Filipino/a/x youth using a social enterprise model?

Evaluation Methods

Data Collection

Over the course of several planning meetings, RDA and KKC leadership worked together to identify expected measurable outcomes to address each evaluation question that would provide a comprehensive understanding of program activities and outcomes. In collaboration with KKC leadership, RDA then identified appropriate data sources for each outcome measure. **Appendix A** summarizes the evaluation domains, outputs/outcome measures, and corresponding data sources.

Qualitative Data Sources

Program Documentation & Observation. RDA reviewed relevant program documentation to support analysis of the evaluation questions. This documentation included program descriptions, implementation plans, training materials, resource handouts, meeting notes, business plans, and other pertinent information provided by BHRS and the KKC interest holders. RDA also used meetings as opportunities to make additional observations.

Focus Groups. RDA conducted a total of five virtual focus groups from August to September 2023 with KKC leadership, internship partners, BRIDGE Advisory Board members, KAYA members, and interns, totaling 13 participants across all focus groups. KKC leadership and RDA worked together to develop each focus group protocol with each protocol containing a range of nine to 13 questions. Focus group discussions sought to identify strengths, gaps, and barriers with KKC development and programming, along with understanding stakeholder experience. The length of time for each focus group varied from 60 to 90 minutes. It is important to note that the individuals who participated in the focus groups represent only a subset of the overall sample, excluding KKC leadership. Therefore, these individuals will be referred to as "focus group participants" throughout the report to clarify that they are not reflective of the full sample.

Table 2. Focus Group Overview

Focus Group Participants	Time in Focus Groups (Minutes)	Topics Covered
KKC Leadership	90	• Funding and sustainability planning • Interest holder support and collaboration • Service development and leadership experiences • Mission alignment and impact
Internship Partners	60	• Partnership experience • Alignment with Kapwa's mission and goals • Opportunities for improvement and future collaboration

Focus Group Participants	Time in Focus Groups (Minutes)	Topics Covered
BRIDGE Advisory Board	90	• Role and collaboration with Kapwa leadership • Partnerships and progress toward Kapwa Café • Mission alignment and cultural impact • Mental health needs and program impact
KAYA	90	• Contribution impact • KAYA involvement in Kapwa Café • KAYA capacity building, leadership interactions, and café development • Kapwa café impact
Interns	60	• Internship experience • Alignment with Kapwa's mission and leadership • Post-internship reflections

Quantitative Data Sources

Youth Experience Survey. RDA, in partnership with KKC leadership, modified the Youth Experience Survey to capture youths' experiences with the Resiliency and Power of Youth Conference. The survey aimed to assess attendees' satisfaction and demographics, while also seeking their input on how to enhance the workshop series offered at the conference. RDA fielded the survey throughout July 2024 using the web-based platform, Alchemer. Participants were able to access the survey through a specified web link or by scanning the survey QR code. The survey was available in English and contained 34 questions, 11 of which were dedicated to attendees' demographic characteristics (e.g., age, current gender identity, etc.). All survey questions were optional and the survey itself was voluntary, with attendees who participated in the survey able to complete it in five minutes as most questions were close-ended and in Likert Scale format (disagree, somewhat disagree, neutral, somewhat agree, agree, does not apply). There was a total of 46 workshop attendees who participated in the survey. KKC leadership provided youth survey participants with an incentive. These participants will be referred to as "survey respondents" throughout this report.

Internship Experience Survey. RDA and KKC leadership co-adapted the Youth Experience Survey into the Internship Experience Survey. This version of the survey was designed to reflect the interns' experiences with the internship program. The survey aimed to assess several aspects of the internship, including participants' overall satisfaction, the support they received from KKC staff, the relevance of the internship to their personal and professional development, and its connection to their cultural background. The survey was fielded throughout August 2024 using the web-based platform, Alchemer. Participants were able to access the survey through a

specified link or by scanning a QR code. It was available only in English. The survey consisted of 37 questions, 11 of which were demographic questions aimed at understanding the characteristics of the participants. The survey questions were optional, and participation in the survey was entirely voluntary. Respondents were asked to provide feedback through a mix of question types, including Likert scale questions that measured their level of agreement with various statements. A total of four participants completed the survey. Throughout this report, these individuals will be referred to as "intern survey respondents" or "interns surveyed".

Data Analysis

RDA emphasizes the importance of continuous quality improvement (CQI) as an underlying approach to how data will be analyzed and reported on. RDA conducted qualitative data analysis by organizing and cleaning KKC program documentation and observation materials, along with the KKC leadership, BRIDGE Advisory Board, KAYA, intern, and internship focus group responses.

Qualitative data informed both program development and implementation. To analyze qualitative data, RDA transcribed evaluation focus group participants' responses. RDA then thematically analyzed responses to identify recurring themes and key takeaways. RDA synthesized qualitative findings to learn what aspects of the program are most effective, how to improve, strengthen, and understand the preliminary impacts on KKC youth.

RDA utilized the statistical software, Stata 18, to generate descriptive statistics (e.g., means, frequencies, percentages) from the responses in the Youth Experience and Internship Experience Surveys. This data was used to analyze who KKC served, which workshops survey respondents participated in, the length of time survey respondents have participated in KKC events and activities, respondents' satisfaction, and intentions with KKC events and activities, as well as respondents' experiences with KKC's workshops, services, and staff. These quantitative data were integrated with findings from the focus groups to further bolster the analysis. Based on these findings, RDA will support KKC leadership in their data-driven decision-making and programmatic improvement efforts.

Evaluation Findings

The following section presents the evaluation findings as they pertain to the evaluation questions mentioned above (see '**Evaluation Questions**' for more information). Findings are categorized by domain (Leadership, Service Delivery, Prioritization) and their associated evaluation questions.

Limitations

As with any real-world program, there are inherent limitations to data collection and analysis, and while this report offers a snapshot into the experiences of youth who participate in KKC programs, these limitations must be considered. First, since **not all participants completed the surveys or focus groups**, we are capturing feedback from only a portion of the youth who engaged with KKC. For instance, while 46 youth responded to the Youth Experience Survey, there were over 100 who engaged in the actual workshops. In addition, only four of six interns responded to the Internship Experience Survey, which means the results may not fully reflect the experiences of the entire group. It is important to note that throughout the findings, percentages are provided for the respondents who participated in the Youth Experience Survey given the larger sample size, meanwhile frequencies are only provided for Internship Experience Survey findings as this sample size was less than 11.[7] This was done to protect the privacy of intern survey respondents. In addition, some findings in the demographics section are masked by an asterisk (*) throughout to further maintain the privacy of any sample sizes smaller than 11.[7]

Additionally, because participation in the surveys was voluntary, there is the possibility of **self-selection bias**—those with particularly strong opinions, whether positive or negative, may have been more likely to participate. This could skew the results and overrepresent certain views. **Self-report bias** is also a consideration, as participants may unintentionally misrepresent their experiences, either by exaggerating or downplaying them.

Another factor is **social desirability bias**, where respondents might have felt the need to provide responses they believed were more favorable or acceptable, rather than being fully candid. For example, some participants may have spoken more positively about the program than they truly felt, especially if they were reluctant to express criticism.

Recall bias could also affect the findings, as participants were asked to reflect on past experiences, and their memories may not always be precise, especially for events that took place earlier in the year. Lastly, the **small sample size**, particularly for the internship survey, limits the ability to generalize the findings across all program participants.

Despite these limitations, the feedback collected can help guide KKC in refining its programming to better serve youth and the broader community moving forward.

[7] RDA follows the **Department of Health and Human Services and Department of Social Services' de-identification guidelines** as well as **California Civil Code 1798.24** to protect participants' privacy so as to not identify any individual if a sample size is less than 11 individuals.

DOMAIN: LEADERSHIP

This domain describes the impact that the leadership team has had on the development and implementation of KKC during the third year of program operations.

EVALUATION QUESTION #1: TO WHAT EXTENT IS THE KKC LEADERSHIP TEAM EQUIPPED AND EMPOWERED TO MAKE DECISIONS ON BEHALF OF THE PROGRAM?

The KKC leadership team operates within a non-hierarchical structure, prioritizing shared decision-making and open communication. Collaboration is at the core of their efforts, with youth, community members, and partners contributing to initiatives like shaping strategies, addressing youth needs, and guiding strategic planning. Decision-making processes range from planning events and developing programs to collaborative discussions on staffing decisions. This inclusive approach ensures that diverse perspectives are considered, enhancing the program's effectiveness. As one participant noted, ***"I love that it's non-hierarchical. The decision-making is shared, and we all have a vested interest in it, which makes everything more collaborative and cohesive."***

By fostering this collaborative foundation, the leadership team creates a culture of mutual support and shared responsibility. They actively recognize individual strengths, encouraging members to contribute their unique skills, whether by developing initiatives from the ground up or assisting in day-of-event coordination. The organizational framework prioritizes consistent communication with structured agendas and regular check-ins, ensuring a focused approach. In moments of challenge, the team remains adaptable, ensuring that programming continues to meet the evolving needs of the community. Their commitment to cultural relevance and participant well-being reinforces a supportive environment, allowing individuals to feel empowered as they navigate personal and professional growth.

The leadership team goes further by integrating decolonial practices, fostering vital conversations on how the legacy of colonization affects Filipino/a/x youth in their professional, familial, and academic lives. This focus on identity and self-advocacy encourages participants to reflect on their experiences, fostering a deeper connection to the program's mission. As one leader shared, ***"We really started to connect when we talked about decolonizing mental health. It opened up conversations about family, identity, and self-advocacy in ways we hadn't experienced before."***

EVALUATION QUESTION #2: TO WHAT EXTENT ARE KKC LEADERSHIP SKILLS AND PROJECT MANAGEMENT VALUED BY THE BRIDGE ADVISORY BOARD, KAYA MEMBERS, AND OTHER INTEREST HOLDERS?

The KKC leadership team's skills and project management are highly valued by the BRIDGE Advisory Board, KAYA members, and other community partners. They foster collaboration by engaging these groups thoughtfully, ensuring that contributions are recognized and integrated into the program. One participant shared, ***"I always appreciated how we created a paper trail with an agenda, ensuring everyone understood where we were, where we needed to go, and what we were aiming for."***

Strategically, the leadership team successfully organizes complex projects like youth conferences, which showcase their coordination abilities while offering significant opportunities for youth leadership development. By involving youth participants in both planning and execution, they nurture a partnership that positions youth as decision makers in the processes. One participant reflected, ***"KAYA helped me realize my potential to lead, offering support that made me confident in taking charge and guiding others."***

This collaborative approach breaks down traditional adult-youth power dynamics, allowing youth to actively contribute to program direction and initiatives. Their involvement in organizing events like the youth conference enables them to apply skills, voice ideas, and take ownership of outcomes. This hands-on experience highlights the leadership team's ability to empower youth while strategically advancing the café's broader mission.

EVALUATION QUESTION #3: TO WHAT EXTENT HAS KKC LEADERSHIP ENGAGED IN LONG-TERM SUSTAINABILITY PLANNING AND INCLUDED INTEREST HOLDER ENGAGEMENT IN THAT PLANNING?

The leadership team demonstrates a strong commitment to long-term sustainability through strategic planning and active stakeholder involvement. Recognizing that KKC's success is the result of collective efforts, they emphasize involving all community members in shaping sustainability initiatives. As one leader expressed, ***"We're building a legacy for many generations."***

Transitioning to a 501(c)(3) nonprofit represents a significant opportunity for KKC to broaden its reach and better serve community needs. The leadership views this transition as a pivotal step in advancing their mission. They are aware of the complexities in this transition, particularly in terms of financial stewardship and achieving operational efficiency. To address these, the leadership team is reining internal processes and actively forging relationships with foundations, investors, and consultants. A board member shared, ***"We're making sure that there's always a pipeline of very connected and very aligned advisors to continually support [KKC]."*** Through these proactive measures, the leadership team engages key partners at every step, securing KKC's place as a vital community resource for years to come.

In addition to their strategic priorities, **youth participants remain central to the restructuring process, ensuring that all efforts align with the program's mission and the community's needs.** By involving youth in decisions related to growth such as expanding revenue for the café, the team fosters a sense of ownership and inclusion. Annual retreats are held to review strategic goals and maintain alignment with KKC's mission and vision. The leadership's commitment to operational growth is always balanced with the community's priorities, ensuring that expansion efforts remain true to the program's core values. Their focus on community involvement, fiscal transparency, and youth-centered collaboration highlights their dedication to KKC's long-term success.

DOMAIN: SERVICE DELIVERY

This domain reviews the impact of services delivered during the program year and provides an overview of demographics for youth who participated in services and completed a survey afterward.

EVALUATION QUESTION #4: HOW DO YOUTH PARTICIPANTS EXPERIENCE THE KKC WORKSHOPS AND INTERNSHIP PROGRAM, AND IN WHAT WAYS DO THESE PROGRAMS OR ACTIVITIES IMPACT THEIR PERSONAL OR PROFESSIONAL DEVELOPMENT? IS THE PROGRAM TARGETING ITS INTENDED POPULATION?

Overview

In its third year of implementation, KKC continues to have a significant and positive impact on Filipino/a/x youth, helping participants deepen their connection to their cultural heritage while fostering personal growth, leadership skills, and practical life abilities. KKC's unique blend of cultural learning, community support, and professional development has created a meaningful space for youth to thrive.

KKC programming keeps youth coming back for more, showing that the café has successfully built a welcoming and fundamental space for participants. Nearly three-quarters of workshop participants surveyed participated in multiple KKC events (72%), with many attending at least one workshop ranging from one to three workshops.[8] While the average number of workshops that youth attended slightly decreased compared to the previous year (average: two workshops; range: one to five workshops), these findings suggest that the program offers meaningful content that keeps youth engaged.[9] Similarly, half of the interns surveyed had previously engaged in KKC activities before joining the internship, further demonstrating the lasting connection youth form with the center (2 out of 4 interns surveyed).[10] This ongoing engagement signals that KKC is not only providing a cultural hub but also a safe, supportive space for youth to explore and grow.

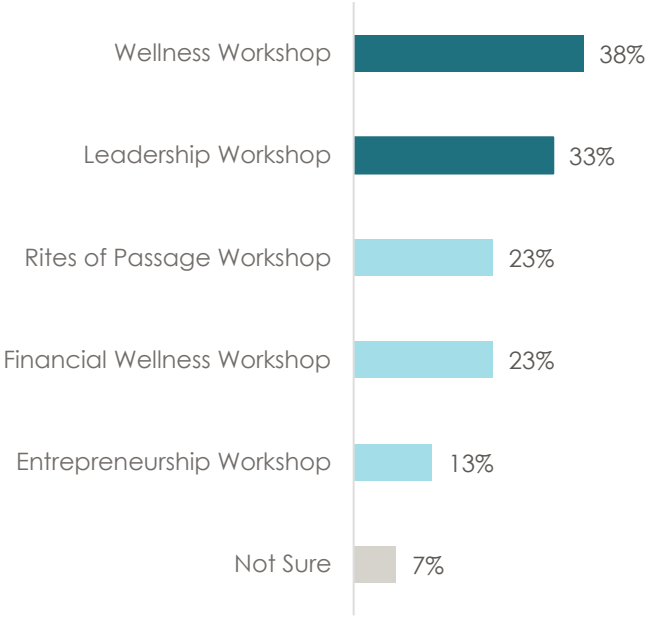
72% of survey respondents **participated in multiple KKC events**

Workshops on wellness and leadership are KKC's most popular service offerings, with a significant portion of workshop participants engaging in these sessions. Nearly three-quarters (71%) of workshop survey respondents attended the wellness (38%) and leadership (33%) workshops, indicating a strong interest in personal well-being and leadership development among youth. In contrast, fewer workshop survey participants attended the rites of passage and financial wellness workshops, with less than one-quarter of respondents participating (<25%) (Figure 3). These findings reflect a shift from the previous year, where the leadership workshop

[8] Data Source: Youth Experience Survey, 2024.
[9] It is important to note that the recruitment and workshop timing were different between the previous year and this year.
[10] Data Source: Internship Experience Survey, 2024.

had the most participants (58%), and there was slightly less engagement in the wellness (36%) and entrepreneurship workshops (30%). Although other workshops like entrepreneurship and rites of passage had lower participation rates this year, they still serve an important role in providing holistic development opportunities for youth. KKC leadership could explore strategies to increase participation in these workshops by further emphasizing their cultural relevance and practical applications in Filipino/a/x communities.

Figure 3. Workshops Survey Respondents Participated In, July 2024, N=39[11]



Comfort and Support in KKC Spaces

94% of survey respondents felt **comfortable** in the workshop space

KKC has created an environment that is culturally affirming, highly supportive, and inclusive. An overwhelming majority of workshop survey respondents agreed that the workshops provided a comfortable space (94%) (Figure 4).[12,13] Interns also reported feeling supported by staff, with all intern survey respondents agreeing they felt physically at ease during their internship experience (4 out of 4 interns surveyed).[14] **In addition, KKC creates a space where youth feel they are supported, connected, or both.** Nearly all workshop survey respondents shared the sentiment that they would return to KKC for support and/or connection (96%) (Figure 4). Three out of four interns

[11] Data Source: Youth Experience Survey, 2024. Seven respondents did not report which workshops they participated in. Respondents could select more than one workshop, reflecting more than 100%.
[12] Data Source: Youth Experience Survey, 2024.
[13] For a breakdown of survey respondents' experiences with comfort and support in KKC spaces by sex assigned at birth, see **Appendix B**.
[14] Data Source: Internship Experience Survey, 2024.

surveyed felt this same way.[15] Similarly, three-quarters of interns surveyed would recommend KKC workshops and activities to someone they know;[16] meanwhile, a slightly higher proportion of workshop survey respondents would recommend KKC workshops and activities to someone they know (97%) (Figure 4).[17] To further strengthen interns' sense of support and connection, KKC leadership could consider implementing structured mentorship and peer support opportunities, such as pairing interns with experienced staff and creating more opportunities for peer interaction through group check-ins or collaborative projects.

KKC positively impacts youths' **health and well-being.**

KKC programming makes a strong impact on participants' emotional, mental, physical, and spiritual well-being, reinforcing both growth and community connection. Most workshop survey respondents felt they learned something that benefitted their overall health (96%) (Figure 4).[18] In comparison, all intern survey respondents reported that they learned something from their internship that impacted their health and well-being (4 out of 4 interns surveyed).[19]

The workshops provided survey respondents with useful and helpful lessons about culture, leadership, and financial literacy, all of which they could apply to their personal and community lives. Many workshop survey respondents shared that they gained a deeper understanding of their Filipino/a/x roots, including learning about Kapwa (shared identity), Bayanihan (collective effort), ancestral knowledge, and the role of Babaylans (spiritual leaders, healers, midwives, wisdom keepers). Others reflected on how culture and food are intertwined, gaining an appreciation for traditional Filipino/a/x foods and their significance in community gatherings. Interns survey respondents also mentioned learning about values in Filipino/a/x culture, which helped them in both professional and personal contexts.

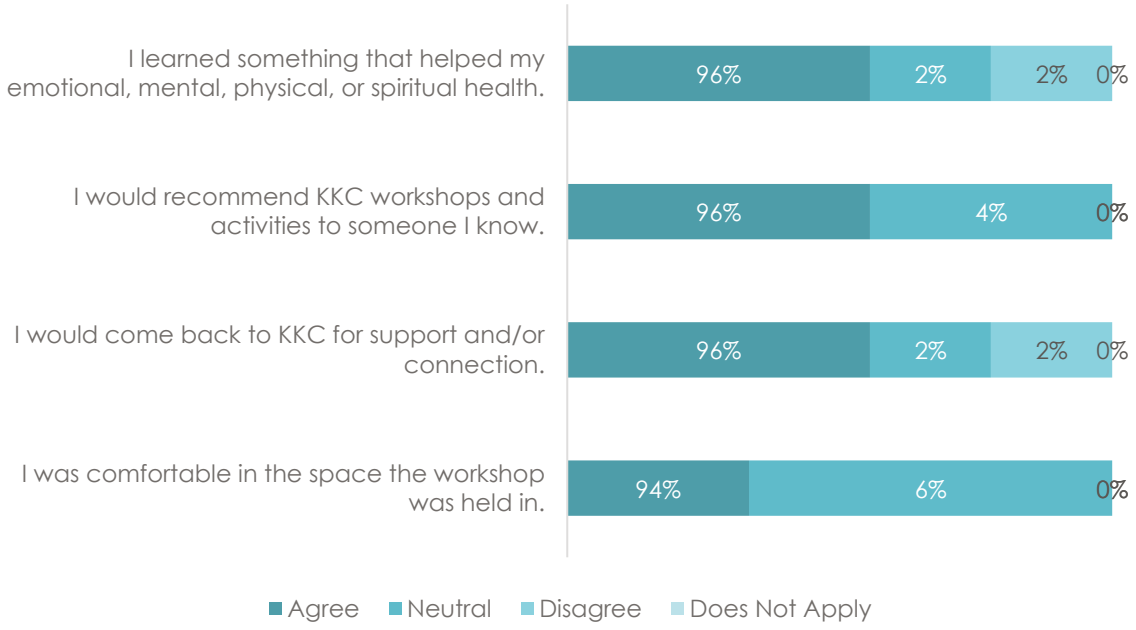
Several workshop survey respondents also learned critical leadership skills, noting that the workshops helped them reflect on their leadership styles and encouraged them to become more confident and self-aware. They discussed the importance of community impact, with some stating that leadership involves both self-reflection and accountability to others. Workshop survey respondents expressed how these insights helped them grow as leaders and connect more deeply with their communities. Similarly, intern survey respondents also reported learning important skills that improved their emotional and mental well-being, such as time management, leadership, and communication.

In addition to cultural and leadership lessons, many workshop survey respondents found the workshops practical, especially in terms of financial education. They learned about money management, including budgeting strategies like the 50-30-20 rule, which encourages saving,

[15] Data Source: Internship Experience Survey, 2024.
[16] Data Source: Internship Experience Survey, 2024.
[17] Data Source: Youth Experience Survey, 2024.
[18] Data Source: Youth Experience Survey, 2024.
[19] Data Source: Internship Experience Survey, 2024.

spending, and investing money wisely. These financial planning skills were highlighted as helpful for future planning and personal success.

Figure 4. Workshop Survey Respondents' Experiences with Comfort and Support in KKC Spaces, July 2024, N=45[20]



Experiences with KKC Groups, Services, and Staff

KKC staff continue to successfully support youth who engage in the program's workshops and activities. Nearly all workshop survey respondents reported they felt supported by KKC staff (93%)

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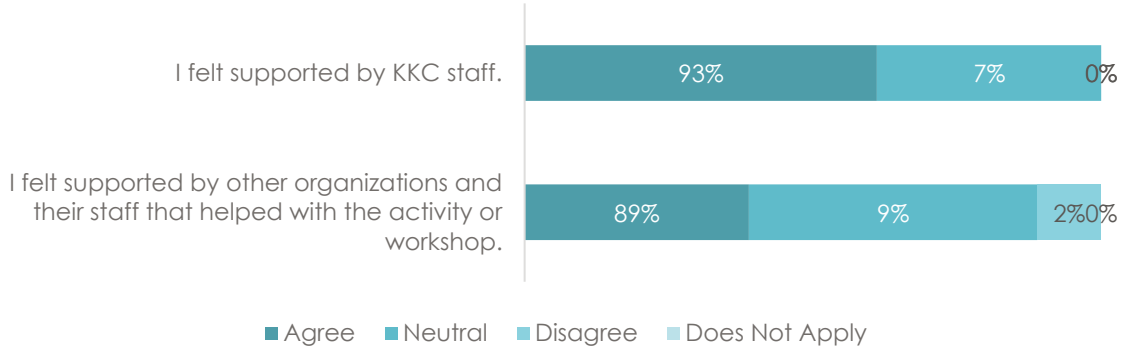
[20] Data Source: Youth Experience Survey, 2024. One respondent did not respond to the statements.

Figure 5), whereas all interns surveyed felt this way (4 out of 4 interns surveyed).[21] However, fewer workshop survey participants felt supported from other partnering organizations (89%), signaling a potential area for growth in collaboration between KKC and its partners.[22] Meanwhile, all interns surveyed felt supported by partners (4 out of 4 interns surveyed).

[21] Data Source: Internship Experience Survey, 2024.
[22] For a breakdown of survey respondents' experiences with staff and partner support by sex assigned at birth, see **Appendix C**.

Figure 5. Workshop Survey Respondents' Experiences with Staff and Partner Support, July 2024, N=45[23]



KKC's programming is rooted in **culture and community.**

One of the program's standout achievements is its ability to continually cultivate a strong sense of cultural identity and community belonging among Filipino/a/x youth. Almost all workshop survey respondents (94%) felt more connected to their Filipino/a/x culture, and an even larger proportion (98%) reported feeling a greater sense of community (Figure 6). Most workshop survey respondents indicated that KKC workshops and activities were related to their cultural background and beliefs (89%).[24] All interns surveyed agreed that they felt more connected to their culture, a greater sense of community, and that the workshops and activities related to their cultural heritage and beliefs (4 out of 4 interns surveyed).[25] Collectively, these findings underscore KKC's role as a vital cultural anchor for Filipino/a/x youth who may not have many opportunities to engage with their heritage in their daily lives. By integrating traditional Filipino/a/x values, practices, and language into its workshops, KKC provides a rare and precious space where participants can not only learn

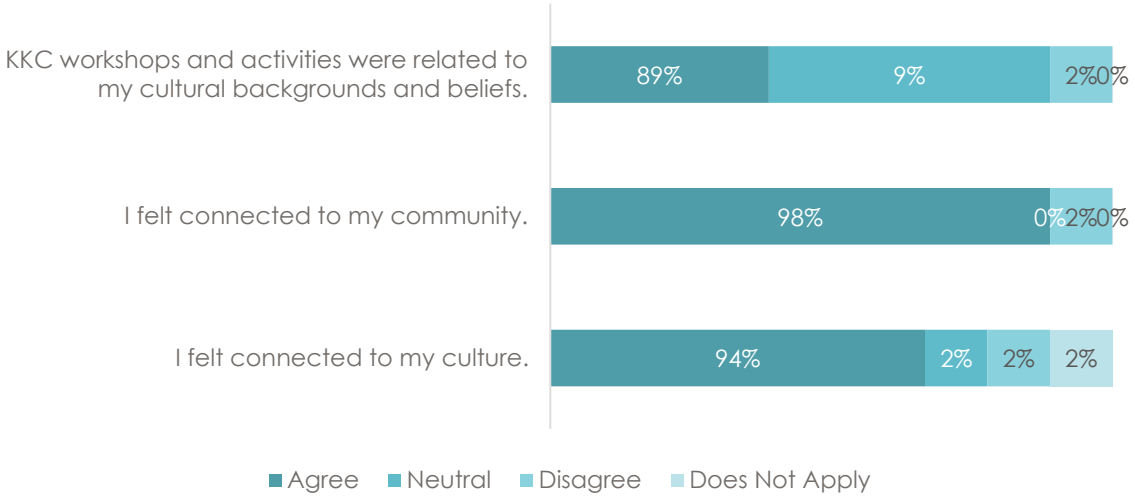
94% of survey respondents felt connected to their **culture**

98% of survey respondents felt connected to their **community**

[23] Data Source: Youth Experience Survey, 2024. One respondent did not respond to these statements.
[24] For a breakdown of survey respondents' experiences with culture and community by sex assigned at birth, see **Appendix D**.
[25] Data Source: Internship Experience Survey, 2024.

about their culture but actively live it. This cultural immersion allows participants to build a deeper sense of identity and belonging, both to their Filipino/a/x roots and to a broader, supportive community of peers and mentors.

Figure 6. Workshop Survey Respondents' Experiences with Culture and Community, July 2024, N=45[26]



KKC has positioned itself as a **vital community resource.**

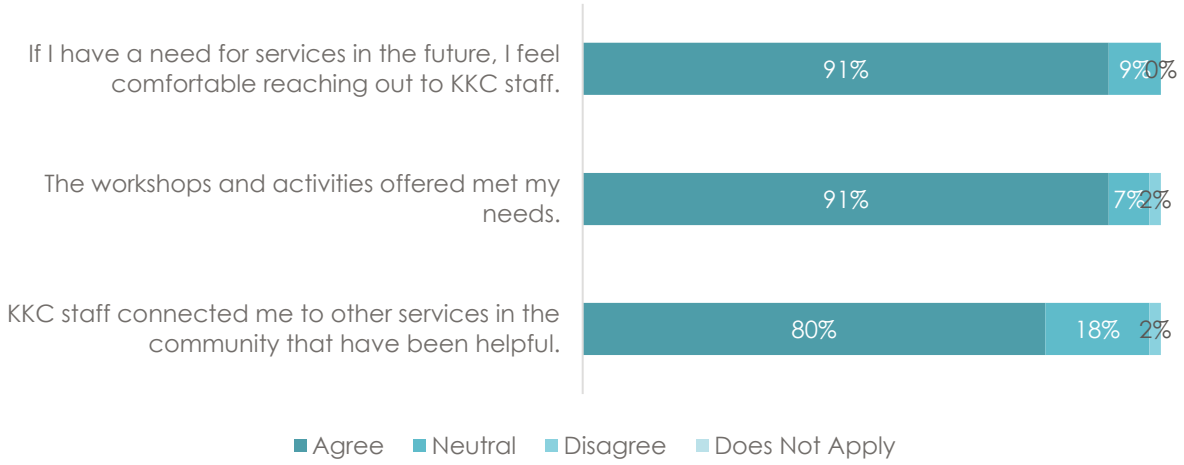
KKC has established itself as an important resource in the community, offering responsive services and connections to much needed resources for youth. Almost all workshop survey respondents indicated that the workshops and activities met their needs (91%), demonstrating KKC's ability to deliver relevant and supportive programming (Figure 7). A sizeable proportion of workshop survey respondents asserted that KKC connected them to other services in the community that were helpful (80%). In addition, nearly all workshop survey respondents would feel comfortable reaching out to KKC staff if they ever needed services in the future (91%).[27] This highlights the trust and rapport established between KKC staff and the youth.

Compared to the workshop survey respondents, the interns who participated in the survey reported mixed experiences with the internship program. While only half of interns surveyed felt the internship met their needs or was exactly what they were looking for (2 out of 4 interns surveyed), all interns surveyed indicated they were successfully connected to other helpful

[26] Data Source: Youth Experience Survey, 2024. One respondent did not respond to these statements.
[27] For a breakdown of survey respondents' experiences with KKC support and community connections by sex assigned at birth, see **Appendix E**.

community services (4 out of 4 interns surveyed).[28] A similar number of interns surveyed expressed that they would feel comfortable reaching out to KKC staff for future services (2 out of 4 interns surveyed). These findings may suggest that while KKC excels in connecting interns to community services, there may be opportunities to improve the alignment of the internship experience with intern expectations and to strengthen ongoing relationships with interns for future support.

Figure 7. Workshop Survey Respondents' Experiences with KKC Support and Community Connections,
July 2024, N=45[29]



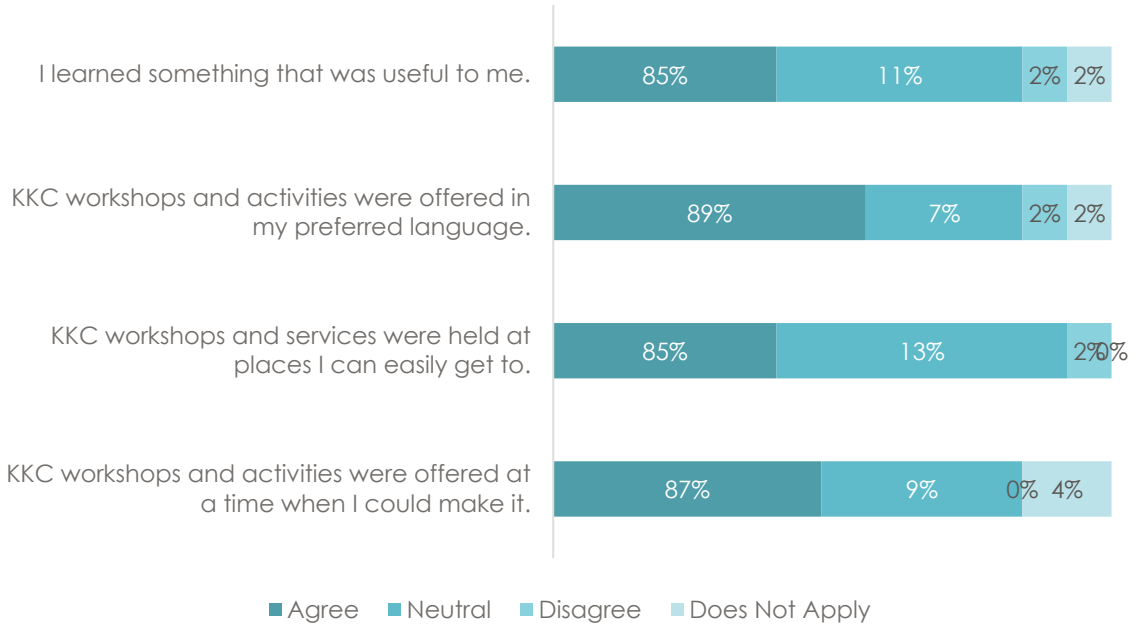
KKC ensures its programming is **accessible and inclusive.**

KKC staff work diligently to make its programs accessible and inclusive to all participants. Most workshop survey respondents found the time of the workshops and activities worked for them (87%), and a slightly higher proportion appreciated that the sessions were held in their preferred language (89%) (Figure 8). Fewer workshop survey respondents felt that the workshops and activities were held at a place they could easily get to (85%).[30] All interns surveyed reported that the internship was scheduled at times that worked for them and in locations that were easy to access (4 out of 4 interns surveyed). Moreover, all interns surveyed expressed that they were able to engage in the internship in their preferred language (4 out of 4 interns surveyed). These efforts highlight KKC's commitment to inclusivity, ensuring that its services meet the needs of all participants. However, some interns surveyed suggested improving communication and planning to make the internship feel more organized and professional, which could further

[28] Data Source: Internship Experience Survey, 2024.
[29] Data Source: Youth Experience Survey, 2024. One respondent did not respond to these statements.
[30] For a breakdown of survey respondents' experiences with KKC workshop and service accessibility and relevance by sex assigned at birth, see **Appendix F**.

enhance accessibility and overall participant satisfaction. It is also worth noting that most workshop survey respondents (85%) and all interns surveyed (4 out of 4 interns surveyed) reported that KKC programs shared content that was useful to them (see '**Comfort and Support in KKC Spaces**' for more information on what respondents learned or felt was useful). All in all, workshop survey respondents were happy with the workshops and activities they participated in (91%)[31], meanwhile, three-quarters of interns surveyed were happy with their internship experience (3 out of 4 interns surveyed). Many described the workshops as ***"perfect"*** and ***"wonderful,"*** with some noting that no improvements were necessary.

Figure 8. Workshop Survey Respondents' Experiences with KKC Workshop and Service Accessibility and Relevance, July 2024, N=45[32]



Demographic Characteristics of Workshop and Internship Survey Respondents

Demographic data helps identify whether the program is effectively reaching its target population, Filipino/a/x youth, and allows KKC to make adjustments to better serve underrepresented groups. Additionally, this information ensures that KKC's culturally grounded programming resonates with the diverse identities within the Filipino/a/x community, fostering a deeper connection and sense of belonging among participants. By continuing to check in with the demographics of those that are engaging with the KKC the leadership team can ensure that they are continuing to seek out new voices, unique points of view, and members from all corners and facets of the community to continue to enrich and grow the KKC.

KKC continues to reach its target population of Filipino/a/x youth, ensuring that participants feel represented and seen. The demographics of the workshop attendees from those that completed a survey during the reporting period are displayed in Table 3. The average age of workshop survey respondents who elected to participate in the demographic portion of the survey was 18 years old, with a range of 13 to 26 years old. This is in alignment with KKC's

[31] For a breakdown of overall survey respondent satisfaction by sex assigned at birth, see **Appendix G**.
[32] Data Source: Youth Experience Survey, 2024. One respondent did not respond to these statements.

intended population – Filipino/a/x youth between the ages of 16 to 24 – as the majority of workshop survey respondents fell within this age range (89%). More than three-quarters of workshop survey respondents indicated that English is their preferred language (78%). To this point, it is important to highlight that about one in ten (<10%) workshop survey respondents felt neutral (7%) or disagreed (2%) that the KKC workshops and activities were offered in their preferred language. As such, KKC may want to consider providing workshops and activities in different languages in the future. Nearly all workshop survey respondents identified their race as Asian/Asian American (93%), and almost all workshop survey respondents identified their ethnicity as Filipino/a/x (91%). These proportions are slightly lower compared to the previous year where all workshop survey respondents identified as the aforementioned race and ethnicity, which may suggest that KKC is attracting more diverse participants and may need to consider this in future programming planning. Over half of workshop survey respondents identified as female (58%), the majority identified as a cisgender woman/woman or cisgender man/man (80%), and more than half (58%) identified as bisexual (31%) or heterosexual or straight (27%). Nearly two-thirds (63%) of workshop survey respondents reside in Daly City (36%) or San Francisco (27%). For more detailed information on demographic characteristics of workshop survey respondents, see **Appendix H**.

Demographic characteristics for the intern survey respondents followed a similar pattern to that of the workshop survey respondents. Intern survey respondents were between the ages of 17 to 19, and all identified their race as Asian/Asian American and their ethnicity as Filipino/a/x. The majority of intern survey respondents identified as female, cisgender woman/woman and, all interns surveyed preferred to speak English. Most intern survey respondents identified as heterosexual or straight or pansexual and many came from Daly City or San Francisco.

Table 3. Demographic Characteristics of Workshop Survey Respondents, July 2024, N=45[33,34]

Category	Percent
Age (Years)	
16-24	89%
Preferred Language	
English	78%
Tagalog	16%
Race[35]	
Asian/Asian American	93%
Ethnicity[36]	
Filipino/a/x	91%

[33] Data Source: Youth Experience Survey, 2024. One respondent did not respond to the questions.
[34] RDA follows the **Department of Health and Human Services and Department of Social Services' de-identification guidelines** as well as **California Civil Code 1798.24** to protect participants' privacy so as to not identify any individual if a sample size is less than 11 individuals.
[35] This demographic category reflects more than 100% since respondents were able to select more than one race they identified with.
[36] This demographic category reflects more than 100% since respondents were able to select more than one ethnicity they identified with.

Category	Percent
Sex Assigned at Birth	
Female	58%
Male	42%
Intersex Identification	
No	83%
Current Gender Identity	
Cisgender Man/Man	42%
Cisgender Woman/Woman	38%
Sexual Orientation	
Bisexual	31%
Heterosexual or Straight	27%
Disability Status[37]	
No disability	82%
City of Residence	
Daly City	36%
San Francisco	27%
Veteran Status	
No	96%

KKC Referral Sources

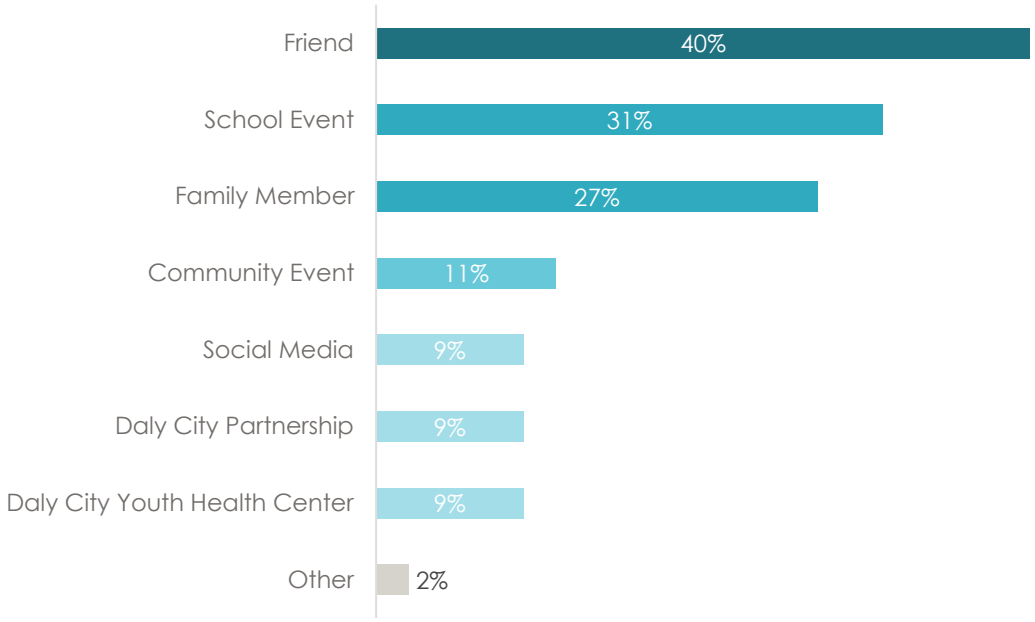
Friends continue to be cited as the main referral source to KKC. Two in five survey respondents were referred to KKC by a friend (40%) (

[37] This demographic category reflects more than 100% since respondents were able to select more than one ethnicity they identified with.

Figure 9).[38] Intern survey respondents were also mostly referred to KKC by a friend.[39] Of the survey respondents who reported where they heard about KKC, more than one-quarter were referred by more than one source (28%). On average, survey respondents were referred to the KKC by one referral source, with a range of one to four sources.

[38] Data Source: Youth Experience Survey, 2024. One survey respondent did not respond to this question.
[39] Data Source: Internship Experience Survey, 2024.

Figure 9. Workshop Survey Respondents' Referral Source to KKC, July 2024, N=45[40]



Youth Feedback on Opportunities for Growth for KKC Workshops and Activities

Several workshop survey respondents identified areas for enhancement that could elevate youths' experiences with the KKC to the next level. Because KKC targets youth, it is crucial to take their feedback into consideration to ensure the program continues to meet their needs. These suggestions are highlighted below (Table 4).

Table 4. Workshop Survey Respondents' Feedback on KKC Workshops and Activities, July 2024[41]

Opportunities for Growth	
More Interactive Elements	Participants suggested adding more interactive components to the workshops. This could involve activities where attendees can participate more directly during the workshops.
Better Organization	Some participants mentioned that the workshops could be better organized, particularly with scheduling, assigning students, and improving flow.
More Breaks	Several participants suggested incorporating more breaks during the workshops to make the sessions less overwhelming.
Workshop Length	A few participants noted that the workshops could be shortened, though some also enjoyed the pacing.

[40] Data Source: Youth Experience Survey, 2024. One survey respondent did not respond to this question.
[41] Data Source: Youth Experience Survey, 2024.

Opportunities for Growth

More Engagement	There were suggestions to make the workshops more engaging, such as offering different ways to listen to lectures or engage with the content.
More Coaching & Support	One suggestion was to offer more coaching and guidance to volunteers to improve their experience and the overall flow of the workshops.
Food Integration	One participant recommended incorporating food more directly into the learning experience, such as eating the food being discussed during the workshops.
Advertising & Outreach	One suggestion highlighted the need for better promotion of the workshops to reach more participants, such as showcasing presenters in promotional materials.

EVALUATION QUESTION #5: HOW DID PARTNER ORGANIZATIONS AND YOUTH CONFERENCE WORKSHOP FACILITATORS EXPERIENCE THEIR COLLABORATION WITH THE KKC LEADERSHIP TEAM, AND WHAT WAS THEIR EXPERIENCE LIKE IN PARTICIPATING IN AND CONTRIBUTING TO THE WORKSHOPS AND INTERNSHIP PROGRAM? WHAT IMPACTS, IF ANY, DO THESE EXPERIENCES HAVE FOR FUTURE OFFERINGS?

A part of the evaluation, RDA gathered insights from various partners, including the BRIDGE Advisory Board and internship hosts. However, direct feedback from the Youth Conference workshop facilitators was not collected.

The BRIDGE Advisory Board, with its close connection to the KKC leadership, played a key role in aligning the organization's mission with community needs and contributing to strategic planning. Internship partners expressed that they enjoyed their collaboration with the leadership team, describing the experience as engaging and mutually beneficial. Nevertheless, there were challenges, particularly in orienting interns to their roles within daily operations, but the supportive relationship fostered meaningful learning opportunities. Despite these hurdles, both partners and interns found the experience valuable in cultivating future community leaders.

Youth participants emphasized that conference workshops focusing on personal stories and professional insights resonated deeply with them. This engagement strengthened connections between facilitators and attendees, reinforcing cultural identity and fostering a sense of community. Although direct feedback from workshop facilitators was not collected, the positive responses from youth suggest that the facilitators' collaboration with the KKC leadership team was highly effective. One youth participant expressed, ***"You know, sometimes my voice can be suppressed or invalidated or even just outright ignored, but spaces like KAYA and Kapwa, and adult allies that intentionally listen—actively listen—to our voices... it just feels so different because you can feel that you're making an impact in real time."***

DOMAIN: PRIORITIZATION

This domain discusses how KKC has prioritized impacting youth and the mandate to create culturally appropriate spaces for youth.

EVALUATION QUESTION #6: TO WHAT EXTENT CAN YOUTH, KAYA, AND INTEREST HOLDERS DISCUSS THE PURPOSE AND MISSION OF KAPWA CAFÉ? IF SO, DO THEY FEEL AS THOUGH THE MISSION IS BEING ACCOMPLISHED?

Youth participants, KAYA members, and other community partners demonstrate a clear understanding of Kapwa Café's purpose and mission. They articulate the mission as creating a culturally affirming space with an emphasis on supporting Filipino/a/x youth. When presented with the specific mission statement, participants agreed there is strong alignment between the KKC's practices and its stated goals. One youth participant expressed, ***"It's incredible to see how they have made us, the youth, partners in this journey to achieve the mission statement. That's the beauty of it—we're addressing the mission and helping them achieve it."***

The BRIDGE Advisory Board and internship partners, feel that the mission is being effectively accomplished through the KKC's various programs and initiatives. The integration of Filipino/a/x culture into daily activities and the emphasis on mental health and decolonization practices resonate deeply with them. An internship partner noted, ***"KKC has created a space where students feel empowered and can get in touch with different parts of their culture. It's notable that these interns are so insightful and inspiring, and there's a space where all this can happen."***

EVALUATION QUESTION #7: HOW HAS THE PROGRAM PRIORITIZED THE MANDATE TO CREATE A CULTURALLY APPROPRIATE SPACE FOR FILIPINO/A/X YOUTH USING A SOCIAL ENTERPRISE MODEL?

KKC's development is deeply informed by the long prioritized culturally affirming programming for Filipino/a/x youth. While the café has yet to open, the center's mission—to integrate leadership skills, workforce preparedness, entrepreneurial mentorship, and ethnic studies—has shaped the formation of its practices. Strategically located in Daly City, home to a significant Filipino/a/x population, the café aims to seamlessly weave Filipino/a/x culture into its daily operations. Through focus groups, it is evident that while many youth may not fully understand the complexities of a social enterprise model, their enthusiasm for the café is palpable. They see the café as a space where they can meaningfully contribute, whether by working as baristas, supporting marketing efforts, or assisting in the day-to-day operations. This active participation not only equips them with practical skills but also deepens their sense of ownership and connection to the café's mission.

The guiding principle of "Boba with a Purpose" further anchors the café's alignment with cultural and community objectives. This framework ensures that the café's operations offer youth real-world entrepreneurial and leadership experiences while reinforcing their cultural identity. As the café moves closer to opening, it remains a direct extension of KKC's mission, creating a space where cultural pride and economic opportunity go hand in hand. By intertwining the lessons learned at the center with the café's future activities, KKC will ensure that Filipino/a/x youth remain at the heart of everything it does.

Key Program & Operational Learnings

The evaluation of KKC's current initiatives has revealed several key strengths and areas for growth as the center prepares for the café's official opening. While the café is still in development, the center has already begun aligning its day-to-day operations with its mission of empowering Filipino/a/x youth through culturally relevant practices. By embedding Filipino/a/x heritage into its social enterprise model, the center continuously ensures that its activities reflect its vision. This alignment is especially evident in the way youth-focused programs allow participants to connect with their cultural roots while developing critical leadership and entrepreneurial skills.

Each initiative—from internships to organizing events like the youth conference—reflects a deliberate effort to ensure that the café's mission of fostering personal growth and community engagement is upheld. The KKC leadership team, BRIDGE Advisory Board, KAYA, youth participants, and community partners work together to ensure that all activities meaningfully contribute to this vision. This ongoing alignment between practice and mission has created a strong foundation for the café as it nears its official launch.

Additionally, the non-hierarchical decision-making structure employed by the center has been effective in fostering collaboration and shared responsibility. Both youth participants and external partners appreciate being involved in key decisions, which has helped dismantle traditional adult-youth power dynamics and empowered participants to actively shape the café's direction. This approach has allowed the center to remain flexible and responsive to community needs, ensuring that its work remains relevant and impactful.

Moreover, KKC's success thus far has been driven by its strategic partnerships and a focus on operational improvements. Collaboration with community partners—including the BRIDGE Advisory Board, internship hosts, and workshop facilitators—has introduced a range of perspectives that have enriched the center's programming. Clear communication, regular check-ins, and structured coordination have cultivated a culture of mutual respect and engagement among all partners. Leadership's focus on streamlining operations, improving fiscal transparency, and addressing challenges by centering community interests has provided a strong foundation for future growth.

The involvement of youth in these efforts has been critical. Through internships and event participation, youth have gained valuable experience in leadership and program development, ensuring that KKC's mission remains responsive to community needs. Their collaboration with elder mentors has preserved cultural knowledge while introducing fresh perspectives that continually enrich the center's work. This multigenerational approach, along with the café's commitment to inclusivity, extends beyond the Filipino/a/x community, fostering cross-cultural engagement and reinforcing a sense of unity among diverse groups.

As the café moves closer to its opening, the lessons from this evaluation highlight the importance of maintaining these successful practices while addressing areas for growth. By continuing to build on its collaborative decision-making structure, refining feedback mechanisms, and staying aligned with its mission, Kapwa Café is well-positioned to evolve as a vital community resource for Filipino/a/x youth and beyond.

Future Directions

As KKC moves toward its 501(c)(3) status and prepares for its official opening, its future success will depend on how well it integrates the key lessons learned during its development. Central to its mission is the focus on cultural identity, offering Filipino/a/x youth a space to reconnect with their heritage. This cultural grounding is essential, not just as a symbolic gesture but as a necessary tool to help participants navigate complex issues like generational trauma and identity formation. By embedding cultural sensitivity into its future operations, the café ensures that its programs deeply resonate with the community it seeks to serve.

Equally important is KKC's focus on mental health, a core part of the café's mission. Recognizing the intrinsic connection between cultural identity and mental well-being, KKC plans to provide holistic care that addresses both. Early lessons from program design and partnerships emphasize that youth benefit most when their cultural pride and mental health are prioritized together. This approach fosters personal resilience and equips young participants with tools to face challenges that are often unspoken within their communities. By doing so, the café aligns its SDoH efforts with its broader cultural mission, creating a space where healing and empowerment occur simultaneously.

As the café prepares to launch, adaptability remains a critical factor. The leadership's willingness to incorporate feedback and refine its programs ensures that the café will remain responsive to the evolving needs of the community and the behavioral health landscape changes being introduced to legislation like Proposition 1. By forming strategic partnerships, fine-tuning operational plans, building infrastructure to respond to new behavioral health requirements, and ensuring continuous improvement, the café positions itself for long-term sustainability. Streamlining operations and securing diverse funding sources will help KKC navigate the complexities of opening and growing a nonprofit, while maintaining its commitment to cultural and community-centered programming.

Appendices

Appendix A. Evaluation Domains, Outcome Measures, and Data Sources

Evaluation Domain		Outputs and Outcome Measures	Data Sources
Leadership	*Evaluation Question #1:* To what extent are KKC leadership equipped and empowered to make decisions on behalf of the program?		
	Responsibility & Plan Enactment	• Ability to meet project deadlines • Accounting of delays in progress toward opening • Implementation successes & challenges	• Focus Groups • Program Documents • Background/Observation
	Evaluation Question #2: To what extent are KKC leadership skills and project management valued by the BRIDGE Advisory Board, KAYA members, and other interest holders?		
	Leadership Skills & Engagement	• Stakeholder satisfaction overall and with leadership • Clarity and transparency among interest holders • Diverse interest holders and support	• Focus Groups • Program Documents
	Evaluation Question #3: To what extent has leadership engaged in long-term sustainability planning and included stakeholder engagement in that planning?		
	Plan Sustaining	• Collaboration and communication (changes, successes, challenges) • Business plan updates to reflect ongoing communication and feedback	• Focus Groups • Program Documents
Service Delivery	*Evaluation Question #4:* How do youth participants experience the KKC workshops and internship program, and in what ways do these programs or activities impact their personal or professional development? Is the program targeting its intended population through its programming?		
	Youth Experience and Target Population	• Youth satisfaction • Youth perceived value of programming	• Youth Surveys • Focus Groups

Evaluation Domain		Outputs and Outcome Measures	Data Sources
		• Youth skill development • Youth voice within services • Youth demographics • Barriers to access and participation • Program improvement	• Program Documents
	Evaluation Question #5: How did partner organizations and youth conference workshop facilitators experience their collaboration with the KKC leadership team, and what was their experience like in participating in and contributing to the workshops and internship program? What impacts, if any, do these experiences have for future offerings?		
	Partner Experience and Collaboration	• Partner satisfaction and collaboration • Collaboration clarity • Effectiveness of communication • Partner contribution experience • Engagement and impact on youth • Partnership sustainability • Program improvement	• Focus Groups • Program Documents
Prioritization	*Evaluation Question #6:* To what extent can youth, KAYA, and interest holders discuss the purpose and mission of Kapwa Café? If so, do they feel as though the mission is being accomplished?		
	Attitude and Understanding	• Project awareness across interest holders and youth	• Focus Groups • Program Documents
	Evaluation Question #7: How has the program prioritized the mandate to create a culturally appropriate space for Filipino/a/x youth using a social enterprise model?		
	Mandate and Financial Support/Sustainability	• Space evaluation by interest holders and youth • Impact of funding sources and model of services	• Focus Groups • Program Documents

Appendix B. Workshop Survey Respondents' Experiences with Comfort and Support in KKC Spaces by Sex Assigned at Birth

What was your assigned sex at birth?	I was comfortable in the space the workshop was held in.		
	Agree	Neutral	Somewhat agree
Female			
Count	23	2	1
Percent	59%	67%	33%
Male			
Count	16	1	2
Percent	41%	33%	67%

What was your assigned sex at birth?	I would come back to Kapwa Kultural Center for support and/or connection.			
	Agree	Neutral	Somewhat agree	Somewhat disagree
Female				
Count	22	1	3	0
Percent	58%	100%	60%	0%
Male				
Count	16	0	2	1
Percent	42%	0%	40%	100%

What was your assigned sex at birth?	I would recommend Kapwa Kultural Center workshops and activities to someone I know.		
	Agree	Neutral	Somewhat agree
Female			
Count	25	0	1
Percent	63%	0%	33%
Male			
Count	15	2	2
Percent	37%	100%	67%

What was your assigned sex at birth?	I learned something that helped my emotional, mental, physical, or spiritual health.			
	Agree	Neutral	Somewhat agree	Somewhat disagree
Female				
Count	24	1	1	0

Percent	63%	100%	20%	0%
Male				
Count	14	0	4	1
Percent	37%	0%	80%	100%

Appendix C. Workshop Survey Respondents' Experiences with Staff and Partner Support by Sex Assigned at Birth

What was your assigned sex at birth?	I felt supported by Kapwa Kultural Center staff.	
	Agree	Neutral
Female		
Count	25	1
Percent	60%	33%
Male		
Count	17	2
Percent	40%	67%

What was your assigned sex at birth?	I felt supported by other organizations and their staff that helped with the activity or workshop.			
	Agree	Neutral	Somewhat Agree	Somewhat Disagree
Female				
Count	20	3	3	0
Percent	63%	75%	37%	0%
Male				
Count	12	1	5	1
Percent	37%	25%	63%	100%

Appendix D. Workshop Survey Respondents' Experiences with Culture and Community by Sex Assigned at Birth

What was your assigned sex at birth?	I felt connected to my culture.				
	Agree	Disagree	Does not apply	Neutral	Somewhat agree
Female					
Count	22	0	1	0	3
Percent	65%	0%	100%	0%	37%
Male					
Count	12	1	0	1	5

Percent	35%	100%	0%	100%	63%

What was your assigned sex at birth?	I felt connected to my community.		
	Agree	Disagree	Somewhat agree
Female			
Count	22	0	4
Percent	61%	0%	50%
Male			
Count	14	1	4
Percent	39%	100%	50%

What was your assigned sex at birth?	Kapwa Kultural Center workshops and activities were related to my cultural background and beliefs.			
	Agree	Disagree	Neutral	Somewhat agree
Female				
Count	22	0	2	2
Percent	61%	0%	50%	50%
Male				
Count	14	1	2	2
Percent	39%	100%	50%	50%

Appendix E. Workshop Survey Respondents' Experiences with KKC Support and Community Connections by Sex Assigned at Birth

What was your assigned sex at birth?	The workshops and activities offered met my needs.			
	Agree	Neutral	Somewhat agree	Somewhat disagree
Female				
Count	21	1	4	0
Percent	64%	33%	50%	0%
Male				
Count	12	2	4	1
Percent	36%	67%	50%	100%

What was your assigned sex at birth?	Kapwa Kultural Center staff connected me to other services in the community that have been helpful.			
	Agree	Neutral	Somewhat agree	Somewhat disagree

Female				
Count	18	4	4	0
Percent	62%	50%	57%	0%
Male				
Count	11	4	3	1
Percent	38%	50%	43%	100%

What was your assigned sex at birth?	If I have a need for services in the future, I feel comfortable reaching out to Kapwa Kultural Center staff.		
	Agree	Neutral	Somewhat agree
Female			
Count	22	3	1
Percent	58%	75%	33%
Male			
Count	16	1	2
Percent	42%	25%	67%

Appendix F. Workshop Survey Respondents' Experiences with KKC Workshop and Service Accessibility and Relevance by Sex Assigned at Birth

What was your assigned sex at birth?	Kapwa Kultural Center workshops and activities were offered at a time when I could make it.			
	Agree	Does not apply	Neutral	Somewhat agree
Female				
Count	21	2	1	2
Percent	62%	100%	25%	40%
Male				
Count	13	0	3	3
Percent	38%	0%	75%	60%

What was your assigned sex at birth?	Kapwa Kultural Center workshops and services are held at places I can easily get to.			
	Agree	Neutral	Somewhat agree	Somewhat disagree
Female				
Count	19	4	3	0
Percent	61.29	66.67	42.86	0.00
Male				
Count	12	2	4	1

Percent	38.71	33.33	57.14	100.00

What was your assigned sex at birth?	Kapwa Kultural Center workshops and activities were offered in my preferred language.				
	Agree	Does not apply	Neutral	Somewhat agree	Somewhat disagree
Female					
Count	24	0	1	1	0
Percent	65%	0%	33%	33%	0%
Male					
Count	13	1	2	2	1
Percent	35%	100%	67%	67%	100%

What was your assigned sex at birth?	I learned something that is useful to me.				
	Agree	Does not apply	Neutral	Somewhat agree	Somewhat disagree
Female					
Count	22	0	3	0	1
Percent	61%	0%	60%	0%	100%
Male					
Count	14	1	2	2	0
Percent	39%	100%	40%	100%	0%

Appendix G. Workshop Survey Respondents' Overall Satisfaction with KKC Workshops and Activities by Sex Assigned at Birth

What was your assigned sex at birth?	Overall, how happy are you with the workshops and/or activities you attended?			
	A little Happy	A little unhappy	Neutral	Really Happy
Female				
Count	3	0	2	21
Percent	43%	0%	67%	62%
Male				
Count	4	1	1	13
Percent	57%	100%	33%	38%

Appendix H. Demographic Characteristics of Workshop Survey Respondents

Category	Percent
Age (Years)	
<16	*
16-24	89%
25+	*
Preferred Language	
English	78%
Tagalog	16%
Cantonese	*
Ilocano	*
Race[42]	
Asian/Asian American	93%
Black or African American	*
Native Hawaiian or Pacific Islander	*
Another Race[43]	*
Prefer not to answer	*
Ethnicity[44]	
Filipino/a/x	91%
Another Ethnicity or Tribe[45]	*
Prefer not to answer	*
Sex Assigned at Birth	
Female	58%
Male	42%
Intersex Identification	

[42] This demographic category reflects more than 100% since respondents were able to select more than one race they identified with.
[43] Another Race includes Latino/a/x and/or Hispanic; Native American, American Indian, or Indigenous; and White or Caucasian.
[44] This demographic category reflects more than 100% since respondents were able to select more than one ethnicity they identified with.
[45] Another Ethnicity or Tribe includes Mexican/Chicano/a/x; Japanese; Chinese.

Category	Percent
No	83%
I am not sure	*
Yes	*
Prefer not to answer	*
Current Gender Identity	
Cisgender Man/Man	42%
Cisgender Woman/Woman	38%
Genderqueer/Gender Non-Conforming/Neither Exclusively Male nor Female	*
None of the above	*
Trans Man / Transgender Male / Trans-masculine / Female-to-Male (FTM) / Man	*
Another Gender Identity[46]	*
Prefer not to answer	*
Sexual Orientation	
Bisexual	31%
Heterosexual or Straight	27%
Prefer not to answer	*
Gay or Lesbian	*
Pansexual	*
Asexual	*
Questioning/Unsure	*
None of the above	*
Queer	*
Disability Status[47]	
No disability	82%
Difficulty seeing	*
Not sure	*
Another type of disability[48]	*
Mental disability	*
Difficulty hearing or having speech understood	*
Prefer not to answer	*

[46] Another Gender Identity includes Questioning or Unsure of Identity and Gender Fluid.
[47] This demographic category reflects more than 100% since respondents were able to select more than one ethnicity they identified with.
[48] Another type includes learning disability and special needs.

Category	Percent
City of Residence	
Daly City	36%
San Francisco	27%
Lathrop	*
Brisbane	*
Colma	*
Millbrae	*
Redwood City	*
San Bruno	*
San Carlos	*
San Mateo	*
Veteran Status	
No	96%
Prefer not to answer	*
Yes	*

APPENDIX 10. ADULT RESIDENTIAL IN-HOME SUPPORT ELEMENT (ARISE) INN EVALUATION REPORT, FY 2023–24

San Mateo County Behavioral Health and Recovery Services FY 2023–24 ARISE Program: Year 1 Annual Evaluation Report

Brooke Shearon, MPP; Danielle Agraviador, MPH; Laina Serrer, MS; Koray Caglayan, PhD; Tania Dutta, MPP, PMP

December 2024

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Introduction

A lack of proper housing can have negative effects on an individual's mental health. California's In-Home Supportive Services (IHSS) program provides in-home assistance to eligible aged, blind, and disabled individuals, enabling them to remain safely in their own homes. However, individuals living with mental illness, especially those who have not received a mental health evaluation, are often denied services through IHSS. The Adult Residential In-home Support Element (ARISE) program is a new approach to solving these issues and has been approved by the County of San Mateo for Mental Health Services Act (MHSA) Innovation (INN) funding. ARISE provides residential in-home services for individuals living with serious mental illness (SMI) and/or substance use disorders (SUD) who are not approved for IHSS. Without additional support, these individuals can lose their housing due to difficulty managing their living environments. ARISE helps these individuals keep their housing, as they are unable to gain home assistance through IHSS. The ARISE program is implemented and managed by the Mental Health Association of San Mateo County through a grant from San Mateo County (SMC) Behavioral Health and Recovery Services (BHRS).

The pilot of this new program began in August 2023. SMC BHRS contracted the American Institutes for Research® (AIR®) to conduct a multiyear evaluation of the ARISE program, concluding in 2026. The purpose of this evaluation is to (a) report on ARISE program learning goal outcomes, (b) support program improvements or adjustments as needed, and (c) satisfy MHSA INN regulatory requirements. This report summarizes evaluation results for the first year of the program.

Learning Goals

The program's learning goals are as follows:

1. Do clients receiving in-home supports tailored for individuals with behavioral health needs **maintain their housing**?
2. To what extent does the ARISE program support clients' **health, well-being, and recovery**?
3. To what extent does the ARISE program **improve capacity** for in-home support to serve individuals with complex behavioral health challenges?

Exhibit 1 presents the objectives, discussion topics, and data sources for the quantitative evaluation. Exhibit 2 presents the same for the qualitative evaluation.

Exhibit 1. Learning Goals, Outcomes, and Data Sources for the Quantitative Evaluation

Learning Goal (As described by program staff)	Identified Measures and Outcomes	Data Source(s) to Calculate Measure	File(s) Containing Data Source(s)
Maintain Housing	• **Failed a housing inspection.** Of the clients enrolled and served for at least one month, no more than 5% will fail a housing inspection. This target was determined by program staff, and housing data will be compared to the target at the end of each fiscal year.	• Date of Enrollment • Date of Inspection • Result of the Inspection	• ARISE Demo_Services *(Actual Hours Worked 2023)* • ARISE Client Services (*Housing Status)*
	• **Complaints or lease violations.** Of the clients enrolled and served for at least one month, no more than 10% will receive complaints or lease violations for reasons of health and safety issues related to the state of their unit.	• Date of Enrollment • Date of Complaint • Date of Lease Violation	• ARISE Demo_Services *(Actual Hours Worked 2023)* • ARISE Client Services (*Housing Status)*

	• **Asked to leave their current housing.** Of the clients enrolled and served for at least one month, none will be asked to leave their current housing situation as a result of health and safety issues related to the state of their unit.	• Date of Enrollment • Result of Event (failure, complaint, or violation) • Housing Event 2 (if there was a reinspection) • Date of Housing Event 2 • Housing Event 2 Result (reinspection result)	• ARISE Demo_Services *(Actual Hours Worked 2023)* • ARISE Client Services (*Housing Status)*
Health, Wellbeing, and Recovery	• **Engagement.** Percent of clients engaged in BHRS services at baseline and follow-up.	• Number of clients engaged in BHRS services at baseline • Number of clients engaged in BHRS services at follow-up.	• ARISE Client Services (*OT Services)*
Improve Capacity	• **Provider availability.** Number of available IHSS workers in the County at baseline and follow-up who are willing to provide in-home support for individuals with challenging behaviors.	• Number of available IHSS workers in the county as baseline who are willing to provide in-home support for individuals with challenging behaviors (which is inherently part of being an ARISE provider) • Number of available IHSS workers in the county at follow-up who are willing to provide in-home support for individuals with challenging behaviors	• ARISE Providers *(Columns B and H)*

Exhibit 2. Objectives, Discussion Topics, and Data Sources for the Qualitative Evaluation

Learning Goal (As described by program staff)	Program Evaluation Objective	Discussion Topics	Data Source(s)
Maintain Housing	Assess whether clients receiving in-home supports tailored for individuals with behavioral health needs maintain their housing	• Evaluate client perceptions of how the ARISE program is helping them maintain their living environment • Assess ARISE in-home support workers' perceptions of how the program is helping clients maintain their living environment	Client and in-home support worker interviews

Learning Goal (As described by program staff)	Program Evaluation Objective	Discussion Topics	Data Source(s)
Health, Wellbeing, and Recovery	Assess the extent to which the ARISE program supports clients' health, well-being, and recovery	• Assess the extent to which the ARISE program supports clients' health, well-being, and recovery • Assess client satisfaction with the ARISE program • Assess how the ARISE program improves quality of life for the clients it serves • Evaluate client and in-home support worker experiences with the referral process to BHRS • Evaluate client experiences with services offered by BHRS	Client and in-home support worker interviews
Improve Capacity	Evaluate the extent to which the ARISE program improves capacity for in-home support workers to serve individuals with complex behavioral health challenges, and how these outcomes could inform changes to the state IHSS program	• Evaluate how effective MHA's strategies (increasing worker pay, guaranteed hours, and specialized training) are in improving capacity for in-home supports for individuals with complex behavioral health challenges • Assess the satisfaction of ARISE in-home support workers with the program	Client and in-home support worker interviews

Methods

To comprehensively evaluate the identified learning goals and the program's impact, AIR performed a mixed-methods evaluation. The following section outlines the evaluation methods, including the measures, data sources, and analytical processes utilized in the assessment.

Data Collection

The following sub-section details the quantitative and qualitative data collection methods that AIR used to prepare for and gather the necessary data in FY 2023-2024.

Quantitative

Based on the learning goals and program objectives, AIR collaborated with program staff at the start of FY 2023-2024 to develop an evaluation plan and to design data collection processes to best capture the measures needed to evaluate the learning goals during FY 2023-2024. The data collection process began with program staff sending AIR the baseline data for the fiscal year by November 2023 (to include all enrollments through July to November 2023). Program staff then tracked the data throughout the fiscal year using the methods and files described in Exhibit 1 and provided AIR with one file at the end of the fiscal year in June 2024. The file contained four tabs tracking the necessary information per Exhibit 1 to analyze the three learning goals: "LG1 – Maintain Housing", "LG2 – Health, Wellbeing, and Recovery", "LG2 – Charts", and "LG3 – Improve Capacity".

Although AIR included clients who joined the program in June 2024 in the fiscal year client list, their outcomes will not be reported until the next fiscal year, as the measures required that clients are enrolled and received services for at least one month. This report therefore specifies the number of clients served from July 2023 to June 2024, but the outcomes for clients who joined in June 2024 are not included in the learning goal analyses.

Qualitative

Based on the learning goals, objectives, and discussion topics, AIR developed tailored interview guides for clients, in-home support workers, and program staff. The guides were reviewed by staff from MHA and SMC BHRS. AIR's Institutional Review Board (IRB) reviewed the interview guides and information sheets and considered the proposed evaluation to be exempt from a full review. Some in-home support workers were bilingual and preferred to conduct the interview in Spanish. For this reason, the interview guide and information sheet for the in-home support worker interviews were translated into Spanish.

AIR worked with Mental Health Association staff to recruit clients and in-home support workers. We also interviewed program staff to understand their experiences with the program.

Each interview lasted about 45 minutes and was conducted on the phone. The interviewer obtained consent and permission from all participants before starting the recording.

Analysis

The following sub-section details the quantitative and qualitative analysis processes that AIR used to examine and interpret the data.

Quantitative

To determine program impact, AIR conducted analyses on the three identified learning goals: (1) Maintain Housing; (2) Health, Wellbeing, and Recovery; and (3) Improve Capacity. See

Exhibit 1 for objectives and measures for each goal. All data analysis processes and calculations for the quantitative learning goals were performed in Excel. The specific methodologies for each learning goal are discussed next.

Maintain Housing

For this learning goal, AIR compared measures to pre-determined program targets, which were determined by program staff. See Exhibit 1 for the measures for this goal. To calculate the number of clients that **failed a housing inspection**, AIR calculated the number of individual clients with failed inspections based on the "LG1-Maintain Housing" tab from program staff. If a client had more than one failed inspection, their additional incidents were not re-counted. We then calculated the proportion of clients by dividing the number of clients with a failed housing inspection by the total number of clients served in the program over the fiscal year. We then compared the proportion of clients to the program target to determine whether the program target was met.

To calculate the number of clients with **complaints or lease violations**, AIR calculated the number of individual clients with reported complaints or lease violations based on the "LG1-Maintain Housing" tab from program staff. If a client had more than one complaint or lease violation, their additional incidents were not re-counted. We then calculated the proportion of clients by dividing the number of clients with a complaint or lease violation by the total number of clients served in the fiscal year. We then compared the proportion of clients with the program target to determine whether the program target was met.

To calculate the number of clients who have been **asked to leave their current housing**, AIR calculated the number of individual clients who were asked to leave their current housing based on the "LG1-Maintain Housing" tab from program staff. If a client had more than one complaint or lease violation, their additional incidents were not re-counted. We then calculated the proportion of clients by dividing the number of clients who were asked to leave their current housing by the total number of clients served in the program duration of interest, or the fiscal year. We then compared the proportion of clients with the program target to determine whether the program target was met.

Health, Wellbeing, and Recovery

AIR calculated the percent change in the number of **clients engaged in services** between the start and end of the evaluation period. See Exhibit 1 for the measures to this goal. To calculate this measure, AIR identified the number of clients engaged in BHRS services at evaluation baseline and at one year evaluation follow-up, or at the end of June of the fiscal year. Engagement was identified by whether there is a value of "Y" (or "1") for the "BHRS Member Y/N" field (for baseline) and values of "Y" (or "1") in the "Referred" (for follow-up) in the "LG2-Health, Wellbeing, and Recovery" tab of the data obtained from program staff. This highlighted

the number of clients that were engaged at baseline and the number engaged at evaluation follow-up, respectively. The binary "1" and "0" refers to whether there was engagement in any BHRS service.

Improve Capacity

To calculate this measure, AIR identified the number of available IHSS workers at baseline and at follow-up. See Exhibit 1 for the measures for this goal. The number of available workers at follow-up were determined by the number of workers who were available for at least for one month between the baseline and the follow-up. We then calculated the percent change between these two values.

Qualitative

All interviews were recorded and transcribed. Three analysts used a deductive method to code the transcripts based on objectives and discussion topics in Exhibit 1. We then conducted a thematic analysis of the concepts discussed by clients, in-home support workers, and program staff.

ARISE Client and In-Home Support Worker Findings

This section presents findings by learning goal from the quantitative and qualitative analyses. The quantitative findings are based on information from the 22 clients who were admitted and actively part of the ARISE INN program during fiscal year (FY) 2023-2024. The qualitative findings are based on interviews conducted with nine clients and five in-home support workers.

Maintain Housing

The following sub-section details the quantitative and qualitative results related to the "Maintain Housing" learning goal, which aims to evaluate whether clients receiving in-home supports tailored for individuals with behavioral health needs maintain their housing. See the full goals and objectives for the "Maintain Housing" learning goal in Exhibits 1 and 2. The program met 66.7% (two out of three) of its target quantitative goals. One client was asked to leave their current housing (4.5% of clients), so the program did not meet its target goal of 0% of clients being asked to leave their current housing. Qualitatively, clients were satisfied with the program and saw a significant improvement in their living environment after enrollment. In-home support workers provided tailored support to their clients through a variety of services and reported cleaner and less cluttered client living environments as a result of receiving ARISE services.

Quantitative

In this section, we analyze the program's support for maintaining client housing.

Exhibit 3 summarizes the housing information of the 22 clients who were admitted and actively part of the ARISE INN program during FY 2023-2024. The program met its target goal of having no more than 5% of clients failing a housing inspection, as no clients failed a housing inspection. The program met its target goals of no more than 10% of clients receiving complaints or lease violations, with only one client (4.5%) receiving this kind of violation. However, the program did not meet its target goal of 0% of clients being asked to leave their current housing, as one client (4.5%) was evicted.

Exhibit 3. Quantitative Evaluation Metrics for Housing

Measure	Number of Clients	Proportion of Clients	Program Target	Target Met (Yes or No)?
Failing a Housing Inspection	0	0%	< 5%	Yes
Complaints or Lease Violations	1*	4.5%	< 10%	Yes
Asked to leave current housing	1**	4.5%	0%	No

*Infractions referred to in Notice to Cease occurred prior to ARISE beginning.

** Clients' case was already in a critical condition before connecting with ARISE services. ARISE staff connected the client with Legal Aid, but the client ultimately settled with property management. The client moved out of the unit and into a Skilled Nursing Facility.

Qualitative

In this section, we discuss how clients' housing has changed since enrollment in the program. Exhibit 4 summarizes clients' and in-home support workers' perspectives on improvements in clients' living situations since enrollment in the program. We first discuss findings from client interviews, followed by findings from interviews with in-home support workers.

Exhibit 4. Changes in Clients' Housing Since Enrolling in the ARISE Program

Client Perspectives	In-Home Support Workers' Perspectives
Clients found it difficult to maintain a clean living environment before enrolling in the program. Clients saw a significant improvement in their living environment after enrolling in the program.	In-home support workers provide support to clients by cleaning the housing, cooking, doing laundry, and going out to run small errands such as buying groceries.
Clients acknowledged that enrollment in the program minimized their chances of getting being evicted.	In-home support workers tailor their services to meet each client's specific needs.

Most clients indicated that they were satisfied with the services that are currently being provided and did not need additional support.	In-home support workers shared stories of about how their clients' living environments have had become cleaner and less cluttered because of receiving ARISE services.

Clients' Perspectives on Changes in Their Housing After Enrollment in the ARISE Program

Clients found it difficult to maintain a clean-living environment before enrolling in the program. A client explained, "Well, my apartment was actually very dangerously messy. And because of a few outside influences, like COVID and stuff, I kind of went into a funk. It took a lot to get me out." ***Clients saw a significant improvement in their living environment after enrolling in the program.*** Each client was assigned an in-home support worker, who would come in once a week for 3–4 hours to clean their house and help with other chores. A client described this support as follows: *"Well, they had a person come to help me to clean the mess up. I mean, it was a big mess. It was affecting my well-being and they told me they could do anything I wanted them to do. I just really... I needed my house cleaned up. I was not comfortable being in my house anymore."* In-home support workers vacuumed clients' houses, cleaned the kitchen and bathrooms, helped clients with their laundry, and in some cases cooked for the clients. In time, the clients' living environment improved significantly. For example, one client said, *"The house got cleaner. The stuff got more put in place and I mean it helped me mentally and everything because things were more organized and smoother functioning."*

Clients acknowledged that enrolling in the program minimized their chances of getting evicted. One client reported, "*right now I'm not in any danger of losing my housing or anything."*

Most clients indicated that they were satisfied with the services that are currently being provided and did not need additional support. When asked about the need for additional services to maintain housing, one client requested help organizing their closet.

In-Home Support Workers' Perspectives on How Clients' Housing Has Changed Since Enrollment in the Program

***In-home support workers described several ways in which they provide support to clients to maintain their living environment*.** This includes cleaning the living environment, cooking, doing laundry, and going out to run small errands such as buying groceries. One in-home support worker said, *"Mostly just trying to keep them in their boundaries, for some reason they tend to collect stuff. They tend to, you know what I mean? Stuff like that. Trying to keep them, just bring it to their attention and helping them not clutter up their place and stuff like that. That's the most challenging."*

In-home support workers tailor their services to meet each client's specific needs. For example, one in-home support worker mentioned that they have a client who accumulates library books, and they will help return library books for them. Another in-home support worker talked about how a client's level of involvement will vary based on their physical abilities. They said, *"Because everyone's at a different level, I have a client who's elderly and so he's physically unable to do a lot, so I do a lot more for him, whereas other clients, they are able to help. So it's more of a team effort."*

In-home support workers shared stories about how their clients' living environments have become cleaner and less cluttered as a result of receiving ARISE services. For example, one in-home support worker said, *"A lot of great changes like reduction in clutter, not per se, like hoarding situations, but just a little bit too much stuff and helping people clear out stuff. And also helping people who previously had pets, so just getting that under control. So it's like certain things that were previously overwhelming them. Say it might be something like just built-up laundry or there's bags and bags and closets full or a room full of laundry and we've been able to get that down to where's manageable for them."*

Health, Well-Being, and Recovery

The following sub-section details the quantitative and qualitative results related to the "Health, Well-Being, and Recovery" learning goal that aims to assess the extent to which the ARISE program supports clients' health, well-being, and recovery. See the full goals and objectives for the "Health, Well-Being, and Recovery" learning goal in Exhibits 1 and 2. Although the evaluation of this goal used both quantitative and qualitative methods, the quantitative analysis focused on change in client engagement with other BHRS programs facilitated through ARISE program's referrals, which would eventually affect longer term health outcomes. The in-depth interviews conducted with clients, and in-home support workers provide insights into how the program supports clients' health, well-being and recovery.

Findings from the interviews show how clients reported a variety of positive impacts since joining the program, including improved mental and physical health, engagement in hobbies, and social lives. In-home support workers acknowledged that the ARISE program supports clients' health needs by alleviating the stress that comes from maintaining their living environment and that clients are experiencing positive changes in their lives. Clients also reported generally positive experiences with the non-housing services offered by the ARISE program, including occupational therapy assessments, health check-ups, and transportation assistance. While most clients did not require engagement with external support services such as Alcoholics Anonymous, they expressed interest in trauma-informed care following personal losses. This was supported by the quantitative findings that show that only 54.5% of clients engaged in the referred services. Many clients also highlighted that to improve their wellbeing,

it may be helpful to get additional support such as transportation for non-medical needs. Interviews did not have any findings related to changes in recovery.

At one year follow-up, our findings show that 90.9% of clients were referred to BHRS services (a decrease of 9.1% from baseline). However, only 54.5% were engaged in BHRS services at follow-up (a decrease of 45.5% from baseline). The clients who used these services, reported having positive experiences with medical services provided by San Mateo County and referrals from their case managers to other services provided by the County. In-home support workers said they were not involved in referring clients to county services.

Quantitative

In this section, we analyze the program's support for the health, wellbeing, and recovery of clients' engagement in and referrals to BHRS services at baseline and follow-up. Possible examples of services include Alcoholics Anonymous (AA) and the Friendship Center.
Exhibit 5 summarizes the engagement information of the 22 clients who were admitted and actively part of the ARISE INN program during fiscal year (FY) 2023-2024. Referrals indicate ARISE INN's ability to engage with other well-being and recovery services that will ultimately result in changes to client health. To determine engagement through referrals, program staff monitor clients' interactions with SMC BHRS through their electronic health record system, Avatar. Avatar records the date a client contacts the ACCESS Line[1], the entry point for individuals seeking BHRS services. This allows the program to track whether clients referred by our ARISE program subsequently engage with BHRS services by initiating contact with the ACCESS Line. This data helps assess the ARISE program's effectiveness in connecting clients with necessary support.

- Number of Clients **Referred to** BHRS Services: At baseline, all 12 clients were referred to BHRS services (100% of clients at baseline). At follow-up, 20 of the 22 total clients were referred to BHRS services (90.9% of clients at follow-up).
- Number of Clients **Engaged in** BHRS Services: At baseline, all 12 clients were engaged in BHRS services (100% of clients at baseline). At follow-up, 12 of the 22 total clients were engaged in BHRS services (54.5% of clients at follow-up).[2]

Exhibit 5. Changes in Clients' Health, Well-Being, and Recovery Since Enrollment in or Referral to the Program

Measure	Baseline n(%)	Follow-Up n(%)	Change (%)

[1] ACCESS Call Center - San Mateo County Health
[2] Note that program staff does not have control over whether a client engages in the program/service after ARISE's referral.

	Total Clients Served=12	*Total Clients Served=22*	
Number and Proportion of Clients **Referred to** BHRS Services	12 (100%)	20 (90.9%)	-9.1%
Number and Proportion of Clients **Engaged in** BHRS Services	12 (100%)	12 (54.5%)	-45.5%

Qualitative

In this section, we discuss how clients' health, well-being, and recovery from SMI and/or SUD has changed since enrollment in the program. Exhibit 6 summarizes findings from client and in-home support worker interviews. We first discuss findings from client interviews, followed by findings from in-home support worker interviews.

Exhibit 6. Changes in Clients' Health, Well-Being, and Recovery Since Enrollment in the Program

Client perspectives	In-home support workers perspectives
Clients mentioned that since joining the program, they have seen an improvement in their mental and physical health and are proactively taking care of their health.	In-home support workers had a difficult time identifying what they thought were the greatest needs of their clients, noting that all their clients had different needs.
Clients mentioned that in-home support workers and case managers have been checking on their health and helping them in the recovery process.	In-home support workers recognized that the ARISE program supports clients' health needs by alleviating the stress that comes from maintaining their living environment.
Clients mentioned that they have engaged in more hobbies since enrolling in the ARISE program. Some of these hobbies require transportation and clients mentioned that they would benefit from transportation assistance to pursue these hobbies.	In-home support workers reported that they do not formally assess clients' progress toward achieving health and recovery goals. However, some in-home support workers said they recognize when clients are experiencing positive changes in their lives by comparing the first time they visited to clean their homes to the visits that followed.
Clients mentioned that their social lives have improved since joining the program.	N/A

Clients' Perspectives on Changes in Their Health, Well-Being, and Recovery After Enrollment in the ARISE Program

Clients mentioned that since joining the program, they had seen an improvement in their mental and physical health. A client explained, "*Well, because the quality of my apartment was kind of making me sick, my health has gotten a* lot *better, and the worker has been also helping me with my diet a little bit. So I've had a lot more strength, and they've been trying to keep me a lot more positive.*" Another client said, "*Yeah, that's improved my mental health because it*

doesn't feel the same to live in a dirty room. Every time I have an inspection, I don't have to worry about cleaning up a year's worth of mess. People are jealous in my community … as I have the cleanest room in the whole apartment complex."

Clients also shared how they are proactively taking care of their health. Clients are having regular check-ups with their nurse or physician and therapist, taking their medications on time, feeling less depressed, and engaging in more social activities. A client said, "*Well, I'm definitely more up on taking care of things around ... Taking care of things that need to be done. I mean, I'd pretty much given up and now I'm pretty much thinking ahead. I'm trying to take care of myself as I should have been doing."*

Clients mentioned that in-home support workers and case managers have been checking on their health and helping them reach their health goals. One client mentioned that when they were hospitalized, the case manager checked on them frequently and offered to help with anything that required assistance. In-home support workers and case managers helped clients improve their health outcomes. A client said, "*I got really sick and I have basically lost all the muscle in my body. I lost tremendous amount of weight. I look sickly. Even looking at myself in the mirror, I look like I was dying. You can see my whole bone structure. And so, they gave me physical therapy. And so, they just work with me on how to do the exercises I need. And they got me on a strict protein diet. And so, I've noticed the improvement."*

Clients mentioned that they have engaged in more hobbies since enrolling in the ARISE program. Support from their in-home support workers in maintaining their living environment has given clients an opportunity to engage in other activities of interest. Activities discussed by clients include walking, cooking meals for friends, flower arranging, building computers, writing, and knitting. A client said, *"I build computers. I go and gather old computers from recycling places, and I take them and then we go and make new ones. And work on TVs and things like this. It gives me more time to do that, and it makes it where mentally I'm better off because I have the time to focus."*

Clients discussed that they may need travel assistance to pursue their interests or may need to be accompanied by their in-home support worker. Some clients mentioned that their hobbies require transportation and without a car they are unable to pursue their interests. A client said, "*All my hobbies in this county, they require a car. I can't go to the beach, I can't go hiking, I can't walk around a park. I can't fish, I can't crab, I can't go on a long walk. Everything requires a car.*" Clients suggested that they would benefit from accessing transportation assistance through the ARISE program to pursue their hobbies, which may help improve their mental health. Other clients mentioned that, due to their physical health, it is difficult for them to pursue any hobbies, and it would be helpful if in-home support workers were able to

accompany them. A client said, "*Because I never get out. The only time I get out of the house is when I'm going to appointments. And so, the lady that's my case worker right now, … she had told me that she would start doing outings with me just to get me out of the house and see something different, do something different."*

Clients mentioned that their social lives had improved since joining the program. Clients mentioned that they enjoy welcoming their friends into their homes, going out to visit friends, and in some cases preparing meals for guests in their homes. A client said, "*I am kind of a hermit. So I don't really go out and do much. However, she [in-home support worker] has been trying to influence me to go out and exercise more and has been getting me to exercise a little more. And because of all the improvements, I finally got the courage to actually go out and visit a friend."*

In-Home Support Workers' Perspectives on Changes in Clients' Health, Well-Being, and Recovery After Enrollment in the ARISE Program

When asked what they saw as the greatest health needs of clients, some in-home support workers had trouble identifying the greatest need, noting that all their clients had different needs. Two in-home support workers said that although they observed some of their clients' health needs during their visits, such as physical or mental health challenges, they are not told what their clients' health needs are by program staff or clients. They were therefore unable to identify the greatest health needs of their clients.

While some in-home support workers were unable to identify the greatest health needs of their clients, they recognized that the ARISE program supports clients' health needs by alleviating the stress that comes from maintaining their living environment. One in-home support worker said, *"I think ARISE supports these* people *by helping them get help from someone else with their chores. I feel that's what this program wants, to help these people so they can stand up a bit. I feel the program is helping these people so that with time they can get used to living a different life, to live in a clean environment, to be able to do their things. That's what I feel is the purpose of this program, to lift them up and let them keep walking on their own. That's what I've seen is the focus of this program."*

In-home support workers reported that they do not formally assess clients' progress toward achieving health and recovery goals, but some in-home support workers said they recognize when their clients are experiencing positive changes in their lives by comparing the first time they visited to clean their homes to the visits that followed. When asked to describe the ways in which the ARISE program has affected clients' quality of life, in-home support workers noted that in addition to improving their living environments, clients appear to be more motivated to maintain a clean living environment. One in-home support worker said, *"They are improving*

more and with the help we give them. They are doing their part so that the help continues to come to them and I tell them to collaborate, to help, to change their way of living and everything will be better for them. They understand." When asked how the program has helped clients better participate in social activities, one in-home support worker said, *"I have a client who I would always go over and he'd always be in bed and just telling me he's tired or feeling weak or just not... I guess like restless. And then I would just come over and just naturally my presence, he would hop up out of bed and come sit on the couch and talk to me. And I think it just lifts people's spirit just a little bit just to know that somebody's coming over on a weekly basis that kind of understands what they're going through."*

Experiences With Services Offered by the County of San Mateo

Exhibit 7 summarizes the perspectives of clients and in-home support staff on services offered by the County of San Mateo.

Exhibit 7. Experiences With Services Offered by the County of San Mateo

Topic	Client findings	In-home support workers findings
Experiences with services offered by the County of San Mateo	Overall, clients had an overall positive experience with medical services provided by the County of San Mateo. Clients also had a positive experience with referrals to other services provided by the county.	Most in-home support workers were unable to speak to how their clients were referred to behavioral health services offered by the county.

Overall, clients had a positive experience with medical services provided by the County of San Mateo. Some clients are seeking mental health therapy at county clinics and have had good experiences with nurses and therapists. Clients mentioned that clinicians at county clinics engage them in a shared decision-making process to identify and monitor their goals. A client said, *"My therapist is on top of things really quick. When I'm going through a dark place in my mental stability, she helps even me out as far as trying to get me into a better mental state of mind."*

Clients also had a positive experience with referrals to other services provided by the county. Clients mentioned that their case managers from the county connect them to services that they need. These include food stamps, Medi-Cal, Meals on Wheels, and Medical Uber for medical appointments and picking up prescriptions. Clients also get a housing voucher through the county that helps subsidize their housing costs. One client explained, "*The apartment that I live in is more than $2,500 a month, and I only have to pay like 650 bucks a month, which is pretty decent."*

Most in-home support workers were unable to speak to how their clients are referred to behavioral health services offered by the county. Their understanding is that referrals and

connections to county services are managed by program managers. One in-home support worker was able to speak to some services their clients have been receiving, but they said they do not typically discuss their clients' experiences with those services. They said, *"I have a couple clients that I know that they go to the county to see a therapist, and that's a crucial part of their, I guess, maintaining their well-being. I haven't really talked to any clients after they come back from these visits. Yeah, that's not really something that we typically discuss. I haven't heard any good or bad about that."*

Clients' Experiences With Non-Housing Services Provided by the ARISE Program

In addition to helping clients maintain a clean living space, the ARISE program provides regular well-being checks, transportation services, access to peer support members to accompany clients to community and recovery events, occupational therapy (OT) assessments, and tailored service plans with OT goals. As needed, the program also refers clients to organizations like Narcotics Anonymous, Alcoholics Anonymous, the Friendship Center, and other AOD services. None of the clients interviewed needed referrals to these organizations.

Clients had good experiences with other ARISE services, such as assessments by an occupational therapist. Clients were also getting regular health check-ups from their medical team from the county. Many clients were not using these services as they were being seen by physicians in other hospitals or health systems (e.g., Kaiser Permanente, Stanford). None of the clients interviewed received services from organizations like Alcoholics Anonymous, Narcotics Anonymous, or the Friendship Center. Although clients were aware of these organizations, they did not need these services. Some clients indicated that after personal incidents (death of a friend or family member), they would like to receive trauma-informed care at organizations like the Friendship Center.

Since most activities in the county are car-dependent, clients said that they would appreciate the ARISE program providing transportation assistance for non-medical appointments such as grocery shopping, visiting friends and family, and pursuing hobbies that require a car. A client mentioned, *"It's a real chore to do anything that's extracurricular. Because if it doesn't fall to getting my medicine, I really don't get the opportunity because the transportation is the real difficult part. Because the Medical Uber only does for pharmacies and medical so it's not within that scope. I don't just participate because I don't have the means to get out and about."*

Clients' Experiences With ARISE In-Home Support Workers

Exhibit 8 summarizes client experiences with ARISE in-home support workers.

Exhibit 8. Clients' Experiences With ARISE In-Home Support Workers

- Clients had positive experiences with in-home support workers but in some cases requested more privacy.
- Clients discussed their appreciation for being able to talk to in-home support workers.
- Clients also appreciated help with other services from in-home support workers, like cooking.

Clients had positive experiences with in-home support workers but in some cases requested more privacy. A client mentioned, "*they've been helping me a lot. They have a lot of patience and have been very nice. And when it comes to doing the work and stuff, they are intensely skilled, and they've been teaching me a lot of little tricks."* Although overall, clients were receiving exceptional services from in-home support workers, in some cases they felt they were intruding into their privacy. Clients suggested that in-home support workers could provide them with notice in advance before entering specific areas in their house.

Clients discussed their appreciation for being able to talk to the in-home support workers. These interactions helped clients feel valued and less lonely. A client said, *"I get along with her great … We've got it set up, she comes once a week and she spends four hours and my dog likes her. I mean, she's been very helpful. She listens to me and she'll let me talk, if I need to."* Another client said, *"well, [in-home support worker name] is like my friend. Aside from being a good housekeeper, she's a good person. I know about her family. She talks about her kids. She's really nice, to be around. She's very welcome in my house."*

Clients also appreciated help with other tasks from in-home support workers, like cooking. A client with physical disabilities discussed how their in-home support worker cooked meals for them that would last a few days and opened soup cans that they could use during the week. Although many clients are not using help from the in-home support workers for meal preparation or cooking, they appreciate that it will be helpful if provided as an option if needed.

Experiences With ARISE Program Staff

Exhibit 9 describes the experiences of clients and in-home support workers with ARISE program staff.

Exhibit 9. Clients' and In-Home Support Workers' Experiences With ARISE Program Staff

Topic	Client findings	In-home support workers findings
In-home support workers' experiences with ARISE program staff	Clients had positive experiences with program staff and indicated that case managers checked in with them regularly.	In-home support workers reported a positive experience with ARISE program staff overall. They said program staff were likable, responsive, open to suggestions, and provided them with supplies as needed.

Clients had positive experiences with program staff and indicated that case managers checked in with them regularly. A client mentioned, "*When I got sick and was in the hospital, they were still there for me, and I had no visitors during that time. It was good to hear somebody calling me and worrying about what I was doing.*"

In-home support workers reported a positive experience with ARISE program staff overall. They said program staff were likable, responsive, open to suggestions, and provided them with supplies as needed. When asked whether they needed additional support from program staff, one in-home support worker suggested that program staff could provide more information to the client when they first enroll in the program so that expectations and boundaries are communicated up front. They said, *"Just kind of setting the boundaries at the beginning has been helpful because then when I go and meet the people, they already have an idea of what to expect. So it just makes my job a little easier."* Another in-home support worker described additional support they need when they encounter a new client. They suggested having two in-home support workers present during the first meeting with a client to help with cleaning the living environment. They said, *"They send me the first time, they send each of the workers the first time. I was talking to the boss to see if we can go with two people, at least one or two times a week, because the apartments are scary, they are so dirty. For example, I've been given many apartments that are too dirty, they have never been cleaned. They have many things that need to be arranged and fixed to maintain the cleanliness. I tell the boss we can go, because I've realized that when they get a person and it's full of things, I've realized that they have paid up to five thousand dollars to clean them out and throw so many things away. And I tell the boss, because they don't give us more help, to get two people, because for just one person it's too much."*

Improving Capacity

The following sub-section details the quantitative and qualitative results related to the "Improving Capacity" learning goal, which aims to evaluate the extent to which the ARISE

program improves capacity for in-home support workers to serve individuals with complex behavioral health challenges, and how these outcomes could inform changes to the state IHSS program. See Exhibits 1 and 2 to see the full objectives for the "Improving Capacity" learning goal. The program retained the same number of available workers at follow-up as baseline. In-home support workers generally had positive experiences with the program, noting that their visits helped clients maintain clean living spaces and provided valuable companionship. Workers expressed satisfaction with their work-life balance but suggested improvements in compensation and benefits, including tax withholding and medical coverage. They also emphasized the importance of training, particularly in mental health support, and suggested that additional staffing be provided for challenging first visits to particularly difficult living environments.

Quantitative

In this section, we analyze the change in number of available IHSS workers throughout the duration of the program evaluation. Exhibit 10 summarizes the number of available workers in the county at baseline and follow-up who are willing to provide in-home support for individuals with challenging behavior during fiscal year (FY) 2023-2024. Throughout the FY, the program saw no change in the number of available IHSS workers, with five at baseline and follow-up.

Exhibit 10. Changes in IHSS Worker Availability Since Program Launch

Measure	Baseline	Follow-Up	Change (%)
Number of available IHSS workers who are willing to provide in-home support for individuals with challenging behaviors	5	5*	0%

*One provider was active for 28 days, but because they were active for less than a month, they were not included in the follow-up count. This provider had a medical emergency and was no longer able to continue.

Qualitative

In-Home Support Workers' Experiences With the ARISE Program

In-home support workers reported working with the program for an average of 1.5 years. In-home support workers reported serving an average of three clients, with most reporting that they meet with their clients at least once a week. Exhibit 11 summarizes these findings.

Exhibit 11. In-Home Support Workers' Experiences With the ARISE Program

- In-home support workers reported that the program is helping clients maintain a clean living area and is helping provide company to clients.
- In-home support workers are satisfied with their current work–life balance. Some workers suggested increasing their compensation.
- Most in-home support workers reported that they are satisfied with their guaranteed hours of work, but a couple of in-home support workers said they could use more hours.
- In-home support workers get onboarding training around client privacy and are starting training about providing mental health support to clients. They feel that more training about mental health support can improve their capacity to help clients.
- An in-home support worker mentioned that it would be helpful if the program took taxes out of their salaries every month. They also mentioned that it would be beneficial if they received [medical] benefits as an employee.

When asked about the key strengths of the program, in-home support workers described how their visits motivate clients to maintain a clean-living space. One in-home support worker explained, *"And now I see them more motivated, happier ... because when I arrive, they already know I'm coming, and they seem happier. They wait for me eagerly. And well, the experience I have is also that sometimes, as I was saying, it's about cleaning, specifically cleaning, that when I'm cleaning, they see that I'm carrying things, then they come and help me clean the bathroom, pick up trash, and all that. So, I see that motivation in them."*

Another strength of the program is that in-home support workers are able to communicate and provide company to clients. One in-home support worker said, *"Well, I like to help them a lot. I talk to them, there are people who are depressed, who feel lonely, and sometimes I give them therapy, like what I know, what I can do, and what is within my reach to help them, to support them, so that they don't feel alone, that there is always someone who cares for them."*

Overall, in-home workers reported that they were satisfied with their current work–life balance. One in-home support worker said, *"I'm very satisfied. I enjoy working for the program. I think we're doing good work, important work. So yeah, it just brings joy to be able to help people and to be involved with the other people who want to help just as much."*

Many in-home support workers had suggestions regarding their compensation. One in-home support worker recommended increasing the compensation because their services can be intensive, especially when a client's living environment has not been properly maintained prior to their services. Two in-home support workers mentioned that the program does not take taxes out of employees' pay each month, which means they have to pay taxes at the end of the year. One in-home support worker said, *"It's a bit tough because we have to pay taxes at the end of the year. So it's not very good because I would prefer them to deduct the taxes from one single payment so we don't get hit with a huge amount all at once."* Among these in-home support workers, one expressed frustration that in addition to having to pay taxes, they have to pay for gas to transport themselves to meet the client, as well as parking tickets they acquire when it is difficult to find parking near a client's residence.

Most in-home support workers reported that they were satisfied with their guaranteed hours of work, but a couple said they could use more hours. One in-home support worker said, *"For example, when I go with the client, I mean, I have the hours, it's three, four hours that I'm going to work with the client. And if not, and the client doesn't let me in, there I lose the hours. I feel that we're not ... it doesn't benefit us because if the client doesn't let us in and then they don't pay us, so there we lose."* In-home support workers also described how the reduction in allocated hours for each client (from 4 hours to 3 hours) was affecting them financially.

In-home support workers described onboarding trainings around client privacy and general orientation to the program. Some in-home support workers noted that the program has started to introduce trainings about providing mental health support to clients. One in-home support worker said, *"I actually just went through a mental health first aid class last Friday, and I got 100% on my test, and I feel a little better equipped having gone through that. I feel confident that if anything were to happen in the future, whatever, that I would be able to deal with it in the correct manner and confidently."*

An in-home support worker mentioned that it would be helpful if the program took taxes out of their salaries every month. They also mentioned that it would be beneficial if they received [medical] benefits as an employee. They recommended that the program take taxes out of employees' pay each month because they are finding that they must pay taxes at the end of the year.

Overall Satisfaction With the ARISE Program (Qualitative Findings)

Clients and in-home support workers rated their satisfaction with the ARISE program on a scale from 0 to 10, where 0 suggested they were not at all satisfied and 10 indicated they were extremely satisfied. Most clients gave the program a score of 9 or higher; the remaining two clients rated the program between 7 and 8. One adult client, who gave the program a score of 11 out of 10, cited the quality of services provided by the program, in-home support worker, and program staff as the primary reason for their high level of satisfaction. This client shared that their in-home support worker and program staff went above and beyond to take care of them and improve their living situation, health, and well-being. This client explained, "*All right, I'll say 11. That rating is they've done above and beyond. They've not only been there for me, but they've been there when they really didn't have to be, when I was in the hospital, nobody had to call me and ask how I was doing and if I was going to be okay when I came out. But they did and they seriously went over and beyond their duties.*" Clients who gave a slightly lower rating cited factors like not being able to maintain their privacy when in-home support workers were around and being asked to get specific mental health tests done as part of the program.

Two in-home support workers rated their satisfaction at a 10, while others rated their satisfaction between 8 and 9. In-home support workers who rated their satisfaction at a 10 said they were satisfied with their work and that program staff were supportive. One in-home support worker said, *"They're always there. They always help me with everything. I can call them. If they don't answer, they call back. They're very communicative. They listen to how I feel, and they never make me do anything I don't want to do."* Among in-home support workers who gave a slightly lower rating, they acknowledged that the program is still new. One said, *"We're still a new program, and so as we encounter issues, we address them and then we keep going. As we continue to work with different people, I'm sure we'll have different situations that we need to address. And as we address those situations, then the program will get stronger and stronger."*

ARISE Program Staff Interview Findings (Qualitative Findings)

This section presents findings from interviews conducted with two program staff. These staff have been with the program for an average of 1.5 years.

Intake Process for New Clients

Program staff explained the intake process for new clients. The process begins when case managers fill out a referral form with information about their client's state of living, risk of losing housing, lease violations, photos of their home, or communications from the property manager demonstrating the need for an intervention. Referral forms are collected by the ARISE program manager, administrator, or field program manager and passed on to the ARISE program director. The program manager, administrator, and program director meet weekly to

review referrals. The program manager and administrator notify the case manager that their client has been denied or accepted into the program. When a client is accepted, program staff meet with the case manager to gather details about the client and search for an in-home support worker who is accepting new clients. Once an in-home support worker accepts, the field program manager holds an introductory meeting with the client and in-home support worker to discuss goals and next steps for the client's involvement in the program, including scheduling the client for an occupational therapy assessment.

Program staff identified areas of improvement for the intake process. Program staff often experienced delays in completing the initial client meeting, which one staff member attributed to difficulty maintaining contact with clients and resolving client confusion about the ARISE program. To mitigate these delays, program staff created a welcome packet for case managers to provide to clients when explaining the program. They also mentioned that coordinating client engagement between program staff, case managers, and occupational therapists can be difficult. Further, one staff member explained that the occupational therapist assessment currently occurs after the field program manager's introduction to the client, but scheduling the assessment before the introductory meeting would be helpful. Based on this feedback, additional process improvements may make the process more efficient.

Program Staff Interactions With Clients and In-Home Support Workers

Exhibit 12 summarizes program staff interactions with clients and in-home support workers.

Exhibit 12. Program Staff Interactions With Clients and In-Home Support Workers

Client interactions	In-home support workers interactions
The field program manager is the main point of contact for the client. The program manager administrator operates behind the scenes.	Program staff check in via phone call with in-home support workers at least weekly to discuss any challenges they are facing with clients, timesheets, or paychecks.
Program staff mentioned that referrals to BHRS go through their peer support person, who checks in with the client biweekly.	The field program manager calls in-home support workers almost daily, as availability permits, and no less than three times per week.

Client Interactions

After program enrollment, program staff's level of interaction with clients is dependent on their role. To limit client confusion, the program streamlines communication with clients by reducing staff points of contact. The field program manager is the main point of contact for the client, and the program manager administrator operates behind the scenes. For example, the field program manager meets with the client on the day of enrollment and schedules a follow-up meeting within a week. They then hold weekly status check-ins with the client. Once the field

program manager deems the client's condition stable, their meeting frequency is reduced to 30-, 60-, and 90-day in-person appointments. The program manager administrator stays informed about the client by reading the case manager's notes and regularly checking in with in-home support workers about successes and challenges they are facing.

When asked about referrals to BHRS, program staff mentioned that this can be done through the peer support person, who should be checking in with the client biweekly. The program had challenges filling that position until recently, but one staff member explained, "*Thankfully … **we got somebody consistently and now we're finally seeing the benefits of that program.***" **Clients may also ex**press interest in services to their case manager or field program manager. The program manager administrator would then assist the client and case manager with the BHRS application process.

Interactions With In-Home Support Workers

Program staff reported frequent contact with in-home support workers. They check in via phone with in-home support workers at least weekly to discuss any challenges they are facing with clients, timesheets, or paychecks. They also connect with in-home support workers in person when possible. The field program manager calls in-home support workers almost daily, as availability permits, and no less than three times per week. They noted, "*[In-home support workers'] jobs can be pretty stressful sometimes … I also just want to do regular check-ins with them and see what they need to be able to support them best way possible*."

Program Staff Perspectives on Program Successes

Exhibit 13 summarizes program staff perspectives on program success.

Exhibit 13. Program Staff Perspectives on Program Successes

Program staff described the adaptability of the program to meet clients' diverse needs as a success.
Successfully training in-home support workers has helped them gain confidence in serving the diverse needs of clients enrolled in the program.

Program staff described the adaptability of the program to serve clients' diverse needs as a success. They stated, *"we also understand, … this is an experiment. We're trying to see if this is a viable program … I'm always trying to see … **what other programs are around. What can I take and implement into this program to make it efficient, to make it work?"***

Program staff mentioned that they were able to successfully train in-home support workers, improve their knowledge about the program, and help them gain confidence in serving clients enrolled in the program. Through these successes, program staff have witnessed an increase in

the number of clients served by ARISE. Program staff mentioned that they are able to assist their clients in maintaining a clean home and are teaching them to be more independent.

Program Staff Perspectives on Program Challenges

Exhibit 14 summarizes program staff perspectives on program challenges and proposed solutions.

Exhibit 14. Program Staff Perspectives on Program Challenges and Proposed Solutions

Program challenges	Proposed solutions
A lack of supplies for in-home support workers was identified as a challenge.	To address the lack of supplies for in-home support workers, the program has an upcoming donation scheduled and will continue to look for additional sources of funding.
There is a need to improve safety protocols to ensure that in-home support workers and program staff feel comfortable serving clients.	Program staff have implemented training and monthly meetings for in-home support workers and often seek help from their colleagues to diffuse difficult situations.
The program needs to improve client engagement by improving its communications, providing more resources to explain the ARISE program, and having a peer support person interact with the clients.	Strategies for client engagement include providing incentives and using education to inform clients about the benefits of the program.

One staff member stated, "Definitely one of the biggest needs for them [in-home support workers] were having the supplies in order to do the job." **Often, clients are unable to fund cleaning supplies.** Program staff recently purchased a small inventory of supplies for in-home support workers but need additional funding or donations to maintain supplies.

Safety protocols are needed to ensure that in-home support workers and program staff are comfortable interacting with the clients. To address this need, program staff explained that "*we have been getting them training and regular monthly meetings with them as well, so that they feel confident*." Program staff mentioned that there have been instances where they felt unsafe entering a client's apartment because it had not been maintained according to program requirements. It has been difficult for staff members to explain to clients that "*these are our* ***rules and regulations,*** *and these are our expectations"* to improve the safety of hazardous apartments.

There is a need to improve client engagement. In-home support workers are often denied services when they reach a client's house. One staff member explained that some clients become "*combative*" when they perceive ARISE to be an extension of their property management to enforce lease regulations. It is a challenge to reframe clients' perceptions of the program and encourage them to be receptive to the services being offered. Program staff elaborated further on this challenge, explaining that a lack of effective communication with

clients could potentially compromise client and in-home support worker health and safety. Although the welcome packet has reduced client confusion about ARISE, additional measures like engaging clients through a peer support person and providing access to a phone could help to increase client engagement. One staff member explained that "*more rapport building from a peer rather than from a program*" was extremely helpful.

Plans to Mitigate Challenges in the Future

Program staff mentioned that the advisory board for the ARISE program has been meeting to discuss potential solutions to the challenges discussed. Proposed solutions include the following:

- To address the lack of supplies for in-home support workers, the program has an upcoming donation scheduled and will continue to look for additional sources of funding.
- To improve client and in-home support worker health and safety, the program has implemented training and monthly meetings for in-home support workers to build their confidence in the field. One staff member finds it helpful to reach out to coworkers for support when they feel a situation could be unsafe, asking a coworker to join them in a meeting or case conference with a client.
- To improve client engagement, one suggestion is to provide incentives to clients. Citing specific feedback received from a peer support person who is a previous recipient of ARISE services, gift cards provided by the program incentivized them to complete tasks. The staff member also suggested focusing client education on the benefits of the program and maintaining a clean living space and trying to explain that "*aside from [the program] keeping you housed, it has a lot of beneficial outcomes to your health, to your well-being*."

Recommendations and Conclusions

This section presents recommendations to improve ARISE program implementation based on interviews with clients, in-home support workers, and program staff. Key recommendations for improving the ARISE program focus on (1) increasing funding to support a broader range of services, (2) educating clients about additional services available through the program to increase both awareness and enrollment, (3) introducing measures to increase retention and support future growth among in-home support workers, (4) providing culturally competent training to in-home support workers, and (5) putting together guidelines for interaction between clients and in-home support workers.

Provide Additional Funding to Expand the Program and Available Services

All interviewees indicated a need for additional funding to expand the program and provide additional services. Clients indicated a need for transportation services to pursue their hobbies or go grocery shopping. Many of these clients did not have a car or were unable to drive due to their health condition. They indicated that they would benefit from getting these services through the program. Findings from our quantitative evaluation of the "Housing" learning goal suggest that additional funding would also allow program staff to provide support to clients with critical housing needs, such as connecting clients with necessary services to avoid eviction notices. In-home support workers also indicated that an expansion of program funding would help increase their compensation and total hours of available work, which would enable them to further assist the clients. Additional funds would also help the program provide cleaning supplies to clients and in-home support workers. Program staff indicated that having additional funding would help increase the team's capacity. Specifically, adding more field managers could mitigate the likelihood of experiencing burnout and are able to juggle all their responsibilities and assist clients and in-home support workers.

Educate Clients About Additional Program and BHRS Services

Clients indicated that they mainly use the program to clean and organize their living environment. Only a handful of clients mentioned getting OT assessments, and many were not aware of additional services offered by the program. Additionally, our quantitative analysis of the "Health, Well-Being, and Recovery" learning goal shows that while almost all clients were referred to BHRS services since enrollment in the program, only half of clients were engaged in services outside of the program by the end of the fiscal year. Education about additional available services—like regular well-being checks, transportation services, access to peer support members to accompany clients to community and recovery events (such as Alcoholics Anonymous and the Friendship Center), OT assessments, and tailored service plans with OT goals—would help improve clients' engagement, health, and well-being.

Introduce Measures to Improve Retention and Growth Among In-Home Support Workers

In-home support workers are the backbone of the ARISE program and continual investment in their well-being is crucial to creating and maintaining effective relationships with clients. Interviews with in-home support workers highlighted concerns about compensation and a desire for increased work hours. Clients also mentioned that in-home support workers are key to the success of the program and suggested providing them with a higher level of compensation for their work. Some in-home support workers mentioned that the total number of hours they had for each client had recently been reduced from 4 hours to 3 hours and this was affecting their overall compensation. In-home support workers discussed that having more

hours enabled them to help clients with additional chores. One in-home support worker also mentioned that spending time with clients—taking them for a walk or having a conversation with them—can help to reduce clients' loneliness, thereby improving their mental health and well-being. Program staff shared that it would be helpful for in-home support workers to enroll in direct deposits and have access to a more efficient time sheet system. Addressing the concerns about compensation, hours worked (which affects their compensation), and efficient compensation processes, such as the time sheet system, would help improve both retention among current workers and encourage growth of the program by attracting additional staff to join to ensure the success and sustainability of the program moving forward.

Provide Culturally Competent Training to In-Home Support Workers to Interact With Clients

Although the ARISE program provides onboarding trainings around client privacy, as well as general orientation to the program, there is a need to develop trainings that enable in-home support workers and program staff to provide culturally competent mental health support to clients. These trainings would help in-home support workers better understand and address clients' behavioral health issues. To better serve the diverse backgrounds of clients, it will be critical to make these trainings culturally competent.

Guidelines for Interactions Between Clients and In-Home Support Workers

Clients and in-home support workers requested more support from the program in setting boundaries. For example, a client indicated that it would be beneficial for in-home support workers to notify them when they intend to enter specific areas in their house. Similarly, in-home support workers requested that the program set stricter boundaries. For example, they requested that clients do not smoke when workers are cleaning clients' homes. It would be helpful for the ARISE program to develop policies or guidelines to improve interactions between clients and in-home support workers.

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APPENDIX 11. FARMWORKER EQUITY EXPRESS INN EVALUATION REPORT, FY 2023–24

Farmworker Equity Express Annual Evaluation Report Fiscal Year 2023-2024

RDA CONSULTING

40 YEARS of Systems Change

ALAS

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

San Mateo County Behavioral Health and Recovery Services

Mental Health Services Act Innovation Evaluation

Farmworker Equity Express Annual Report

Fiscal Year 2023-2024

This report was developed by RDA Consulting under contract with the County of San Mateo Behavioral Health and Recovery Services.

RDA Consulting, 2024

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COMMUNITY SUMMARY

The Farmworker Equity Express program, launched in partnership between Ayudando Latinos a Soñar (ALAS) and San Mateo County Behavioral Health and Recovery Services (BHRS), began in August 2023 to address the mental health needs of farmworkers and their families in San Mateo County. Funded through the Mental Health Services Act (MHSA) Innovation (INN) component, this program strives to improve access to behavioral health care for a community often facing challenges like isolation, language barriers, and limited health services. The program uses a mobile bus that travels to farms across the region, bringing culturally responsive mental health support to over 1,500 farmworkers and their families in familiar, accessible settings.

Evaluation Overview

In collaboration with ALAS, RDA Consulting (RDA and hereafter the evaluation team) conducted an evaluation of the Farmworker Equity Express program using a mixed-methods approach to address the following four evaluation questions (EQs):

1. How is the Farmworker Equity Express program being implemented over time? **[Program Implementation]**
2. To what extent does the Farmworker Equity Express program, a culturally responsive mobile behavioral health resource, expand access to and utilization of behavioral health services in the Latinx farmworker community? **[Access to Services]**
3. To what extent does the Farmworker Equity Express program, an integrated approach using cultural arts and formal clinical services, support behavioral health service adoption and outcomes among the Latinx farmworker community? **[Participant Outcomes]**
4. To what extent does the Farmworker Equity Express program identify the needs and best practices to support farmworker behavioral health? **[Needs and Best Practices]**

The evaluation employed both qualitative and quantitative data collection methods, including:

Focus Groups

- Program Participants
- ALAS Staff
- Cultural Arts Providers

Surveys and Forms

- Participant Survey
- Intake Assessment Form

Meetings and Observations

- Monthly Evaluation Meeting Notes
- Site Observation

Using the data sources, the evaluation team analyzed Farmworker Equity Express implementation processes and adaptations, services, strengths, as well as challenges. The evaluation team also examined program participant demographics, experiences with the program, program satisfaction, and outcomes. Finally, the evaluation team explored participant needs and program best practices.

EQ1. PROGRAM IMPLEMENTATION

Key Service Offerings

To meet the needs of program participants, the Farmworker Equity Express Program offered a variety of services (Figure 1):

Figure 1. Key Service Offerings

Program Adaptations and Innovations

Program Launch. ALAS intended to launch the Farmworker Equity Express program in July 2023; however, due to delays in contracting approval on behalf of the Board of Supervisors, the program ultimately launched in August 2023.

Evaluation Processes. ALAS and RDA held a launch meeting for the MHSA program evaluation in July 2023 and collaboratively participated in a series of culturally responsive evaluation planning sessions that took place in August, September, and October 2023.

Referral Pipeline. In the Fall of 2023, ALAS began solidifying plans to use their monthly thematic workshops as a pipeline for initial client engagement and connection to other program services, such as individual therapy. The team worked to finalize a protocol for their referral and tracking system in December 2023.

Service Developments. The team launched several new service groups and offerings between the Fall of 2023 and the Spring of 2024, based on participant feedback, including:

- Asesoría individual (individual counseling),
- Asesoría grupal (group counseling),
- Exploración o evaluación (screening or assessment),
- Actividades artísticas culturales (cultural arts activities),
- Arte como Sanación (Art as a Form of Healing group),
- Grupos Compadres (Friends group),
- Grupos Corazones de Oro (Hearts of Gold group),
- Taller/grupo de parejas (Couples group),
- Hijas de la Luna (Daughters of the Moon group),
- Aprendiendo y jugando (Learning and Playing group),
- Reinas de Corazones (Queen of Hearts group),
- Grupos de madres "Bebé y yo" (“Baby and Me” Mothers group),
- Talleres sobre el duelo (Grief workshops), and
- Basic needs support.

Mobile Service Engagement. During the storms and flooding in the Winter and Spring, ALAS staff creatively adapted to the conditions by using a truck to provide in-the-field services, until the mobile services bus began running again in May 2024.

Community Engagement. ALAS engaged current and new program participants at a variety of social and community events throughout FY 23-24.

Advisory Board Development. ALAS experienced some delays in developing and convening a community advisory board. After months of diligent recruitment and planning, the program’s first community advisory board meeting took place in May 2024.

Staff Transitions. In February 2024, the team welcomed a new program director to the program. In the Spring of 2024, ALAS underwent an operations office restructuring that led to a staff transition for the team’s original assistant director to a community liaison role.

EQ2. ACCESS TO SERVICES

Program Engagement and Awareness

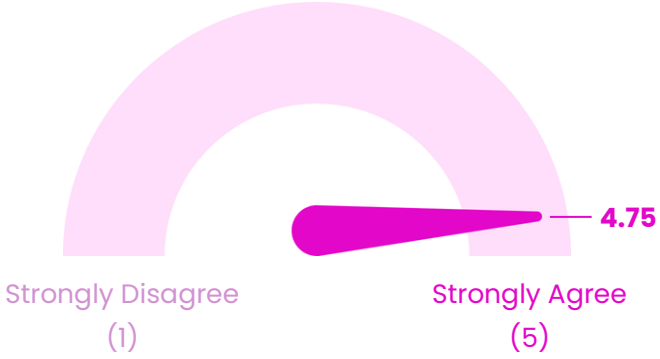
- The Farmworker Equity Express program made significant strides in breaking down barriers to behavioral health care, effectively **expanding farmworkers' access to and utilization of behavioral health services**.
- By incorporating the mobile bus, the program **reduced common barriers** such as transportation, cost, and time, making it easier for farmworkers to engage in the services offered.
- **Culturally relevant activities and an emphasis on relationship-building** were also key program elements that influenced how farmworkers engaged with services.
- Initially, **farmworkers were not fully aware of the mobile bus' purpose** or the services it provided. In response, program staff organized a welcoming event, inviting farmworkers to a get-together with music, food, and activities to introduce the bus and explain its offerings.

Service Accessibility

The Farmworker Equity Express program prioritized accessibility by ensuring services were culturally responsive, resource-oriented, and conveniently delivered (Figure 2**).**

Figure 2. Participant Survey Respondents' Experiences with Service Accessibility, N=8

On average, participant survey respondents **strongly agree** that:

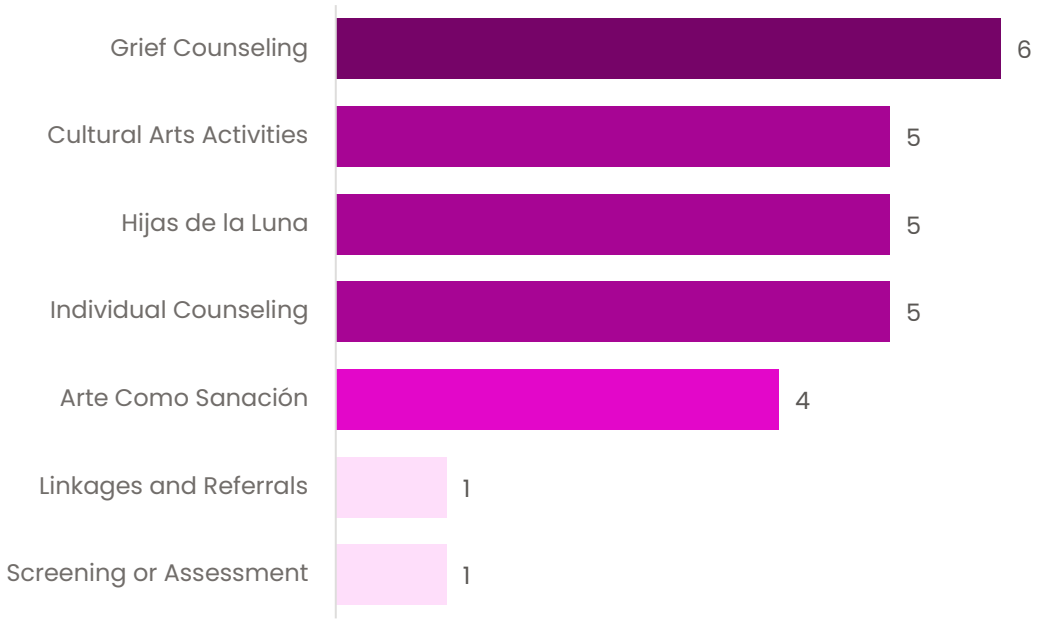


- Groups and services are **relevant to** their **culture** and **beliefs**.
- Staff connected them to **other helpful resources** and **services**.
- Groups were held at **convenient times** and locations.
- Groups were offered in their **preferred language**.

Service Utilization

There were varied levels of engagement across Farmworker Equity Express program services, with certain offerings utilized more frequently than others (Figure 3**).**

Figure 3. Participant Survey Respondents' Engagement in Services, N=8

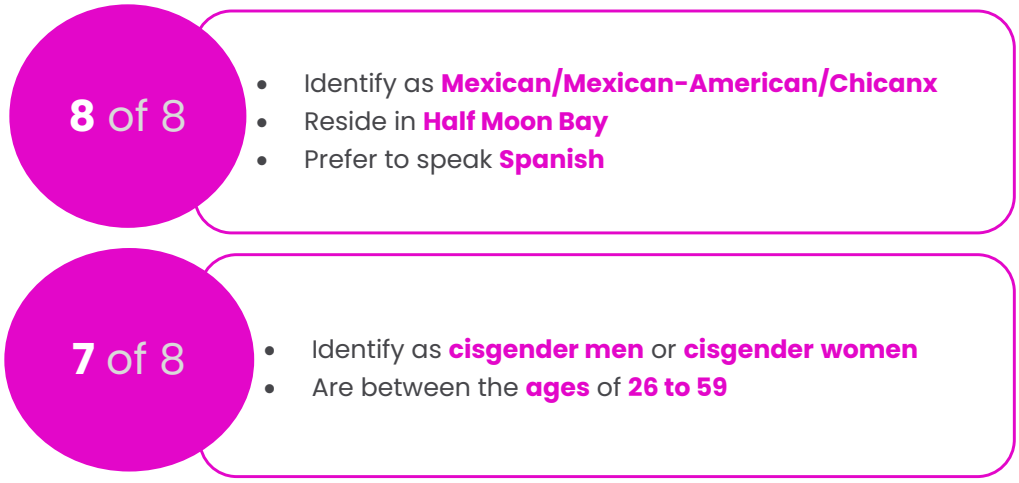


Demographic Characteristics

The Farmworker Equity Express program primarily served a culturally and linguistically unified group of farmworkers, reflecting a strong alignment with the community's identity. All eight intake assessment respondents identified as Mexican, Mexican-American, or Chicanx, and all resided in Half Moon Bay. Similarly, all respondents preferred to receive services in Spanish, underscoring the importance of offering language-accessible support. Seven out of eight respondents identified as either a cisgender man or woman, and the majority fell within the 26-59 age range (

Figure 4).

Figure 4. Demographic Characteristics of Intake Assessment Form Respondents, N=8



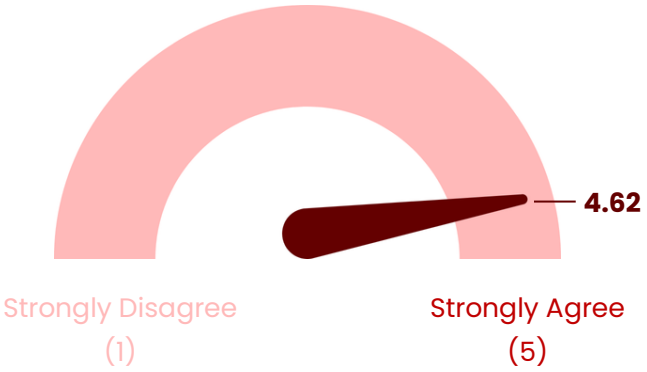
EQ3. PARTICIPANT OUTCOMES

Behavioral Health and Quality of Life

- **Farmworker Equity Express program activities have had a positive impact on participants' behavioral health, quality of life, cultural connection, and adoption of mental health services.**
- A combination of protective factors (i.e., cultural and interactive elements such as painting, folklore dance, and grief groups) **helped reduce stress and stigma around mental health**, creating a supportive environment for emotional expression.
- Furthermore, the program's culturally integrated approach has effectively **promoted both acceptance and sustained use of behavioral health services** among the Latinx farmworker population.
- Participant survey results revealed that respondents, on average, felt very comfortable reaching out to ALAS staff for future resources and services (4.62 out of 5), with six out of eight respondents rating their comfort level a five, one rating it a four, and one a three (Figure 5).
- Half of participant survey respondents (four out of eight) specifically reported that therapy or community connections had positively impacted their mental health.
- Most participant survey **respondents expressed satisfaction** with the Farmworker Equity Express program.
- In addition, seven out of eight respondents noted **they learned something useful** through their participation in the program

Figure 5. Participant Survey Respondents' Level of Comfort Reaching out to Staff, N=8

On average, participant survey respondents **strongly agree** that:



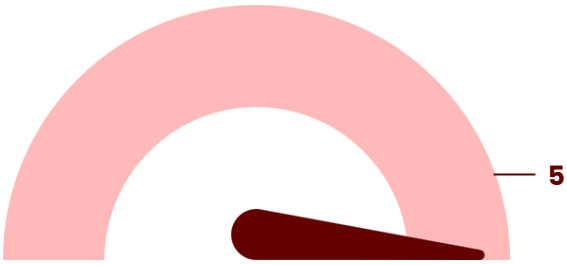
- I feel **comfortable reaching out** to ALAS staff in the future **for resources** and **services**.

Cultural and Community Connection

- **Participant survey data showed that the program significantly strengthened participants' connection to their culture and community,** additional and essential protective factors (
- Figure 6).
- While program staff and cultural arts providers positively impact participants, **the participants, in turn, leave a lasting impression on the staff and providers**.

Figure 6. Participant Survey Respondents' Level of Agreement with Culture and Community, N=8

On average, participant survey respondents **strongly agree** that:



- I felt connected to my **culture**.
- I felt connected to my **community**.

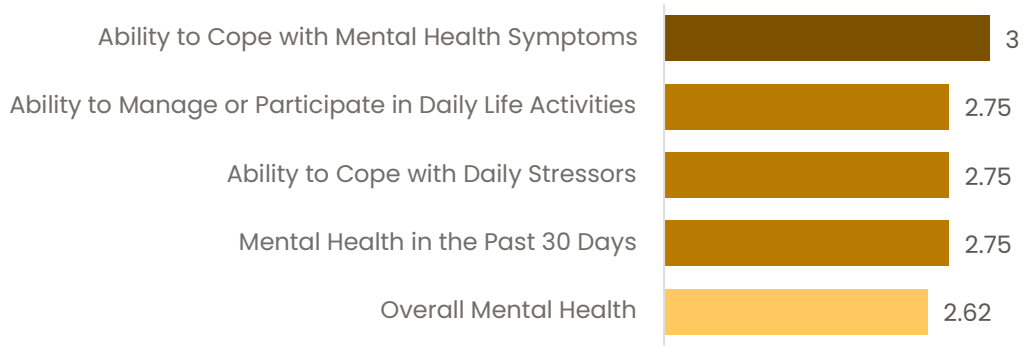
Community Summary: Evaluation Findings – EQ4. Needs and Best Practices

EQ4. NEEDS AND BEST PRACTICES

Throughout the program, there were several key needs and best practices identified at intake to effectively support the behavioral health of farmworkers. Intake assessments revealed moderate challenges in mental health and daily functioning, with average self-ratings of "slightly good" for mental health in the past 30 days, overall mental health, coping with daily stressors, and ability to manage or participate in daily life activities (

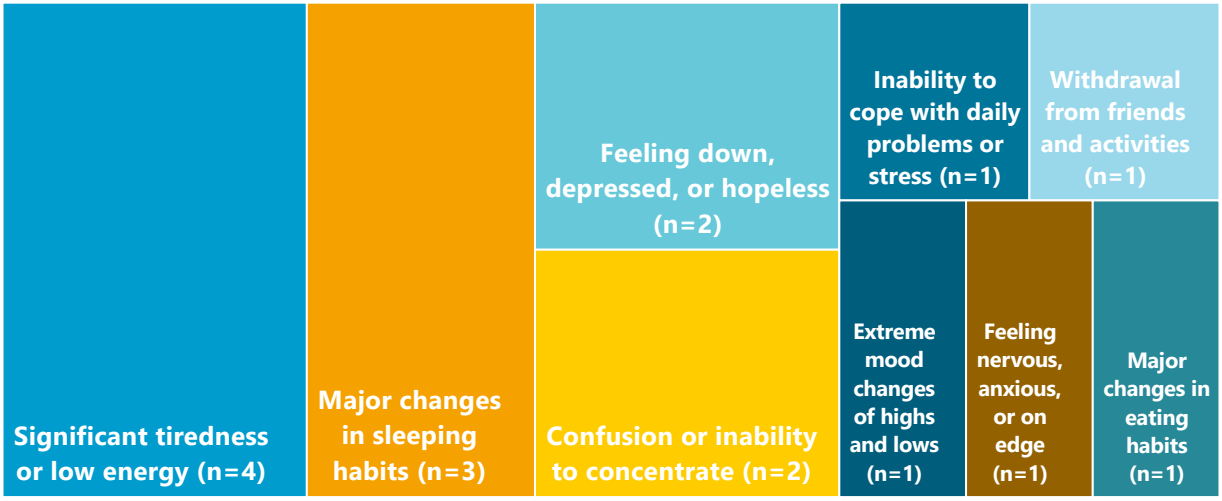
Figure 7). Meanwhile respondents' ability to cope with mental health symptoms averaged at a rating of three or "good."

Figure 7. Intake Assessment Form Respondents' Mental Health and Coping Ability Self-Ratings, N=8



- At intake, participants reported common behavioral health symptoms, including fatigue, changes in sleep, and feelings of hopelessness (Figure 8).

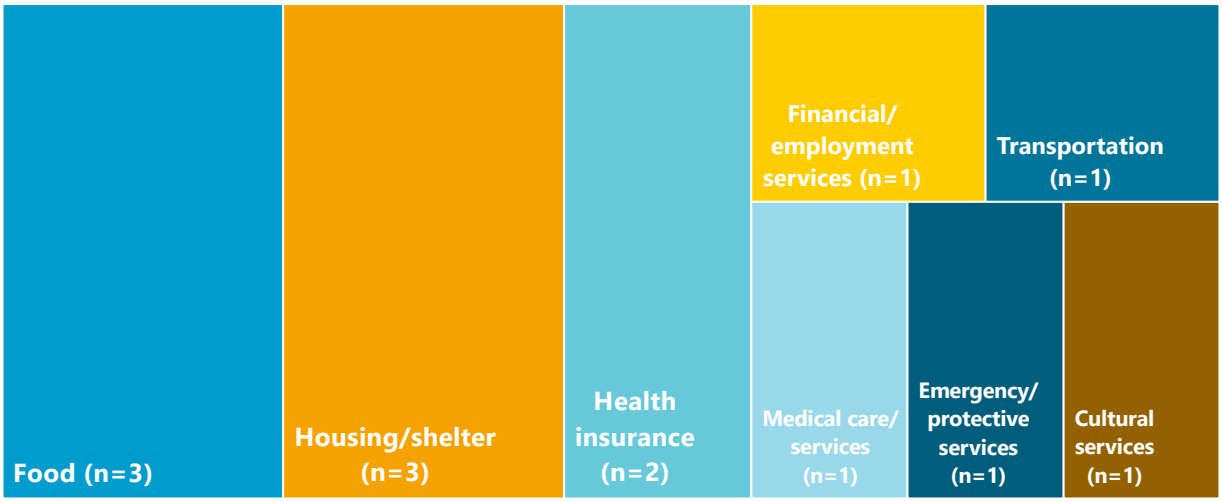
Figure 8. Intake Assessment Form Respondents' Behavioral Health Symptoms at Intake, N=5



Additionally, basic supports such as food, housing, and health insurance were identified as essential to participants' mental health stability (

- Figure 9).

Figure 9. Intake Assessment Form Respondents' Supports Needed at Intake, N=6



- Staff feedback emphasized the importance of language-specific services, mental health education, and trauma-informed care (Figure 10).

Figure 10. Staff-Identified Participant Needs

- Best practices included community involvement in program design, ongoing cultural competency training, and maintaining flexibility to address environmental challenges.

Recommendations

- **Expand Awareness of Referrals and Screening Services.** Since few respondents utilized linkages, referrals, and screening services, consider enhancing communication around these offerings. Staff could integrate information about these services into existing, well-attended, sessions like grief counseling or cultural arts activities to boost awareness and understanding of the benefits they provide.
- **Promote Cross-Participation.** Encourage participants in popular groups, like Hijas de la Luna or Arte Como Sanación, to explore other services that may support their needs, such as individual counseling or assessments. A brief introduction to available services at the start or end of each group session could help participants consider other resources that might be beneficial.
- **Additional Outreach to Younger and Older Age Groups.** Since the majority of participants were between the ages of 26-59, additional outreach might help engage younger or older farmworkers who could benefit from the program. Tailoring services to the interests and needs of these age groups, such as youth-focused workshops or elder-specific support, could increase their engagement.
- **Enhance Stigma Reduction Efforts.** Building on current success, consider additional anti-stigma activities, such as storytelling or peer-led sessions, to further normalize mental health discussions within the community.
- **Evaluate Less Utilized Services.** Consider gathering feedback from participants on why services like linkages, referrals, and screenings are less utilized. This may reveal insights into possible adjustments in service delivery or indicate a need for more culturally relevant adaptations.
- **Encourage Greater Participation in Program Evaluation Activities.** Encouraging higher engagement in evaluation activities will ensure the program continues to reflect the evolving needs of the farmworker community and can support meaningful improvements based on participants' input. Additionally, exploring reasons for low participation in evaluation activities during the first year may reveal barriers that can be addressed to enhance future engagement.

Introduction

In 2004, interest holders throughout the mental health system in California joined together in support of Proposition 63, the Mental Health Services Act (MHSA). The MHSA was intended to "expand and transform" the public mental health system according to the values of: 1) Recovery, Wellness, and Resiliency; 2) Consumer and Family Driven; 3) Community Collaboration; 4) Cultural Competency; and 5) Integrated Services. MHSA provided an infusion of funds to support programs that serve public mental health consumers, their families, and communities.

The purpose of the Innovation (INN) component of MHSA is to pilot new and emerging mental health practices and approaches that seek to address the needs of unserved and underserved populations and that contribute to learning across the state. As such, MHSA INN funds provide an opportunity for counties to implement innovative mental health services and learn about implementing practices that have the potential to transform the behavioral health system.

Pursuant to Welfare and Institutions Code Section 5830, all MHSA Innovation projects must meet the following requirements:

INNOVATION (INN)

INN projects are new, creative mental health practices/approaches that contribute to the learning process in the mental health field. INN projects must be developed in partnership with communities through a process that is inclusive and representative, especially of unserved, underserved, and inappropriately served individuals.

Address one of the following as its primary purpose:

- Increase access to underserved groups.
- Increase the quality of services, including measurable outcomes.
- Promote interagency and community collaboration.
- Increase access to services.

Support innovative approaches by doing one of the following:

- Introducing new mental health practices or approaches, including, but not limited to, prevention and early intervention.
- Making a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community.

- Introducing a new application to the behavioral health system of a promising community-driven practice or an approach that has been successful in non-mental health contexts or settings.

All INN projects must also be approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC), and counties are required to submit annual, as well as final INN Project Reports at the conclusion of the pilot. In December 2022, San Mateo County (SMC) Behavioral Health and Recovery Services (BHRS) was awarded a four-year MHSA INN grant from the MHSOAC to implement their new Farmworker Equity Express Program. This report details the first fiscal year[1] (FY) of program implementation from July 1, 2023, to June 30, 2024 (FY23-24).

Program Overview

Photo 1. Farmworker Equity Express Bus[2]

The Farmworker Equity Express program was created to address the unique challenges faced by farmworkers in SMC, a group that includes over 1,500 individuals and their families, many of whom are immigrants. These farmworkers often struggle with isolation, poor housing, and limited access to health services, contributing to mental health issues like depression, anxiety, and stress. Recognizing the need for accessible and culturally responsive care, the Farmworker Equity Express brings behavioral health services directly to the farms through a mobile bus, making it easier for farmworkers and their families to get help where they live and work. This program offers innovative care tailored to the needs of farmworkers, ensuring services are convenient, culturally relevant, and offered in Spanish.

Developed by Ayudando Latinos a Soñar (ALAS) and SMC BHRS, Farmworker Equity Express helps farmworkers overcome barriers such as transportation and language by bringing bilingual staff directly to farm locations. The mobile bus visits 23 farms in the region, providing a range of services such as counseling, recovery support, and community resources. The program also integrates cultural arts, allowing farmworkers and their families to engage in

[1] A fiscal year goes from July 1st of the previous year to June 30th of the following year.
[2] Photo Source: ALAS Instagram - **https://www.instagram.com/alashmb/?hl=en**

activities like storytelling, creating altars and murals, which celebrate their heritage while promoting healing.

Through this mobile approach, the Farmworker Equity Express connects Latinx farmworkers and their families with much-needed mental health support in a setting that is familiar and welcoming, helping to build stronger, healthier communities. It represents a new way of delivering care by meeting people where they are and honoring their cultural identity, making a lasting impact on the well-being of farmworkers and their families.

Program Innovations and Adaptations

Program Launch. ALAS intended to launch the Farmworker Equity Express program in July 2023; however, due to delays in contracting approval on behalf of the Board of Supervisors, the program ultimately launched in August 2023.

Evaluation Processes. ALAS and RDA held a launch meeting for the MHSA program evaluation in July 2023 and collaboratively participated in a series of culturally responsive evaluation planning sessions that took place in August, September, and October 2023. The teams continued to collaborate to develop data collection tools, train staff, and collect and analyze data for the first annual MHSA evaluation report (for additional details, see '**Evaluation Overview**'). Staff reported using the focus groups as opportunities to implement program changes in response to direct feedback from program participants (e.g., providing mobile outreach to less-visited farms).

Referral Pipeline. In the Fall of 2023, ALAS began solidifying plans to use their monthly thematic workshops as a pipeline for initial client engagement and connection to other program services, such as individual therapy. The team worked to finalize a protocol for their referral and tracking system in December 2023. In May 2024, ALAS began piloting drop-in crisis hours for participants, both on the mobile services bus and onsite at ALAS, as another method of engaging and enrolling new farmworkers. The following month, ALAS found that their food pantry program was growing as a successful initial entry point for farmworkers to learn about the program, connect with a case manager, and obtain mental health referrals.

Service Developments. ALAS began thinking through ideas for mental health service offerings and engagement approaches, including ideas that incorporated mental health de-stigmatization and the arts. The team launched several new service groups and offerings between the Fall of 2023 and the Spring of 2024, including: Asesoría individual (individual counseling), Asesoría grupal (group counseling), Exploración o evaluación (screening or assessment),

Actividades artísticas culturales (cultural arts activities), Arte como Sanación (Art as a Form of Healing group), Grupos Compadres (Friends group), Grupos Corazones de Oro (Hearts of Gold group), Taller/grupo de parejas (Couples group), Hijas de la Luna (Daughters of the Moon group), Aprendiendo y jugando (Learning and Playing group), Reinas de Corazones (Queen of Hearts group), Grupos de madres "Bebé y yo" ("Baby and Me" group), and Talleres sobre el duelo (Grief workshops). Throughout the first program year, ALAS provided trainings to staff and supported delineation of ALAS services specific to Farmworker Equity Express versus other ALAS programs.

Mobile Service Engagement. Throughout the Fall and Winter of 2023, ALAS worked to plan and finalize the logistics and paperwork needed to launch the mobile services bus to provide in-the-field services to farmworkers in their communities. However, complications with the mobile services bus, coupled with numerous storms and flooding throughout the Winter and Spring, ruined crops and roughened the unpaved terrain, which made it difficult both (1) for farmworkers to find work and (2) for the program to reach farmworkers using the mobile services bus. During this period, ALAS staff creatively adapted to the situation by using a truck to provide in-the-field services, until the mobile services bus began running again in May 2024.

Community Engagement. ALAS engaged current and new program participants at a variety of social and community events throughout FY 23-24. Some of these events began in the Fall of 2023, such as monthly breakfast socials, the Half Moon Bay Pumpkin Festival. Other events took place in the Spring and Summer of 2024, including Wellness Day at the park, county fair events, and ALAS's 10-year anniversary gala. The community also held a memorial service in January 2024 for the victims of a mass shooting in Half Moon Bay that occurred the year prior. Additionally, ALAS attended a meeting with the housing commission regarding the "555 Kelly" city housing project in April 2024[3], with many senior farmworkers in attendance to share their stories and advocate that the 555 Kelly property be used as housing for senior farmworkers. The following month in May, ALAS learned that the 555 Kelly housing project was approved as housing for farmworkers.

Advisory Board Development. ALAS experienced some delays in developing and convening a community advisory board. The team spent the Fall of 2023 working to identify key leaders from the farmworker community for the board. In October 2023, RDA engaged in discussions and shared a resource guide with ALAS to help support the development of their advisory board. After

[3] City of Half Moon Bay. (n.d.). 555 Kelly Avenue - Affordable Housing. **https://www.half-moon-bay.ca.us/845/555-Kelly-Avenue---Affordable-Housing**

months of diligent recruitment and planning, the program's first community advisory board meeting took place in May 2024.

Staff Transitions. ALAS experienced a few staffing transitions during their first year of implementation for the Farmworker Equity Express program. In February 2024, the team welcomed a new program director to the program. In the Spring of 2024, ALAS underwent an operations office restructuring that led to a staff transition for the team's original assistant director to a community liaison role.

A table with additional program implementation details may be found in **Appendix A**.

Evaluation Overview

In July 2023, ALAS and SMC BHRS partnered with RDA Consulting[4] (hereafter evaluation team) to conduct a multi-year evaluation of the Farmworker Equity Express program, concluding in 2026. The purpose of this evaluation is to: (1) evaluate Farmworker Equity Express program processes (implementation) and outcomes; (2) support continuous program improvement efforts; and (3) satisfy and comply with MHSA INN regulatory requirements, including annual and final evaluation reports to the MHSOAC.

Since starting the evaluation of the Farmworker Equity Express program in July 2023, the evaluation team has worked closely with ALAS and SMC BHRS to accomplish several key evaluation activities:

Developed an Evaluation Plan. In partnership with ALAS, the evaluation team developed an evaluation plan that is intended to be used as a roadmap throughout the evaluation process. This plan is inclusive of the learning goals, evaluation questions, the proposed evaluation methodology and analytic framework, potential limitations, and reporting requirements.

Created and Adapted Data Collection Tools. Collaboratively, ALAS and the evaluation team created data collection tools such as focus group protocols and an observation checklist. Moreover, the evaluation team worked with ALAS to adapt existing data collection tools such as a participant survey, intake assessment form, and service log.

[4] RDA is an employee-owned consulting firm that provides equity-centered, evidence-driven solutions in collaboration with our partners to improve social systems and services.

Focus Group Training. To best meet the needs of program participants and enhance program staff evaluation skills, the evaluation team designed a focus group training for program staff interested in assisting with focus group facilitation. These staff were provided a stipend. Trained program staff facilitated the program participant and cultural arts provider focus groups.

Site Observation. ALAS invited the evaluation team to visit the program site to observe the art group, "Arte Como Sanación," and learn more about the program's activities. This opportunity allowed for the evaluation team to immerse themselves in a day of program activities to gain a glimpse into how participants experience the program.

Fiscal Year 1 Data Collection. Data collection for the first year of reporting was a collaborative effort. Described in greater detail below, the evaluation team facilitated the program staff focus group, meanwhile the ALAS team helped to facilitate the program participant and cultural art provider focus groups. ALAS also administered the participant surveys and intake assessment forms.

Fiscal Year 1 Data Analysis. To inform this report, the evaluation team analyzed the data collected in the first FY of the program. This includes data gathered from the focus groups, participant surveys, and intake assessment forms. Together, the evaluation team and ALAS made sense of the findings during a virtual data party. During the data party, ALAS provided the evaluation team with additional insights to help inform data interpretation.

Throughout this partnership, the evaluation team also held regular monthly meetings with ALAS and SMC BHRS to stay updated on the program's progress, discuss any new developments, and share evaluation progress. These ongoing meetings will continue to ensure the evaluation remains on track and that the findings are used to support the program's growth and success. Collectively, these efforts have laid the groundwork for an evaluation that will help to answer key questions about how the program is working and the impact it is having on the program participants. The following section outlines the specific evaluation questions guiding this work.

Evaluation Questions

In alignment with the program's learning goals, the evaluation team, ALAS, and SMC BHRS developed a set of four evaluation questions (EQs) to guide the assessment of the Farmworker Equity Express program. The EQs aim to explore how well the program is meeting its goals and how it can continue to improve. By answering these questions, interest holders can gain a clearer picture of the program's contributions to farmworker behavioral health and well-being.

The four EQs and their associated learning goals are outlined in Table 1 below.

Table 1. Evaluation Questions and Associated Learning Goals

Evaluation Questions and Learning Goals	
EQ1.	How is the Farmworker Equity Express **program being implemented** over time?
Learning Goal (EQ1): To assess and improve the implementation of the Farmworker Equity Express program to ensure it effectively meets participant needs, fosters collaboration, and delivers quality services.	
EQ2.	To what extent does the Farmworker Equity Express program, a culturally responsive mobile behavioral health resource, **expand access to and utilization of behavioral health services** in the Latinx farmworker community?
Learning Goal (EQ2): To determine the extent to which the Farmworker Equity Express program enhances access to and utilization of behavioral health services among the Latinx farmworker community, while reducing stigma and increasing awareness of available resources.	
EQ3.	To what extent does the Farmworker Equity Express program, an integrated approach using cultural arts and formal clinical services, **support behavioral health service adoption and outcomes** among the Latinx farmworker community?
Learning Goal (EQ3): To examine the extent to which the Farmworker Equity Express program improves behavioral health service adoption and outcomes within the Latinx farmworker community, integrating cultural arts activities with formal clinical services, ultimately improving mental and behavioral health along with quality of life.	
EQ4.	To what extent does the Farmworker Equity Express program **identify the needs and best practices** to support farmworker behavioral health?
Learning Goal (EQ4): To identify and document the needs, best practices, and lessons learned from the Farmworker Equity Express program, ensuring its adaptability for replication and scaling in other counties implementing similar programs to better support farmworker behavioral health.	

Methodology

For the evaluation of the Farmworker Equity Express program, the evaluation team used a mixed-methods approach, combining both quantitative (numbers) and qualitative (stories

and experiences) data to provide a holistic view of the program. This method ensured that the evaluation team addressed SMC BHRS and ALAS priorities, answered key evaluation questions, and met MHSA INN reporting requirements. The annual evaluation report includes information about how the program was put into action, how participants engaged with services, and the short-term outcomes achieved during FY23-24.

As detailed in the '**Evaluation Overview**' above, the evaluation team used a collaborative and culturally responsive evaluation approach that engaged key interest holders, such as the ALAS team and the farmworker community, and centered their voices throughout the evaluation process. To ensure the farmworker community voice was represented, in September 2024, the ALAS team coordinated and convened the Community Advisory Board (CAB)—comprised of six farmworkers and six ALAS staff. Their feedback and input were pivotal in creating a collaborative and culturally responsive evaluation that reflects the unique needs of the community. For example, the CAB reviewed the participant survey to ensure it was accessible, respectful, and culturally appropriate. Moreover, the evaluation team and ALAS held an additional data party with the CAB members to help interpret findings and add context to the data collected. While the CAB is still in its early convening phases, the evaluation team and ALAS will continue to engage members throughout the evaluation process.

This approach laid a strong foundation for the manner in which the findings are reflected in this report. The next section outlines the specific data sources and collection methods the evaluation team used to gather information for the evaluation.

Data Collection and Sources

As part of the evaluation planning process, the evaluation team, SMC BHRS, and ALAS collaborated to identify and discuss needed and existing qualitative and quantitative data sources that could be used to address the EQs for FY23-24 reporting. **Appendix B** provides a detailed overview of the learning goals, evaluation questions, the indicators and measures, and the data sources used for this evaluation.

Data Sources

Quantitative Data

Participant Survey. In collaboration with ALAS, the evaluation team adapted an existing participant survey from a similar program[5] to understand participants' experiences with services received from the Farmworker Equity Express program as well as other activities participants engaged in. The information gathered from the 9-item participant survey included the length of time participants engaged in Farmworker Equity Express services, the

[5] ALAS Cariño Project.

groups participated in, the services received, experiences with mental health-related groups, workshops, or other events, experiences with participation in groups and services, and program satisfaction. Participants were also asked self-stigma questions. In addition, the survey provided the opportunity for participants to share any learnings from program services and/or activities, general feedback about the program, along with optional demographic information. In June 2024, ALAS administered the survey to participants after engagement in services, groups, workshops, and other activities. The survey was confidential and voluntary. The evaluation team provided incentives to the program participants who completed the survey. There were eight (N=8) farmworkers who participated in the survey.

Intake Assessment Form. In June 2024, ALAS provided the evaluation team with data captured in the intake assessment form. ALAS staff administered this form to all program participants at intake in-person and in paper format. The intake assessment form included four core questions that gathered information around participants' overall mental health as well as self-rated physical and mental health, and ability to: manage symptoms, cope with stressors, and engage in daily life. Similarly to the survey, there were eight (N=8) farmworkers who completed an intake assessment form.

The participant survey and intake assessment form were made accessible to program participants in both English and Spanish. ALAS administered both in-person and in paper format to ensure ease of access. To maintain data security, ALAS staff scanned and securely transferred the completed surveys and assessment forms to the evaluation team, where they were entered into designated Google Forms in a protected folder for analysis.

Qualitative Data

Focus Groups. To address all four EQs, the evaluation team facilitated three focus groups, including one focus group with program participants, one focus group with ALAS staff, and one focus group with the cultural arts provider. Each focus group was tailored to gather unique insights from each group based on their position within the context of the Farmworkers Equity Express program. All focus groups were held in-person and onsite for approximately 90 minutes each. Evaluation team members facilitated the ALAS staff focus group meanwhile two trained ALAS staff conducted the program participant and cultural art provider focus groups. The evaluation team developed all protocols for the focus groups with input from ALAS staff. In addition, the evaluation team provided incentives to the program participants who participated in the focus groups.

The focus group with program participants involved discussions of program access, engagement, and impact; program satisfaction and perceived responsiveness; mental and behavioral health service access, awareness, knowledge, and stigma reduction; as well as the nature of outcomes experienced, including those related to behavioral health, mental

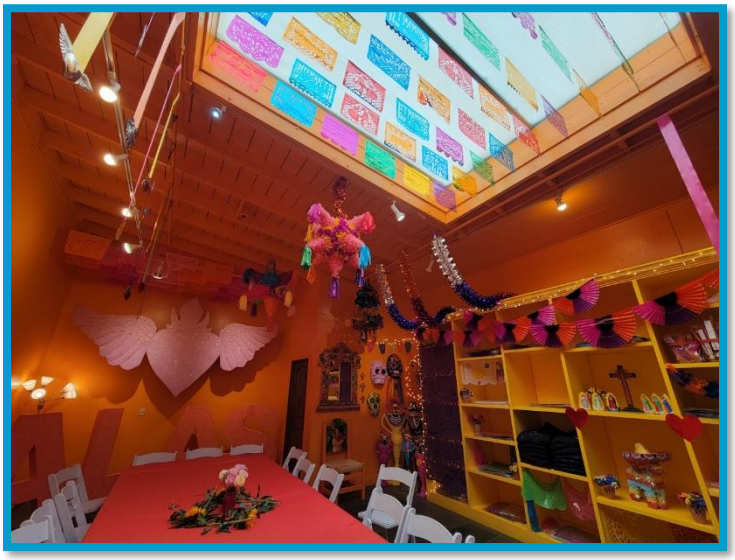
health, and quality of life. There were five (N=5) farmworkers who participated in the focus group.

The focus groups with ALAS staff included discussions of program implementation, successes, challenges, and adaptations; internal and external collaborations; staff support and satisfaction; cultural responsiveness of the program; perceptions of program access and impact; service adoption and outcomes; and behavioral health needs along with best practices for participant behavioral health support. There were five (N=5) staff members who participated in the focus group.

The focus group with the cultural arts provider delved into perspectives on program implementation; cultural responsiveness; collaboration with program staff; participants' engagement and satisfaction with cultural arts activities; and the impact of these activities on participants' outcomes. There were ten (N=10) cultural arts providers who participated in the focus group.

Program Observation. In its first year of implementation, the evaluation team conducted a program observation of the Farmworker Equity Express program. The program observation took place in-person and onsite. During observation, ALAS staff provided the evaluation team with a walkthrough of the program and the services it offers. Furthermore, this mode of data collection allowed for the evaluation team to facilitate the in-person focus group with staff members, as well as provided the evaluation team with the opportunity to train two ALAS staff in focus group facilitation. This observation contributed to the first EQ, which encompasses program implementation successes, challenges, and adaptations, the dynamics of internal and external collaborations, staff support and satisfaction levels, along with the cultural responsiveness of the program.

Photo 2. ALAS Activity Room[6]



Evaluation Meeting Documentation. Evaluation team members utilized monthly evaluation meetings with ALAS as an opportunity to make additional observations of the Farmworker Equity Express program. These meetings allowed the evaluation team to document how the

[6] Photo Source: Evaluation team observation photo of Arte Como Sanación.

program is being implemented over time and to what extent the program is identifying needs and best practices to support participants. The evaluation team documented these additional observations through meeting notes and used a portion of these meetings to gather program updates from ALAS which entailed information on program implementation, its successes, challenges, adaptations, as well as best practices and lessons learned. These meetings were held virtually for up to one hour.

Data Analysis

As detailed in the '**Methodology**' section above, the evaluation team conducted a mixed-methods evaluation using qualitative and quantitative analysis techniques that helped to evaluate the program processes and outcomes. By conducting both qualitative and quantitative analysis, there was an opportunity to triangulate findings from multiple data sources—and data types—to produce a more robust set of findings that complement and build upon each other.

Separate analytic approaches were used to analyze the quantitative and qualitative data. To assess measures from the **quantitative data sources** listed above, the evaluation team utilized Microsoft Excel to calculate descriptive statistics such as basic frequencies and averages, such as the number and demographics of those served, the type and number of services rendered, and the number of participants served by the program, among many others.[7] Data gathered from the **qualitative data sources**, including portions from the intake assessment form and survey, were analyzed using a systematic approach. Responses were transcribed, reviewed, and thematically analyzed to identify recurring themes and key takeaways that informed the evaluation questions.

To further bolster the findings, the evaluation team took a collaborative approach by not only analyzing the data but also hosting a virtual data party with the ALAS team. This data party provided a platform to present the initial findings, encouraging open discussion and feedback. The evaluation team invited the ALAS team to share their perspectives, offer additional context, and ensure that the interpretations were both accurate and culturally appropriate. These discussions were crucial, as they not only validated the findings but also added depth and nuance to the analysis. The insights gathered from this engagement were directly incorporated into the final findings and this report, ensuring that the results were reflective of the ALAS team's and program participants' expertise and experience.

Limitations

Like any real-world program, there are natural limitations to collecting and analyzing data. While this report provides a snapshot of the experiences of farmworkers who participated in the Farmworker Equity Express program, the following limitations should be kept in mind when

[7] See **Appendix B** for more information on additional data measures.

reviewing the findings. First, **not every participant completed the survey or joined the focus group**, meaning only a portion of feedback was gathered from those engaged with the program. For example, although eight farmworkers responded to the survey, more were involved in the program. Similarly, only eight farmworkers completed the intake assessment form, so the results might not fully represent everyone's experiences. Furthermore, the evaluation team was **unable to match data** across the datasets as there were different unique identification numbers provided in both datasets, making it challenging to understand participants' trajectory throughout the program. Additionally, **nonresponse bias** should be considered, as those who chose not to participate in the survey or focus group may have different perspectives or experiences from those who did, potentially impacting the overall findings. Additionally, because participation in the surveys was voluntary, there is the possibility of **self-selection bias**—those with particularly strong opinions, whether positive or negative, may have been more likely to participate. This could skew the results and overrepresent certain views. **Self-report bias** is also a consideration, as participants may unintentionally misrepresent their experiences, either by exaggerating or downplaying them. Another factor is **social desirability bias**, where respondents might have felt the need to provide responses they believed were more favorable or acceptable, rather than being fully candid. For example, some participants may have spoken more positively about the program than they truly felt, especially if they were reluctant to express criticism. **Recall bias** could also affect the findings, as participants were asked to reflect on past experiences, and their memories may not always be precise, especially for events that took place earlier in the year.

Limited access to data also posed a challenge, as not all requested data was provided, limiting the evaluation team's ability to triangulate findings and present a more robust view of farmworkers' experiences throughout the program. Furthermore, while the survey was offered in both English and Spanish, farmworkers who completed the survey in Spanish found the **self-stigma portion difficult to understand**, describing the Likert scale statements as confusing. As a result, the data from this section was incomplete for nearly all participants and was excluded from the evaluation. It is also important to note that throughout the findings, frequencies are used to present most of the quantitative data, such as demographic characteristics and services accessed, while averages are reported for Likert scale responses. This approach was chosen to provide a clear, accurate interpretation of the results given the **small sample size**, avoiding percentages to prevent any potential misrepresentation.

Despite these limitations, the feedback collected can help guide ALAS in refining its programming to better serve farmworkers, their families, and the broader community moving forward.

Evaluation Findings

The upcoming section shares what the evaluation unveiled in response to the evaluation questions (EQs) outlined above (see '**Evaluation Questions**' for more information). Findings are presented in a way that clearly address each question, making it easier to understand the impact the Farmworker Equity Express program has on participants in its first year of implementation. Specifically, each part of the following section is dedicated to one of the EQs: program implementation, access to services, participant outcomes, in addition to needs and best practices. It is important to note that the EQs are not mutually exclusive as findings from one area can often inform another, providing a more interconnected understanding of the program. This approach helps to give a more holistic view of the program and how its meeting the needs of program participants as well as where there may be opportunities for growth.

Photo 3. Depiction of Farmworker Equity Express Bus[8]

[8] Photo Source: ALAS Instagram - **https://www.instagram.com/alashmb/?hl=en**

EQ1. PROGRAM IMPLEMENTATION

This section highlights the Farmworker Equity Express program's first year of implementation, showcasing its adaptability, cultural responsiveness, and role as both a behavioral health resource and community support. It also details key services and challenges related to implementation.

EQ1. HOW IS THE FARMWORKER EQUITY EXPRESS PROGRAM BEING IMPLEMENTED OVER TIME?

Program Offerings

In its first year, the Farmworker Equity Express program was flexible, responsive, accessible, and culturally grounded, adapting to and meeting the unique needs of farmworkers while emphasizing cultural relevance. Of the eight survey respondents, five reported connecting to ALAS services directly through the mobile bus, highlighting the program's ability to serve a dual purpose: (1) key community resource and (2) critical behavioral health service (Figure 11). Building on the resources and knowledge from other ALAS programs, as well as being responsive to the needs of farmworkers, the Farmworker Equity Express program offered a multitude of services to farmworker participants, including a variety of groups, workshops, and classes. Beginning with the Talleres Sobre el Duelo (grief workshops) in October 2023, the program continued to develop and expand service offerings throughout its first year of implementation, such as asesoría individual (individual counseling), asesoría grupal (group counseling), exploración o evaluación (screening or

Figure 11. Survey Respondents' Connection to ALAS Services[9]

Photo 4. Pescadero Farm Food Distribution[10]

[9] Data Source: Participant Survey, 2024.

[10] Photo Source: ALAS Instagram - **https://www.instagram.com/alashmb/?hl=en**

assessment), actividades artísticas culturales (cultural arts activities), Arte como Sanación (Art as a Form of Healing group), Grupos Compadres (Friends group), Grupos Corazones de Oro (Hearts of Gold group), Taller/grupo de parejas (Couples group), Hijas de la Luna (Daughters of the Moon group), Aprendiendo y jugando (Learning and Playing group), Reinas de Corazones (Queen of Hearts group), Grupos de madres "Bebé y yo" ("Baby and Me" group). In addition, the program offered referrals to other services, field trips (e.g., Alcatraz), advocacy in the community (e.g., 555 Kelly), and provided basic needs services (e.g., food pantry) (Figure 12).

Figure 12. Farmworker Equity Express Key Services

Program Implementation Strengths

The Farmworker Equity Express program showcased multiple strengths in its implementation. A core strength of the program was its commitment to meet farmworkers' needs flexibly, often adapting service hours, locations, and offerings based on feedback from participants and staff. As a result, engagement in the program increased, as farmworkers from outside the program's network came to the mobile bus to access services. In addition, the mobile bus was creatively used for various activities, from hosting group therapy on the beach to organizing field trips for farmworkers from the older adult population. This integration of familiar and comforting settings made it easier for participants to engage. Additionally, when unexpected events like storms or incidents of community violence occurred, program staff responded promptly with disaster relief services, offering crisis support, transportation,

> "We meet the needs of the community and adapt quickly."
> – *Focus Group Participant (ALAS Staff)*

and food aid. One participant shared, ***"When the shooting occurred, they were the first to come to provide aid."*** This illustrates the program's commitment to rapid crisis response, which helped to build trust within the farmworker community. Moreover, the program's emphasis on cultural elements, like folklore dance and traditional storytelling, made participants feel understood and supported, aligning services with their cultural values and needs.

Program Implementation Opportunities for Growth

While the program demonstrated notable strengths in its culturally responsive, adaptable approach to service delivery, it also faced challenges in meeting the diverse needs of the farmworker community. At times, resource limitations prevented program staff from providing all items requested by farmworkers during mobile outreach. As such, program staff reported that partnerships with external partners became pivotal for sustaining the program, helping to supply necessary resources and expanding the program's reach. Environmental challenges, such as harsh winter storms and flooding, further complicated the program's ability to provide mobile services. These conditions not only damaged crops and worsened unpaved roads, making it difficult for farmworkers to work, but also made it challenging for the program's mobile bus to reach some remote areas. Despite this, program staff worked to adapt and overcome the situation by using a truck to provide in-the-field services until the mobile bus could be used again.

Photo 5. Farmworker Equity Express Bus[11]

[11] Photo Source: ALAS Instagram - **https://www.instagram.com/alashmb/?hl=en**

EQ2. ACCESS TO SERVICES

The following section provides a detailed overview of respondents' engagement with the Farmworker Equity Express program, including their experiences accessing and utilizing services, levels of service utilization, and the program's reach within the community.

EQ2. TO WHAT EXTENT DOES THE FARMWORKER EQUITY EXPRESS PROGRAM, A CULTURALLY RESPONSIVE MOBILE BEHAVIORAL HEALTH RESOURCE, EXPAND ACCESS TO AND UTILIZATION OF BEHAVIORAL HEALTH SERVICES IN THE LATINX FARMWORKER COMMUNITY?

Program Engagement

Throughout the first year of implementation, **the Farmworker Equity Express program made significant strides in breaking down barriers to behavioral health care, effectively expanding farmworkers' access to and utilization of behavioral health services.** By incorporating the mobile bus, the program reduced common barriers such as transportation, cost, and time, making it easier for farmworkers to engage in the services offered.

> "The bus brings mental health services to those that can't come to the ALAS office. We're able to go to them."
>
> - *Focus Group Participant (ALAS Staff)*

> "[This program], it helps you become aware that [mental health] is very important to take care of."
>
> - *Focus Group Participant (Farmworker)*

Culturally relevant activities and an emphasis on relationship-building were also key program elements that influenced how farmworkers engaged with services. Together, the

mobile bus, culturally-tailored services, and focus on relationships, helped program participants to feel understood and valued, creating an environment where participants were comfortable sharing sensitive information related to their mental and behavioral health—topics they were not accustomed to speak about. One farmworker focus group participant shared that, in the Latinx culture, people are often encouraged to ignore feelings like sadness unless there is physical pain, but through this program, they realized the importance of caring for their mental health as much as their physical health. Similarly, another farmworker focus group participant pointed out how the program has helped them to talk about their trauma.

> "...We all carry some trauma inside of us or something that is good for us to talk about and they have helped me a lot in doing that."
>
> - *Focus Group Participant (Farmworker)*

Program Awareness

Initially, farmworkers were not fully aware of the mobile bus's purpose or the services it provided. In response, program staff organized a welcoming event, inviting farmworkers to a get-together with music, food, and activities to introduce the bus and explain its offerings. This gathering not only clarified the bus's role but also further strengthened farmworkers' trust and interest in the services. To further enhance service accessibility, the mobile bus also offered telehealth services and educational activities, broadening the ways farmworkers could engage with these services.

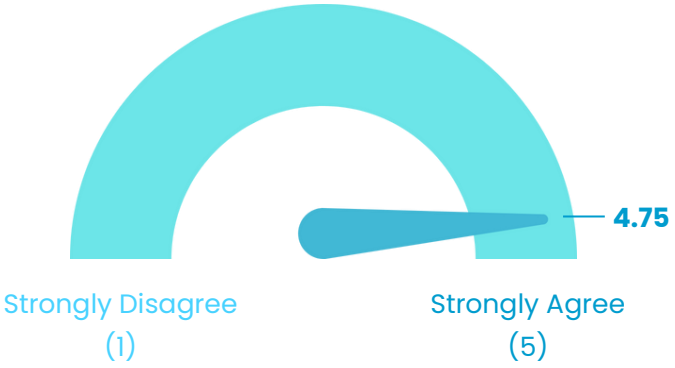
Service Accessibility

The Farmworker Equity Express program prioritized accessibility by ensuring services were culturally responsive, resource-oriented, and conveniently delivered. On average,[12] participant survey respondents strongly agreed (4.75 out of 5) that the program's groups and services aligned well with their cultural beliefs and values, with seven out of eight respondents rating this aspect a five, and only one rating it a three (Figure 13). Additionally, respondents felt well-supported (4.75 out of 5) by staff, with six out of seven respondents indicating that staff connected them to other helpful resources and services, with six respondents giving a rating of five and one respondent rating it at three. The program's

[12] The ratings our based on a five-point Likert scale with 1=strongly disagree, 2=disagree, 3=neutral, 4=agree, and 5=strongly agree.

scheduling and locations were also appreciated, as respondents reported that the groups were held at times and places that fit well with their availability; seven out of eight respondents rated this a five, with one rating it a three. Language accessibility was another key strength, with all eight respondents agreeing that services were offered in their preferred language, predominantly Spanish, and seven respondents rating this a five and one respondent rating it a three. These findings reflect the program's dedication to making behavioral health services accessible and responsive to the specific needs and cultural backgrounds of the farmworker community.

Figure 13. Participant Survey Respondents' Experiences with Service Accessibility, April-June 2024, N=8[13]



*On average, participant survey respondents **strongly agreed** that:*	**N**
• Groups and services are **relevant** to their **culture** and **beliefs**.	8 out of 8
• Staff **connected** them to **other helpful resources** and **services**.	7 out of 8
• Groups were **held** at **convenient times** and **locations**.	8 out of 8
• Groups were **offered in** their **preferred language**.	8 out of 8

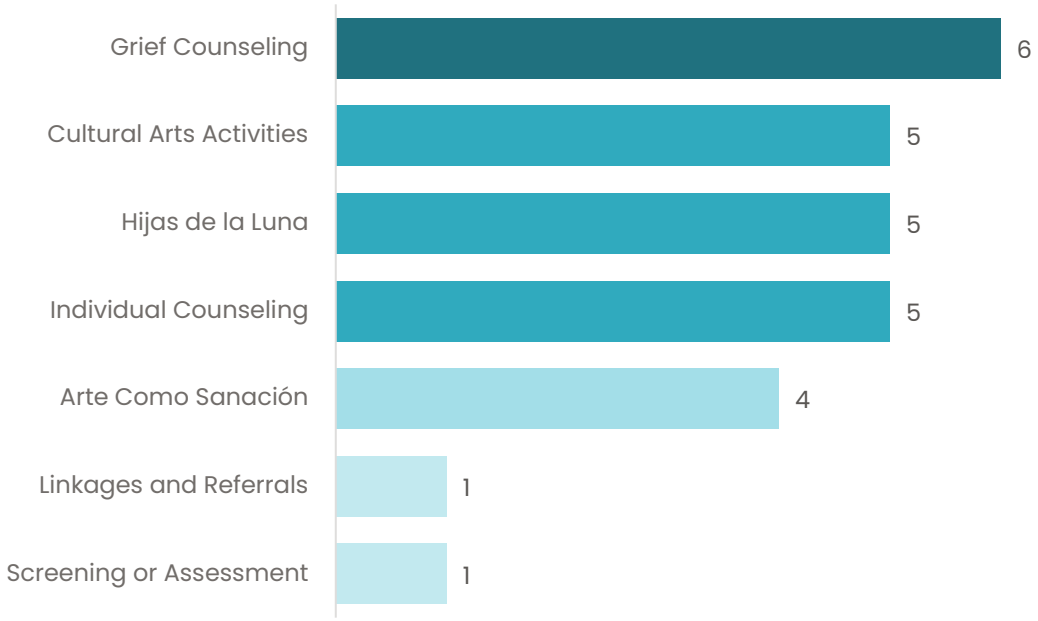
Service Utilization

There were varied levels of engagement across Farmworker Equity Express program services, with certain offerings utilized more frequently than others. Among the eight survey respondents, grief counseling emerged as the most widely accessed service, with six respondents indicating they used it. Cultural arts activities, Hijas de la Luna, and individual counseling were also popular, with five respondents selecting each of these as services they engaged with regularly. Less than five respondents (<5) participated in Arte Como Sanación (four respondents), linkages and referrals (one respondent), as well as screening and

[13] Data Source: Participant Survey, 2024.

assessment services (one respondent). These findings suggest that the program's services that are responsive to the needs of the farmworker community and culturally relevant may be more familiar to the farmworker community. Thus, more awareness of the less utilized services may be needed.

Figure 14. Participant Survey Respondents' Utilization of Services, April-June 2024, N=8[14]



Demographic Characteristics of Respondents

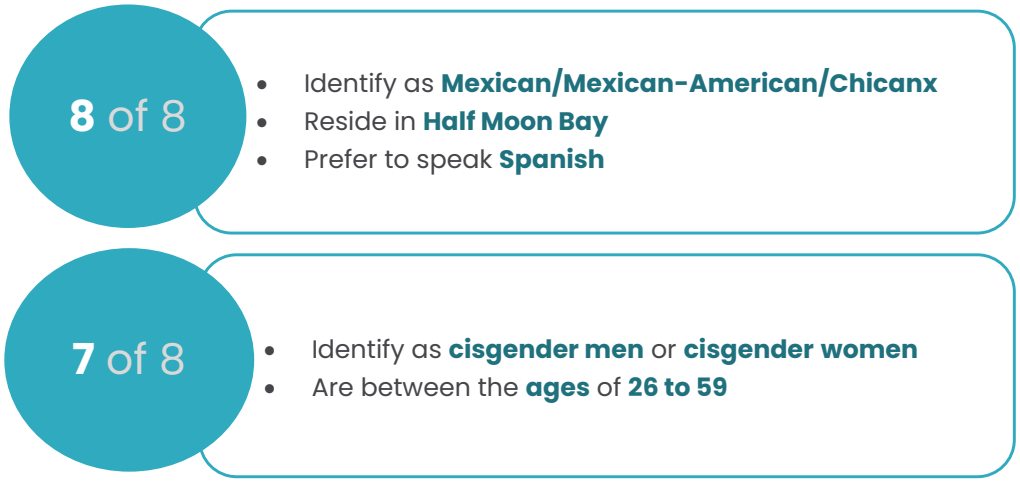
Demographic data helps identify whether the program is effectively reaching its target population, Latinx farmworkers, and allows program staff to make adjustments to better serve underrepresented groups. Additionally, this information ensures that Farmworker Equity Express's culturally grounded programming resonates with the diverse identities within the Latinx community. By continuing to check in with the demographics of those that are engaging with the program, program staff can ensure that they are continuing to seek out new voices, unique points of view, and members from all corners and facets of the community to continue to enrich and grow the Farmworker Equity Express.

The Farmworker Equity Express program primarily served a culturally and linguistically unified group of farmworkers, reflecting a strong alignment with the community's identity. All eight intake assessment respondents identified as Mexican, Mexican-American, or Chicanx, and all resided in Half Moon Bay. Similarly, all respondents preferred to receive services in Spanish, underscoring the importance of offering language-accessible support.

[14] Data Source: Participant Survey, 2024. It is important to note that survey respondents were able to select more than one service.

Seven out of eight identified as either a cisgender man or woman, and the majority fell within the 26-59 age range. These demographics may indicate that the program is reaching a significant segment of the farmworker community in Half Moon Bay, particularly those who identify closely with Latinx and Mexican cultural backgrounds.

Figure 15. Demographic Characteristics of Intake Assessment Form Respondents, April-June 2024, N=8[15]



[15] Data Source: Intake Assessment Form, 2024.

EQ3. PARTICIPANT OUTCOMES

The following section examines how the Farmworker Equity Express program, through its integration of cultural arts and formal clinical services, supports behavioral health service adoption and enhances outcomes among the Latinx farmworker community. It explores improvements in participants' behavioral health, quality of life, cultural and community connections, and highlights the mutual impact between program staff and participants.

EQ3. TO WHAT EXTENT DOES THE FARMWORKER EQUITY EXPRESS PROGRAM, AN INTEGRATED APPROACH USING CULTURAL ARTS AND FORMAL CLINICAL SERVICES, SUPPORT BEHAVIORAL HEALTH SERVICE ADOPTION AND OUTCOMES AMONG THE LATINX FARMWORKER COMMUNITY?

Behavioral Health and Quality of Life

Farmworker Equity Express program activities have made a positive impact on participants' behavioral health, quality of life, cultural connection, and adoption of mental health services – all essential protective factors. Focus group discussions with program participants and staff revealed perceived and observed improvements in participants' emotional wellbeing, trust, and coping skills. Groups like *Corazones de Oro* and *Reinas de Corazones* provided safe spaces for discussing sensitive mental health issues, helping to cultivate trust and a sense of security among participants. Additionally, cultural activities, such as Mariachi sessions and Mexican dance classes, helped participants reconnect with their heritage, making them feel understood, comfortable, and valued. This combination of cultural and interactive elements such as painting, folklore dance, and grief groups helped reduce stress and stigma around mental health, creating a supportive environment for emotional expression. For example, including games like Loteria and Jenga helped to promote emotional expression, built trust, and improved

> "...the game of Loteria...something I grew up with, and they grew up with...how important that game is rooted in culture and their upbringing, great to see them be themselves."
>
> – *Focus Group Participant (Cultural Arts Provider)*

participation, further enhancing engagement, with one program staff focus group participant reflecting on these activities, sharing. Many participants reported that mobile outreach and consistent support from staff helped them manage trauma and develop coping skills, further enhancing their quality of life.

Furthermore, the program's culturally integrated approach has effectively promoted both acceptance and sustained use of behavioral health services among the Latinx farmworker population. Participant survey results revealed that respondents, on average, felt very comfortable reaching out to ALAS staff for future resources and services, with six out of eight respondents rating their comfort level a five, one rating it a four, and one a three (Figure 16). This comfort level, built through culturally tailored activities and trust-building efforts, has led respondents to engage with services they might otherwise avoid. In focus groups, participants shared that the program's supportive environment helped them see mental health as equally important as physical health, challenging cultural norms around ignoring emotional pain. Half of participant survey respondents (four out of eight) specifically reported that therapy or community connections had positively impacted their mental health, illustrating the program's role in normalizing behavioral health care within the farmworker community.

Figure 16. Participant Survey Respondents' Level of Comfort Reaching out to ALAS Staff, April-June 2024, N=8[16]

*On average, participant survey respondents **strongly agreed** that:*	**N**
• I feel **comfortable reaching out** to ALAS staff in the future for **resources** and **services**.	8 out of 8

[16] Data Source: Participant Survey, 2024.

Most participant survey respondents expressed satisfaction with the Farmworker Equity Express program. Five out of six participant survey respondents reported satisfaction with the services provided, with one farmworker focus group participant noting that they especially appreciated the support received from the program. In addition, seven out of eight respondents noted they learned something useful through their participation in the program.[17]

> "More than anything, [I like] the support that ALAS gives us. The support is the best."
>
> - *Focus Group Participant (Farmworker)*

Cultural and Community Connection

Participant survey data showed that the program significantly strengthened participants' connection to their culture and community, serving as additional protective factors. All eight survey respondents strongly agreed that they felt more connected to their cultural roots and the broader community while participating in the program, with each respondent rating this aspect a five out of five (

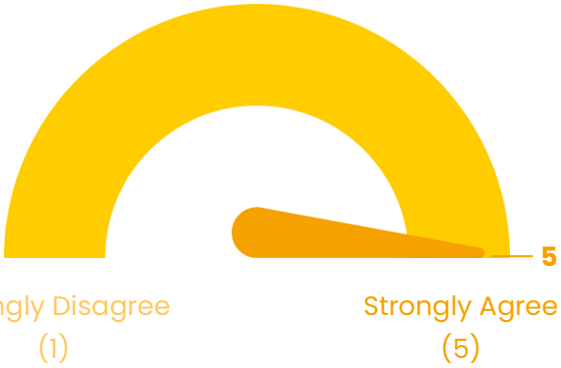
> "…cultural connection is very important as culture has no language…When you have the opportunity to explore [your] culture, you enter another dimension that helps your mental health."
>
> - *Focus Group Participant (Cultural Arts Provider)*

Figure 17). This further reflects the success of the program's culturally responsive approach, which was integral in helping participants feel grounded and understood. Programs like Reinas de Corazones have provided a safe space for participants to release stress and feel comfortable expressing themselves. This blend of cultural connection and community engagement has allowed participants to experience a renewed sense of belonging, emotional release, and empowerment, further underscoring the program's impact on their overall well-being.

> "…We've seen people who were very shy suddenly talking and expressing themselves differently."
>
> - *Focus Group Participant (Cultural Arts Provider)*

[17] Data Source: Participant Survey, 2024.

Figure 17. Participant Survey Respondents' Level of Cultural and Community Connection, April-June 2024, N=8[18]



*On average, participant survey respondents **strongly agreed** that:*	**N**
• I felt connected to my culture.	8 out of 8
• I felt connected to my community.	8 out of 8

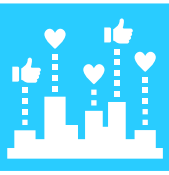
> "...With me, they can open up; some have cried, and they feel comfortable."
>
> - *Focus Group Participant (Cultural Arts Provider)*

While program staff and cultural arts providers positively impact participants, **the participants, in turn, leave a lasting impression on the staff and providers**. A cultural arts provider focus group participant recalled a powerful moment when a farmworker participant shared that the staff and cultural arts providers are important to the participants just as the participants are important to the staff and providers, highlighting the reciprocal relationship and deep connection formed through the program.

> "You are important to me, and I am important to you."
>
> - *Focus Group Participant (Cultural Arts Provider)*

[18] Data Source: Participant Survey, 2024.

EQ4. NEEDS AND BEST PRACTICES



The following section outlines the key needs and best practices identified by the Farmworker Equity Express program to support farmworker behavioral health.

EQ4. TO WHAT EXTENT DOES THE FARMWORKER EQUITY EXPRESS PROGRAM IDENTIFY THE NEEDS AND BEST PRACTICES TO SUPPORT FARMWORKER BEHAVIORAL HEALTH?

As this program is an INN program, it is important to document the needs and best practices to support farmworker behavioral health. Intake assessment form results revealed that respondents, on average, rated their overall mental health and mental health over the past 30 days as "slightly good", with average scores of 2.75 out of 5 and 2.62 out of 5, respectively (

Figure 18).[19] Responses ranged from two to four, with most respondents giving a score of two or three, reflecting room for improvement in respondents' mental health status. Respondents rated their ability to cope with mental health symptoms as "good" (3 out of 5 on average), with one respondent rating it at a five and five rating it at a three. For coping with daily stressors, the average rating was "slightly good" (2.75 out of 5), with six participants rating it at a three and two rating it a two (Figure 19). Similarly, the ability to manage daily life activities was rated as "slightly good" (2.75 out of 5), suggesting that respondents experience moderate challenges in daily functioning (Figure 20).

[19] The intake assessment form statements were rated using a 5-point Likert scale with 1=Poor, 2=Fair, 3=Good, 4=Very Good, and 5=Excellent.

Figure 18. Intake Assessment Form Respondents' Mental Health Self-Ratings, April-June 2024, N=8[20]

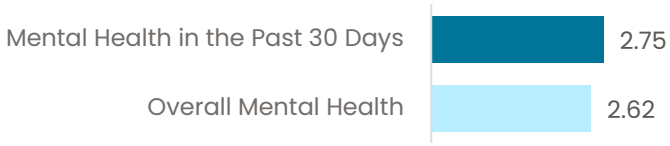


Figure 19. Intake Assessment Form Respondents' Coping Ability Self-Ratings, April-June 2024, N=8[21]

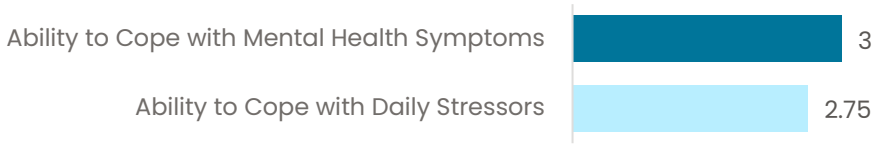
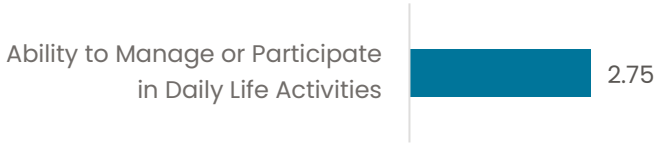


Figure 20. Intake Assessment Form Respondents' Participation in Daily Life Self-Rating, April-June 2024, N=8[22]

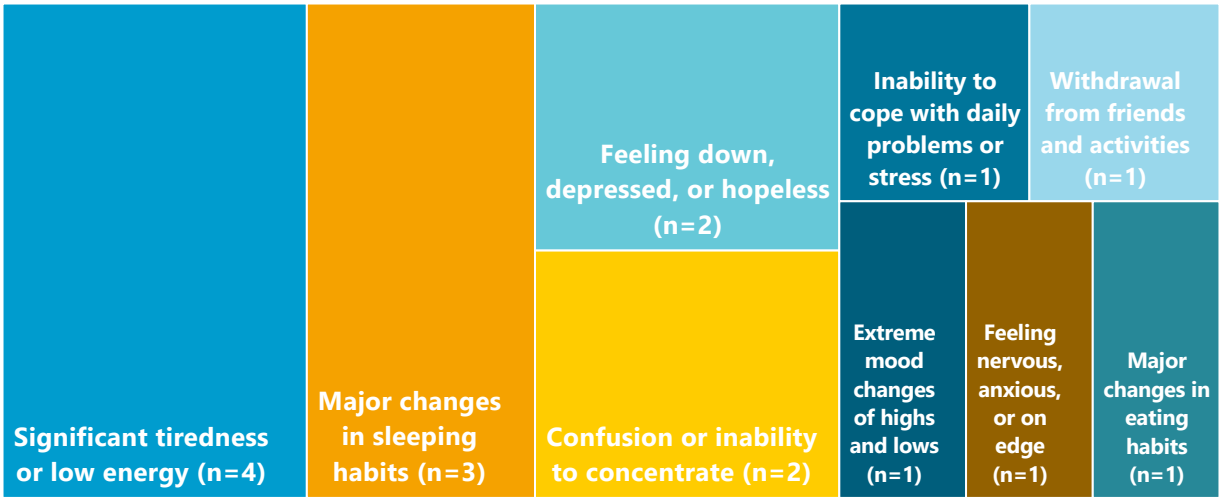


At intake, assessment respondents reported experiencing multiple co-existing behavioral health symptoms, with the most common being significant tiredness or low energy (reported by four respondents), major changes in sleeping habits (three respondents), feelings of depression or hopelessness (two respondents), and confusion or difficulty concentrating (two respondents). This range of symptoms highlights the complexity of participant needs and underscores the necessity of a robust approach to behavioral health support (

[20] Data Source: Intake Assessment Form, 2024.
[21] Data Source: Intake Assessment Form, 2024.
[22] Data Source: Intake Assessment Form, 2024.

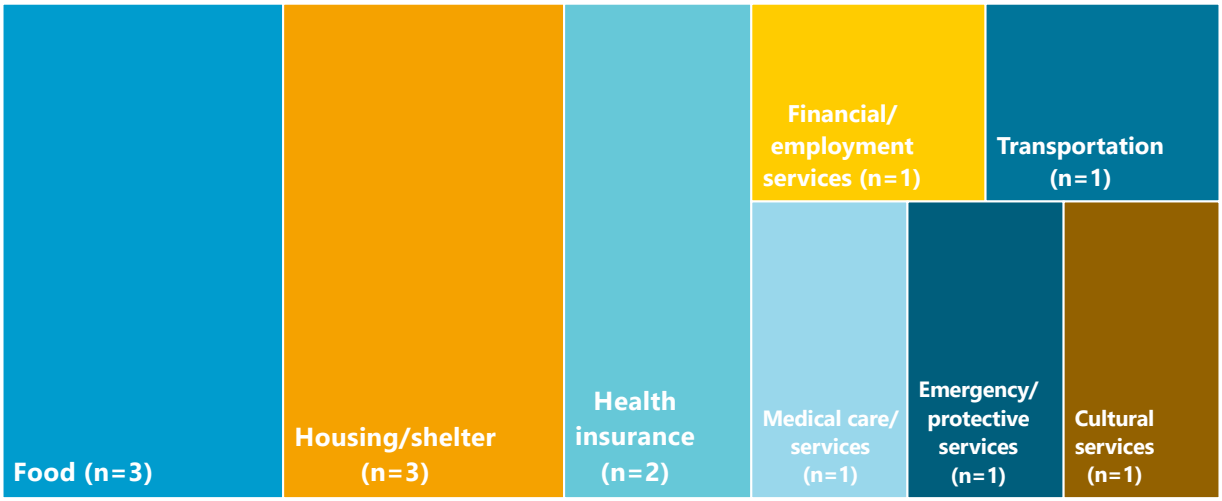
Figure 21).

Figure 21. Intake Assessment Form Respondents' Behavioral Health Symptoms at Intake, April-June 2024, N=5[23]



Additionally, assessment form respondents expressed needs for basic supports at intake, with food and housing or shelter identified as the most common needs (each by three respondents), followed by health insurance (two respondents). These findings indicate that the program's behavioral health support is strengthened by addressing broader socioeconomic needs, as these factors heavily influence participants' mental health and stability (Figure 22).

Figure 22. Intake Assessment Form Respondents' Supports Needed at Intake, April-June 2024, N=6[24]



[23] Data Source: Intake Assessment Form, 2024.

[24] Data Source: Intake Assessment Form, 2024.

Focus group discussions with staff unveiled important perspectives into the unique needs of the farmworker community and the best practices that have proven effective. Staff emphasized the importance of language-specific services, mental health education, and trauma-informed care tailored to the emotional challenges that farmworkers commonly face (Figure 23). Best practices identified to address these needs included involving the community in program design, providing ongoing cultural competency training for providers, and utilizing the mobile bus to reduce barriers related to transportation and remote locations. Staff also highlighted the importance of remaining flexible and adaptable to environmental challenges, such as weather or community incidents, to maintain continuity of care.

Figure 23. Additional Participant Needs Identified by Program Staff

Looking ahead, the Farmworker Equity Express program's experience provides lessons learned and best practices that can inform future behavioral health programs who service underserved communities. Key practices, such as community involvement in program design, ongoing cultural competency training for staff, and a trauma-informed approach tailored to the unique challenges farmworkers face, are promising in enhancing the program's impact. As the program continues to evolve, these strategies will remain central to ensuring that behavioral health services remain accessible, relevant, and responsive to the diverse needs of farmworkers. As it moves forward, the program's ongoing commitment to adapting and expanding its services will continue to strengthen its role as a trusted resource, improving behavioral health outcomes and quality of life for the farmworker community.

Recommendations

Based on findings from the first year of the Farmworker Equity Express program, several recommendations can help to improve the program's impact and sustainability. These recommendations focus on expanding current successes, addressing participant needs, and further strengthening program delivery.

- **Expand Awareness of Referrals and Screening Services.** Since few respondents utilized linkages, referrals, and screening services, consider enhancing communication around these offerings. Staff could integrate information about these services into popular sessions like grief counseling or cultural arts activities to boost awareness and understanding of the benefits they provide.
- **Promote Cross-Participation.** Encourage participants in popular groups, like Hijas de la Luna or Arte Como Sanación, to explore other services that may support their needs, such as individual counseling or assessments. A brief introduction to available services at the start or end of each group session could help participants consider other resources that might be beneficial.
- **Additional Outreach to Younger and Older Age Groups.** Since the majority of participants were between the ages of 26-59, additional outreach might help engage younger or older farmworkers who could benefit from the program. Tailoring services to the interests and needs of these age groups, such as youth-focused workshops or elder-specific support, could increase their engagement.
- **Enhance Stigma Reduction Efforts.** Building on current success, consider additional anti-stigma activities, such as storytelling or peer-led sessions, to further normalize mental health discussions within the community.
- **Evaluate Less Utilized Services.** Consider gathering feedback from participants on why services like linkages, referrals, and screenings are less utilized. This may reveal insights into possible adjustments in service delivery or indicate a need for more culturally relevant adaptations.
- **Encourage Greater Participation in Program Evaluation Activities.** Encouraging higher engagement in evaluation activities will ensure the program continues to reflect the evolving needs of the farmworker community and can support meaningful improvements based on participants' input. Additionally, exploring reasons for low participation in evaluation activities during the first year may reveal barriers that can be addressed to enhance future engagement.

Appendices

Appendix A. Detailed Implementation Timeline

Month/Year	Farmworker Equity Express Implementation Updates
Jul 2023	• ALAS and RDA completed the evaluation kickoff meeting this month • Mobile BHS for Farmworkers project launch was supposed to take place in July 2023; however, there were contracting approval delays on behalf of the Board of Supervisors, which pushed the project launch to August 2023.
Aug 2023	• ALAS launched the project this month • ALAS continued to think through ideas for mental health services and how to engage with clients for individual therapy • ALAS and RDA completed the first evaluation planning session this month
Sep 2023	• ALAS continued to think through ideas for mental health services, including many ideas focused on de-stigmatization and ideas that incorporate the arts • ALAS planned to begin a monthly Grief workshop for Dia de los Muertos at the beginning of October. This was especially needed in light of the recent violence and community member deaths in Half Moon Bay (and over the last few years) • ALAS planned to use monthly thematic workshops as a pipeline to connect clients to other services (e.g., individual therapy) • ALAS started Corazones de Oros this month, a monthly support group for seniors, facilitated by the USF psychologist and mental health team. This will focus on psychoeducation and depression prevention, as well as tracking depressive symptoms and treatment satisfaction. • ALAS and RDA completed the second evaluation planning session this month
Oct 2023	• ALAS held first Grief workshop this month for Dia de los that involved going to the ranch, learning about grief and the connection to skull painting, food, and outreach • ALAS mental health team held a breakfast social event with the farmworker team to get acquainted and facilitate communication. They planned to resume these breakfasts once monthly. • ALAS had 100 participants join the Half Moon Bay pumpkin festival, 20 of which were farmworkers. • ALAS and RDA completed the third evaluation planning session this month • Although ALAS had intended to form and convene and Advisory group, this was ultimately delayed until May 2024. The team spent the Fall of 2023 working to identify key leaders from the Farmworkers community for the board. In October

Month/Year	Farmworker Equity Express Implementation Updates
	2023, RDA engaged in discussions and shared a resource guide with ALAS to help support the development of their advisory board.
Nov 2023	• ALAS concluded the series of 3 Grief workshops this month, and these went really well. The mental health team noticed that attendance got a bit smaller at each successive group, but they weren't sure about the reason for this. • ALAS confirmed they will be offering the following services as part of the program: grief groups, accordion groups, compadres groups, and Corazones de Oro • ALAS outreached individually to folks who might be interested in joining the Advisory Group. David confirmed he would be a member of the group. • ALAS continued to think through appropriate channels/methods for a client referral system.
Dec 2023	• ALAS worked to finalize their referral system protocol and tracking system this month • ALAS planned to re-evaluate their services and programming in the new year • ALAS planned to develop and convene their advisory group around the end of January 2024 • ALAS noted that recent storms have made it difficult for farmworkers to get to work, which has shifted how the program connected with the Farmworker community (e.g., using truck instead of bus). Ultimately, many farmworkers were out of work completely (with a ruined crop) starting in Dec 2023 due to the storms, and this impacted their ability to get services in some cases.
Jan 2024	• This month, the Half Moon Bay community held a memorial for the victims of a mass shooting one year ago
Feb 2024	• ALAS welcomed a new program director for Farmworkers this month, Sandra! • ALAS saw an uptick in referrals from farmworkers and intakes this month, due to the farmworker team proactive engagement and work to recruit trainees • ALAS worked to finalize the paperwork for the mobile van and figure out how to engage folks in services in the field, due to the current demand • ALAS continued to provide services this month, including the Corazones de Oro group for older adults, a workshop focused on narrative approaches led by the mental health team, and individual therapy. • ALAS began screening couples this month in preparation for a new "couples group" they planned to start in April 2024
Mar 2024	• ALAS held a staff training on data collection tools this month • ALAS started a new group this month, "Art for Healing and Resistance", facilitated by licensed social workers • ALAS hosted RDA for a site visit as part of the evaluation activities. RDA trained staff on focus group facilitation, facilitated a staff focus group, and participated/observed the group "Art for Healing and Resistance" (second session)
Apr 2024	• ALAS started a couples workgroup this month, focused on psychoeducation and led by the mental health team

Month/Year	Farmworker Equity Express Implementation Updates
	• ALAS attended a meeting with the housing commission regarding the "555 Kelly" city housing project, with many senior farmworkers in attendance to share their stories and advocate that the 555 Kelly property be used as housing for senior farmworkers. • ALAS prepared for first advisory group convening to take place in May • ALAS continued to engage staff this month in meetings and trainings, as well as working to better delineate "Farmworkers" services at ALAS from other program services at ALAS • ALAS had been using a truck to do Farmworker field outreach because the bus had not been operational for a period. The team discussed ways to overcome barriers to accessing certain farm communities (e.g., bus has hard time reaching very tiny farms without paved roads) • ALAS noted that Farmworkers had been out of work due to the storms. But this month, Second Harvest was able to deliver food to farmworkers in a little mini van.
May 2024	• ALAS finalized activities for a first annual "Wellness Day" at a park, with different stations for self-care, psychoeducation, traditional healers, and a raffle. • ALAS hosted the first advisory group meeting on May 7th. • ALAS got the mobile bus back up and going to farms four days a week to engage and recruit participants for the program. • ALAS started piloting drop-in crisis hours both on the bus and on-site as another method of engaging/enrolling farmworkers who don't already have appointments. • ALAS learned this month that the 555 Kelly housing project was approved as housing for farmworkers! • ALAS has continued to try using every program within ALAS to be creative in meeting community needs (e.g., staff from other ALAS programs can access bus to introduce themselves to farmworkers community).
Jun 2024	• ALAS hosted their program's 10-year anniversary gala this month! • ALAS hosted an event for female farmworkers at the county fair this month. They had the mobile bus there, and the event was recognized by the board of supervisors. • ALAS noticed that the food pantry program has been a successful/common initial entry point for prospective participants to connect to the program, get a case manager, referrals, and mental health. "It's so much more than just getting a bag of food". • ALAS shared that bulk of farmworker crop was ruined or delayed due to the storms, and many farmworkers remained out of work since Dec 2023.

Month/Year	Farmworker Equity Express Implementation Updates
	• ALAS found that it was challenging for their small team of staff to bring services and food to 30 farms each month, especially as they also facilitate health resources, workshops, and other grant projects. During one of the evaluation focus groups with farmworkers, staff responded to feedback from participants that ALAS had not been to their specific farm in awhile, which allowed staff to be responsive to the feedback and prioritize outreach there next (which they did). • ALAS has had some staffing shifts as a result of their operations office restructuring. • ALAS attended three planning commission meetings for the 555 Kelly project after it was approved (for appeals process, public comment). • ALAS planned for their upcoming community advisory board (CAB) meeting

Appendix B. Learning Goals, Evaluation Questions, Data Indicators and Measures, and Data Sources

LEARNING GOAL	PROCESS EVALUATION		
	Evaluation Question	**Data Measures**	**Data Sources**
To assess and improve the implementation of the Mobile BHS for Farmworkers program to ensure it effectively meets participant needs, fosters collaboration, and delivers quality services.	How is the Mobile BHS for Farmworkers program being **implemented over time**?	• Successes and/or challenges to implementation • Adaptations to implementation in response to participant needs	• Farmworker Equity Express staff focus group • Participant focus group • Evaluation meeting notes

		• Demographics of participants served • Total number of participants served • Total, count, and type of services provided • Collaboration • Staff support • Staff satisfaction • Type of culturally responsive interventions used • Participants' behavioral health needs met • Program elements that contributed to participant engagement • Program elements that contributed to participant perceived outcomes	• Participant survey • Cultural art provider(s) focus group • Program observation checklist
To determine the extent to which the Mobile BHS for Farmworkers program enhances access to and utilization of behavioral health services among the Latinx farmworker community, while reducing stigma and increasing awareness of available resources.	**OUTCOME EVALUATION**		
	To what extent does the Mobile BHS for Farmworkers program, a culturally responsive mobile behavioral health resource, **expand access to and utilization of**	• Count of farmworkers/families served by mobile service • Count of farmworkers/families linked	• Intake assessment form • Participant survey • Participant focus group

	behavioral health services in the Latinx farmworker community?	to behavioral health services • Count of farmworkers/families attending behavioral health service appointments • Count of farmworkers/families who experienced increased access to behavioral health services • Count of farmworkers/families who experienced increased awareness of mental health and behavioral health • Count of farmworkers/families who experienced increased knowledge of mental health and behavioral health	• Farmworker Equity Express staff focus group
To examine the extent to which the Mobile BHS for Farmworkers program improves behavioral health service adoption and outcomes within the Latinx farmworker community, integrating cultural arts activities with formal clinical services, ultimately improving mental and behavioral health along with quality of life.	To what extent does the Mobile BHS for Farmworkers program, an integrated approach using cultural arts and formal clinical services, support behavioral health **service adoption and**	• Demographics, count of farmworkers/families participating in cultural arts activities • Farmworker satisfaction with cultural arts activities and behavioral health services	• Intake assessment form • Participant survey • Participant focus group • Farmworker Equity Express staff focus group

	outcomes among the Latinx farmworker community?	• Count and average of farmworkers who report experiencing increased protective factors and improved behavioral health outcomes • Type and count of referrals and linkages to other resources and services (e.g., basic needs) • Count and average of farmworkers who report experiencing improved mental health • Count and average of farmworkers who report experiencing improved quality of life	• Cultural art provider(s) focus group

To identify and document the needs, best practices, and lessons learned from the Mobile BHS for Farmworkers program, ensuring its adaptability for replication and scaling in other counties implementing similar programs to better support farmworker behavioral health.	To what extent does the Mobile BHS for Farmworkers program identify the **needs and best practices** to support farmworker behavioral health?	• Most commonly identified behavioral health symptoms and causes • Most commonly identified unmet basic needs • Most highly rated program components • Program modifications made over time in response to client and staff feedback • Reported lessons learned	• Intake assessment form • Participant focus group • Farmworker Equity Express staff focus group • Evaluation meeting notes

APPENDIX 12. MUSIC THERAPY FOR ASIANS/ASIAN AMERICANS INN EVALUATION REPORT, FY 2023–24

PROGRAM EVALUATION REPORT

2023-24

San Mateo County
Mental Health Services Act (MHSA)

NEMS NORTH EAST MEDICAL SERVICES
NORTH EAST MEDICAL SERVICES
東 北 醫 療 中 心
a california health+ center

INN PROJECT: MUSIC THERAPY FOR ASIANS/ASIAN AMERICANS

Year 1: 2023-24

Creative Vibes
Music Therapy

Evaluation report prepared by:
Community Connections | Psychological Associates

Program Evaluation Report
for the INN project
Music Therapy for Asians/Asian Americans

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2023-24 Program Evaluation Report
Music Therapy for Asians/Asian Americans
San Mateo County, California

BACKGROUND

As part of their MHSA Innovations (INN) Initiatives for FY 2024-26, San Mateo County funded and supported the "Music Therapy for Asian Americans" Innovations project. Aims of the project are to "provide music therapy for Asian/Asian Americans as a culturally responsive approach to reducing stigma, increasing behavioral health literacy, and promoting linkage to behavioral health services. Additionally, music therapy will enhance interpersonal skills and foster connectedness and unity across Asian American communities, thereby building protective factors that can prevent behavioral health challenges and crises" (MHSA Music Therapy for Asians/Asian Americans INN Project Plan, page 4).

San Mateo County engaged Creative Vibes Music Therapy and North East Medical Services (NEMS) to manage and deliver the Music Therapy for Asian Americans program. These organizations are described below.

North East Medical Services (NEMS) is a non-profit community health center serving medically underserved areas and populations in San Francisco, San Mateo, and Santa Clara counties in California. NEMS' mission is to provide affordable, comprehensive, compassionate, and quality health care services in a linguistically competent and culturally sensitive manner to improve the health and well-being of its community. Creative Vibes Music Therapy is a private practice that uses a resource-oriented approach to providing music therapy, grounded in the belief that individuals have the inherent capacity to achieve their goals and that music therapy should focus on enhancing existing strengths and abilities. Creative Vibes' goal is to support and empower their clients as they navigate their unique journey towards health and well-being.

Through the MHSA INN Project, NEMS and Creative Vibes have partnered together to create and implement the Music Therapy for Asian Americans Program, which provides culturally and linguistically appropriate music therapy and behavioral health (BH) peer support groups catered towards Asian/Asian American residents of San Mateo County. The program consists of ten weekly sessions of group music therapy classes and a BH peer support group for elementary, middle, and high school students, as well as adults and seniors. Music therapy is a creative arts therapy that utilizes all aspects of music (both receptive and creative), is easily adapted to each person's needs, and can benefit people of all ages and abilities. The music therapy classes will provide culturally responsive, goal-directed music therapy programming, while the BH peer support groups will focus on building connections and empathy amongst participants. Creative Vibes provides the music therapy programming while NEMS leads the BH peer support groups. The goal of the program is to promote music therapy as a culturally responsive approach to reducing stigma within the Asian community, increasing BH literacy, and promoting linkage to BH services within San Mateo County.

Evaluation Team

San Mateo County engaged Community Connections Psychological Associates, Inc. (CCPA; project lead Joyce Chu, Ph.D., program evaluator and licensed clinical psychologist) to conduct program evaluation services, including developing and implementing an evaluation system, and

conducting mixed-method analysis of quantitative and qualitative data. Aims of the evaluation work are to determine the program's effectiveness and make data-driven recommendations. These recommendations are intended to inform iterative changes as the program innovates to meet the needs of its target communities over a three year duration. The current report details the results and recommendations from the first FY2023-24 program participant cohort.

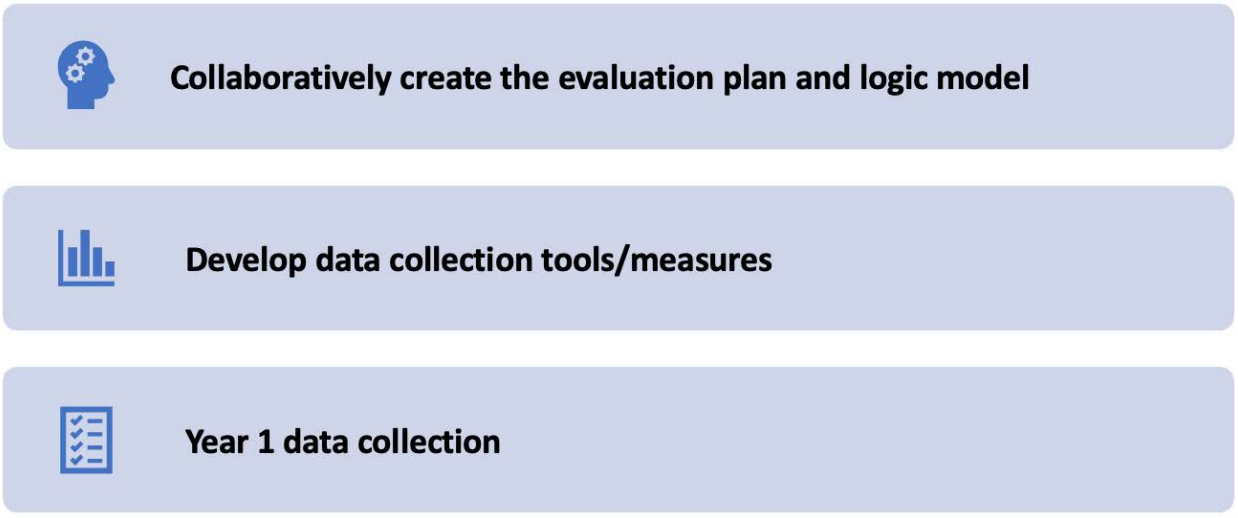
Towards these evaluation goals, CCPA aims to provide the following services over the course of the project:

- Collaboratively develop and implement a comprehensive program evaluation plan inclusive of a logic model and associated outcomes and measures. This program evaluation plan will align with program goals and objectives, and will include identification of data collection measures, variables, tools, and methods. Provide consultation to project leads as they collect data within the Music Therapy for Asian Americans Program implementation.
- Collaboratively ensure that program evaluation activities are responsive to the unique cultural elements and needs of the targeted Asian American communities in San Mateo County.
- Collaborate with the identified project leads to ensure the program evaluation plan fits with program, community, and regulatory needs.
- Collaborate with County MHSA personnel to ensure that evaluation plans and reports meet MHSA regulations.
- Conduct formative evaluation activities to evaluate progress of the project.
- Complete data analysis and draft annual data reports.

METHODOLOGY

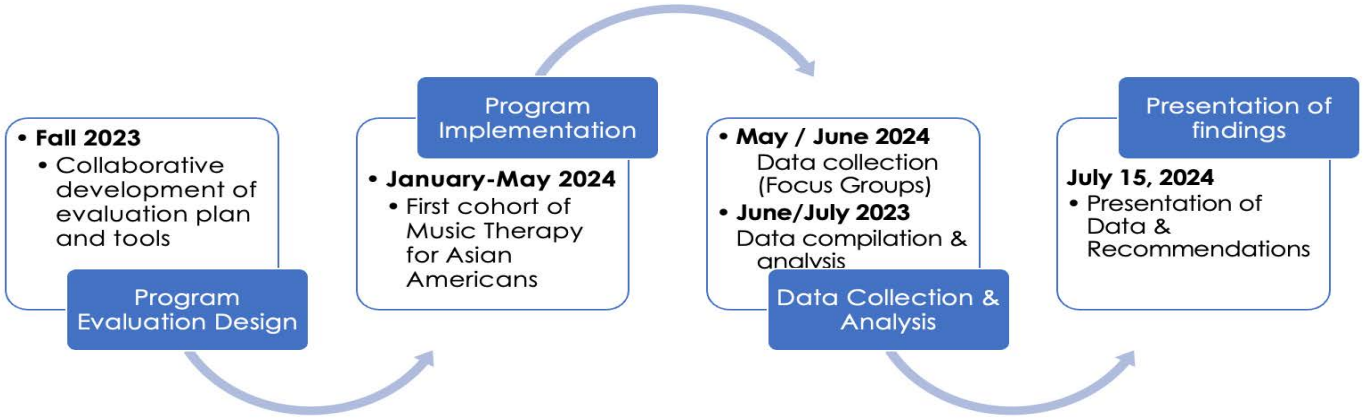
Evaluation Goals for FY24

The first half of the first FY24 project year (approximately August 2023 through August 2024) was focused on program development and management by the North East Medical Services (NEMS) and Creative Vibes Music Therapy staff. Evaluation goals (depicted below) focused on development of the evaluation plan and associated evaluation tools/measures.



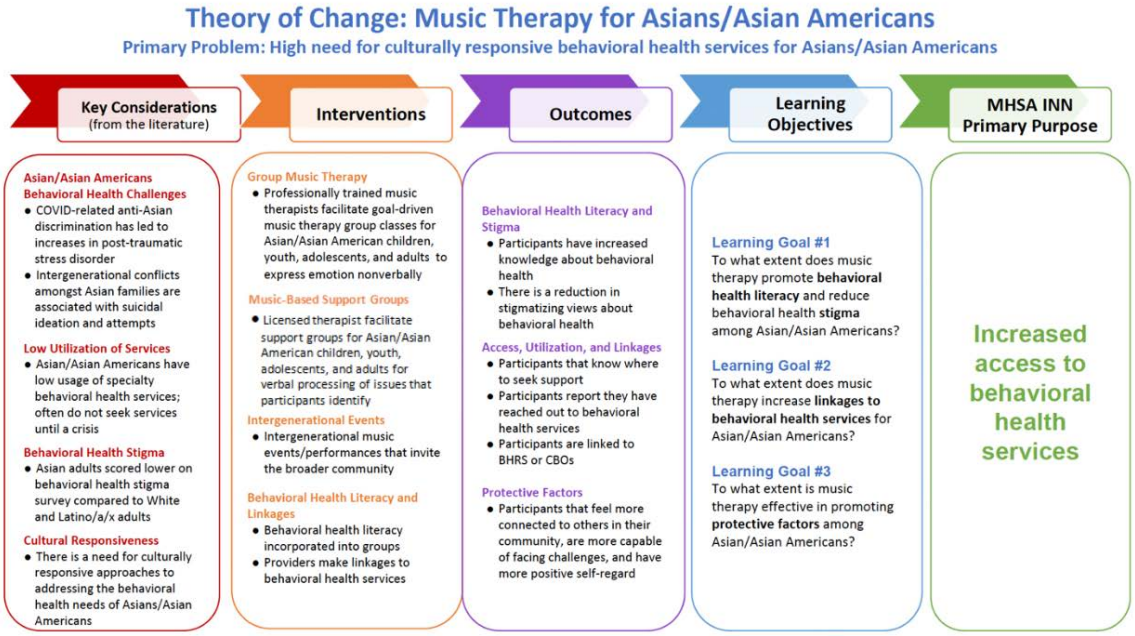
Overall Timeline

The overall timeline for Year 1 of the program and its evaluation are shown in the figure below.



Grant Goals

Identification of targeted program outcomes and the evaluation plan discussed in this report were anchored in the main program goals, objectives, and outcomes specified in the County's grant / Innovation Project Plan. The following figures show the theory of change, goals, and potential measures and data sources outlined in the original project's plan.



Note: The theory of change graphic shown above are pulled, unmodified, from the original County grant description, and may not reflect current or modified program practices.

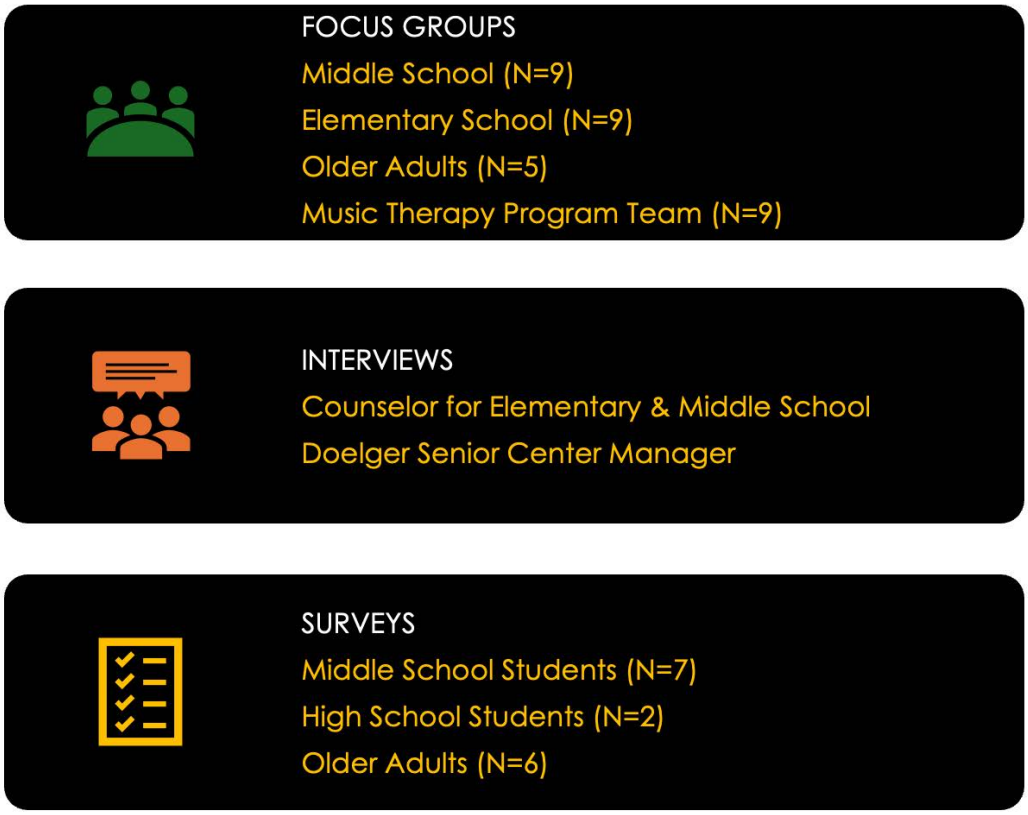
Learning Goal	Potential Measures	Potential Data Sources
1. To what extent does music therapy promote **behavioral health literacy** and reduce behavioral health **stigma** among Asian/Asian Americans?	✓ Percent of participants with increased knowledge about behavioral health ✓ Percent of participants with increased knowledge of where to go to seek support ✓ Percent of participants with a reduction in stigmatizing views about behavioral health	✓ Retrospective survey administered at end of group therapy classes and support groups (e.g., using behavioral health literacy and stigma scales) ✓ Interviews and/or focus groups with program participants and staff
2. To what extent does music therapy increase **linkages to behavioral health services** for Asian/Asian Americans?	✓ Number of linkages made to BHRS ✓ Number of referrals made to community-based behavioral health supports ✓ Number of participants who self-reported reaching out to behavioral health services and supports	✓ Program administrative records ✓ Retrospective survey administered at end of group therapy classes and support groups (asking whether clients were linked) ✓ Interviews and/or focus groups with program participants and staff
3. To what extent is music therapy effective in promoting **protective factors** among Asian/Asian Americans?	✓ Percent of participants that feel more connected to others in their community ✓ Percent of participants that feel more capable of facing challenges in their life ✓ Percent of participants that feel have more positive self-regard	✓ Retrospective survey administered at end of group therapy classes and support groups (e.g., using community cohesion and resilience scales) ✓ Interviews and/or focus groups with program participants and staff

Note: The goals and measures shown above are pulled, unmodified, from the original County grant description, and may not reflect current or modified program practices.

Evaluation Methodology, Year 1

In order to gather feedback about the first cohort of the Music Therapy for Asian Americans Program, both qualitative comments and quantitative survey data were collected through a combination of four focus groups with 32 individuals, interviews with two program collaborative site staff, and surveys from 15 participants. These program evaluation data sources are listed below. Together, these data were analyzed in a mixed-methods approach to inform concrete recommendations by CCPA's independent program evaluation team.

Program Evaluation Data Sources



1. Qualitative Comments about Experiences with the Music Therapy for Asian Americans Program

In order to hear directly from program participants, CCPA staff hosted in-person focus groups: 1 with Elementary School participants, 1 with Middle School participants, and 1 with Older Adult participants. High School participants were unavailable for a focus group, so participants provided comments via written survey. Program participants participated in each conversation through open verbal conversation, and detailed notes were recorded after each focus group by the facilitator. Below are the general focus group questions that guided each session.

Focus Group Prompts for Feedback from Participants about the Music Therapy program team

1. What have you found to be helpful or meaningful about the music therapy program?
2. How does the music therapy and support group program fit or not fit your cultural background?
3. Do you have any recommendations to make the music therapy program better? What about the support group parts of the program?
4. One hope of the music therapy program is to give people from the Asian American communities access to the information, resources, and referrals for mental health or substance use issues, if and when they're needed. How did the program do with this? Any ways for this to be improved?
5. Another hope of the music therapy program is to make people more aware of and comfortable talking about their feelings and mental health. How did the program do with this? Any ways for this to be improved?
6. The music therapy program aimed to make people feel better, more mentally healthy, more proud, less stressed, and better able to cope with the stress of daily life. How did the program do with this? Any ways for this to be improved?
7. Would you recommend the music therapy program to others? Why or why not?

Individual interviews and a focus group were also conducted with staff from program partnership sites (e.g., Franklin D. Roosevelt Elementary and Middle School of the Jefferson School District in Daly City and the Doelger Senior Center in Daly City), Music Therapy for Asian Americans Program staff (e.g., from North East Medical Services and Creative Vibes Music Therapy), and the program's community advisory group. Site administrators at Westmoor High School in Daly City were unavailable for interview. Following are the open-ended qualitative questions that guided these focus groups and interviews with various staff:

MUSIC THERAPY FOR ASIAN AMERICANS PROGRAM
EVALUATION PLAN: FOCUS GROUPS WITH STAFF & COMMUNITY ADVISORY GROUP

1. What has gone well this year? Anything that you're particularly proud of?

2. Please describe any success stories and/or evidence you've seen, of participants in the Music Therapy for Asian Americans Program experiencing improvements in the following outcome areas. *How* did this change come about?
    a. Protective factors (i.e., positive self-regard, community connection, coping skills)
    b. Linkages with behavioral health services
    c. Behavioral health literacy
    d. Reduced mental health stigma

3. What has been valuable about the music therapy as compared to the support group components?

4. What changes or improvements have you made in the course this year? What are ongoing challenges?
    a. Are there any parts of the community that have been hard to reach?

b. Have there been any challenges with the music therapy cohorts?
c. What challenges have been inherent in the music therapy as compared to the support group components?
d. Any challenges in affecting change in the above outcome areas?

5. What goals and/or solutions will you pursue in the next phase of this project?

6. Please describe the key cultural elements of your programmatic activities. What are the specific cultural and spiritual nuances, beliefs, practices, and norms specific to Asian American communities that you've found need to be incorporated into the planning, delivery, and outcomes of the music therapy and support group programs?

Qualitative feedback was also obtained from post-program evaluation surveys from high school and older adult participants, in response to three open-ended write-in questions, listed below. Comments from the above focus group prompts were combined with responses from the following qualitative write-in questions on the post-program evaluation survey.

Post-Program Evaluation Survey Write-In Questions

- What have you found to be helpful or meaningful about the music therapy and support group program?
- How does the music therapy and support group program fit or not fit your cultural background?
- Do you have any recommendations to make the music therapy or support group program better?

Data Analysis for Focus Groups

Verbal and written qualitative responses from all interview, focus groups, and written survey response data sources were combined for qualitative data analysis. There were a total of 304 qualitative comments shared across all qualitative data collection modalities. Each qualitative comment was coded using a thematic analysis approach to identify primary themes, listed in order of frequency mentioned. When applicable, primary themes were also organized into subthemes ("secondary" themes) to clarify participant feedback. These themes were coded for three main categories related to the Music Therapy for Asian Americans Program: 1) areas of strength; 2) areas for growth; and 3) areas for further discussion (i.e., to assist with the goal of innovating and improving the program over the course of the three year project).

2. Quantitative Survey and Demographic Data

Music Therapy for Asian Americans Program participants from the high school and older adult groups were invited to complete quantitative items on a post-program survey to provide feedback about their experiences with the program.

Demographic Data

Demographic items were self-reported by the high school and older adult participants, whereas demographic information for elementary and middle school students were either: a) culled from school administrative records, or b) recorded by the Music Therapy for Asian Americans Program staff. Demographic questions included in the quantitative survey included questions from the San Mateo County MHSA reporting form, shown below.

MUSIC THERAPY FOR ASIAN AMERICANS PROGRAM

Pre-Program Survey

San Mateo is committed to serving diverse communities. Your answers to these questions will help us understand who we serve and who we need to reach. All this information is voluntary and confidential.

Instructions: The information below will be kept anonymous and confidential. Your name will not be attached to your answers, and only the Music Therapy for Asian Americans Program staff will have access to the information.

Name:

1. Date of today's event or program:

2. Location of Music Therapy for Asian Americans Program:

3. Name of facilitator:

4. What age range are you under? (check ONE)
- ☐ 0-15 years
- ☐ 16-25 years
- ☐ 26-59 years
- ☐ 60-73 years
- ☐ 74+ years
- ☐ Decline to state

5. What is your primary language spoken at home? (check ONE)
- ☐ English
- ☐ Spanish
- ☐ Mandarin
- ☐ Cantonese
- ☐ Tagalog
- ☐ Russian
- ☐ Samoan
- ☐ Tongan
- ☐ American Sign Language
- ☐ Another language:
- ☐ Decline to state

6. What race(s) do you identify with? (check ALL that apply)
- ☐ Asian or Asian American

7. What ethnicity or ethnicities do you identify with? (check ALL that apply)

Latino/a/x or Hispanic
- ☐ Caribbean
- ☐ Central American
- ☐ Mexican/Mexican-American/Chicano
- ☐ South American
- ☐ Another ethnicity or tribe:
- ☐ Decline to state

Non-Latino/a/x or Non-Hispanic
- ☐ African
- ☐ Asian Indian/South Asian
- ☐ Chamorro
- ☐ Chinese
- ☐ Eastern European
- ☐ European
- ☐ Fijian
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Middle Eastern or North African
- ☐ Samoan
- ☐ Tongan
- ☐ Vietnamese
- ☐ Another ethnicity or tribe:
- ☐ Decline to state

8. Do you have a disability?[1] (check ONE)
- ☐ Yes
- ☐ No
- ☐ Decline to state

9. If you have a disability, what type do you have? (check ALL that apply)
- ☐ Mental disability[2]

☐ Black of African American ☐ Native American, American Indian or Indigenous ☐ Native Hawaiian or Pacific Islander ☐ White or Caucasian ☐ Another race: ☐ Decline to state	☐ Physical/mobility disability ☐ Chronic health condition[3] ☐ Difficulty seeing ☐ Difficulty hearing or having speech understood ☐ Another type of disability: ☐ Decline to state

10. What group(s) are you part of? (check ALL that apply)

☐ Behavioral health consumer/client
☐ Family member of a behavioral health consumer/client
☐ Provider of behavioral health services
☐ Provider of health and social services
☐ Law enforcement
☐ Homeless
☐ Student
☐ Community member
☐ Another group:
☐ Decline to state

11. Are you a Veteran? (check ONE)

☐ Yes
☐ No
☐ Decline to state

12. What city do you live in San Mateo County?

(1) Disability includes physical or mental impairment of medical condition lasting at least six months and limiting major life activity (not the result of a severe mental health condition); (2) Mental disability refers to impairment in the mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia); (3) Chronic health condition includes (but is not limited to) chronic pain. (4) Cisgender is a term used to describe people who, for the most part, identify as the gender they were assigned at birth; (5) Transgender is a term used to describe people whose gender identity and/or gender expression differs from what is typically associated with the gender they were assigned at birth; (6) Intersex is a general term for several conditions resulting in a reproductive or sexual anatomy that doesn't seem to fit the typical definitions of female or male at birth.

***Note**: County-funded programs (including the Music Therapy for Asian Americans Program) are required to ask the following questions about gender identity and sexual orientation.*
***Reminder**: All questions are voluntary; if you prefer not to answer any of the questions on this form, select "Decline to state." Your responses will not affect your ability to participate in the Music Therapy for Asian Americans Program.*

13. What is your gender identity? (check ONE)

☐ Female/Woman/Cisgender[4] Woman
☐ Male/Man/Cisgender[4] Man
☐ Transgender[5] Woman/Trans Woman/Trans-Feminine/Woman
☐ Transgender[5] Man/Trans Man/Trans-Masculine/Man
☐ Questioning of unsure of gender identity
☐ Genderqueer/Gender Non-Conforming/Gender Non-Binary/Neither exclusively female or male
☐ Indigenous gender identity
☐ Another gender identity:
☐ Decline to state

14. What is your sex assigned at birth (check ONE)

☐ Female
☐ Male
☐ Decline to state
☐ Other:

15. Are you intersex?[6] (check ONE)

☐ Yes
☐ No
☐ Decline to state

16. What is your sexual orientation? (check ONE)

☐ Lesbian or Gay
☐ Straight or Heterosexual
☐ Bisexual
☐ Queer
☐ Pansexual
☐ Asexual
☐ Questioning or unsure of sexual orientation
☐ Indigenous sexual orientation:
☐ Another sexual orientation:
☐ Decline to state

A total of 50 individuals participated in Year 1's 2023-2024 Music Therapy for Asian Americans Program, including: 9 elementary school, 10 middle school, 6 high school, and 25 older adult participants. Of the 50 participants, demographic information was obtained from 31 participants, including: 9 elementary school, 10 middle school, 6 high school, and 6 older adult participants. Only race/ethnicity, gender identity, and preferred language were collected for elementary and middle school students. Below are demographic tables detailing available demographic data by age cohort.

Available Demographic Data for High School Participants (N=6)	
Race or ethnicity	6 (100%) Asian or Asian American 1 (16.7%) African 1 (16.7%) Asian Indian / South Asian 3 (50%) Filipino/a/x 1 (16.7%) Decline to state
Preferred language	3 (50%) English 3 (50%) Tagalog
Disability	3 (50%) No 3 (50%) Decline to state
City of residence	5 (83.3%) Daly City 1 (16.7%) Unknown
Gender identity	3 (50%) Female/Woman/Cisgender Woman 3 (50%) Male/Man/Cisgender Man
Sex assigned at birth	3 (50%) Female 3 (50%) Male
Intersex	6 (100%) No
Sexual orientation	1 (16.7%) Bisexual 4 (66.7%) Straight or heterosexual 1 (16.7%) Decline to state

Available Demographic Data for Older Adult Participants (N=6)	
Race or ethnicity	5 (83.3%) Asian or Asian American 2 (33.3%) Chinese 2 (33.3%) Filipino/a/x 1 (16.7%) Chinese and Filipino/a/x 1 (16.7%) Unknown
Preferred language	1 (16.7%) Cantonese 1 (16.7%) English 3 (50%) Tagalog 1 (16.7%) Unknown
Disability	3 (50%) No 2 (33.3%) Yes 1 (16.7%)Physical/mobility disability and Difficulty hearing or having speech understood 1 (16.7%) Physical/mobility disability 1 (16.7%) Unknown
City of residence	1 (16.7%) Daly City 1 (16.7%) San Francisco 4 (66.7%) Unknown
Gender identity	2 (33.3%) Female/Woman/Cisgender Woman 3 (50%) Male/Man/Cisgender Man 1 (16.7%) Unknown
Sex assigned at birth	2 (33.3%) Female 3 (50%) Male 1 (16.7%) Unknown
Intersex	4 (66.7%) No 1 (16.7%) Decline to state 1 (16.7%) Unknown
Sexual orientation	4 (66.7%) Straight or heterosexual 1 (16.7%) Decline to state 1 (16.7%) Unknown

Note: The music therapist recorded a total of 25 older adult participants over the course of the program (11 males, 14 females). Complete demographic information was only completed for the above 6 individuals

Available Demographic Data for Elementary School Participants (N=9)	
Race or ethnicity	1 (11.1%) African American 1 (11.1%) Asian Indian 1 (11.1%) Chinese 2 (22.2%) Filipino/a/x 3 (33.3%) Hispanic or Latino/a/x 1 (11.1%) Mixed race (2 or more races/ethnicities)
Preferred language	6 (66.6%) English 1 (11.1%) "Philippine languages" 1 (11.1%) Mandarin Chinese 1 (11.1%) Spanish
Gender Identity	4 (44.4%) Female 5 (55.5%) Male

Available Demographic Data for Middle School Participants (N=10)	
Race or ethnicity	1 (10%) African American 1 (10%) Chinese 2 (20%) Filipino/a/x 1 (10%) Korean 1 (10%) Hispanic or Latino/a/x 1 (10%) Mixed race (2 or more races/ethnicities) 2 (20%) Other Asian 1 (10%) White
Preferred language	6 (60%) English 1 (10%) Hindi 2 (20%) "Philippine languages" 1 (10%) Spanish
Gender Identity	10 (100%) Male

Targeted Program Outcomes

A total of 15 participants responded to the post-program survey. Post-program quantitative survey items measured targeted program outcomes that are linked to: 1) original goals of the grant; 2) the design of the Music Therapy for Asian Americans Program (including innovations in programming); and 3) key common outcomes measured across County behavioral health programming.

Listed in the Table below are the program's overarching outcome categories, specific outcomes, and their corresponding survey items. Each survey item was measured on a 5-point Likert scale used throughout San Mateo County program evaluation efforts: 1=Strongly Disagree; 2=Disagree; 3=Neither Agree nor Disagree; 4=Agree; 5=Strongly Agree.

Table 1: List of Overarching Outcome Categories, Specific Measured Outcomes, and Corresponding Survey Items

Overarching Outcome Category (in CAPS) & Specific Measured Outcome	Corresponding Survey Item
CULTURAL HUMILITY / IDENTITY (San Mateo Indicator 3)	I feel like my identity, cultural background, and experiences (race, ethnicity, gender, sexuality, religion, etc.) were affirmed by the Music Therapy for Asian Americans Program.
All of the below items have the prefix of "Because of the Music Therapy for Asian Americans Program…"	
PROMOTION OF PROTECTIVE FACTORS Positive self-regard or self-esteem	…I feel more proud or confident.

PROMOTION OF PROTECTIVE FACTORS Feelings of community and connection with each other	…I feel more connected with other people.
PROMOTION OF PROTECTIVE FACTORS Feelings of community and connection with each other	…I learned how to listen to other people and/or their music.
PROMOTION OF PROTECTIVE FACTORS Acquired coping skills to face challenges in life (for support group and music therapy components)	…I learned new coping skills.
PROMOTION OF PROTECTIVE FACTORS Acquired coping skills to face challenges in life (for support group and music therapy components)	…I learned how to use music to feel better.
PROMOTION OF PROTECTIVE FACTORS Emotional Health	…I am less stressed out and more calm.
INCREASED BEHAVIORAL HEALTH LITERACY Knowledge about mental health	…I know more about how music affects my behavioral health.
INCREASED BEHAVIORAL HEALTH LITERACY Knowledge about mental health	…I know more about my behavioral health.
INCREASED BEHAVIORAL HEALTH LITERACY Insight about behavioral health issues (being more aware)	…I am more aware of how music makes me feel.
INCREASED BEHAVIORAL HEALTH LITERACY Insight about behavioral health issues (being more aware)	…I understand myself and my feelings more.
INCREASED BEHAVIORAL HEALTH LITERACY Insight about behavioral health issues (being more aware)	…I feel like I have more tools to talk about my behavioral health.
INCREASED BEHAVIORAL HEALTH LITERACY Insight about behavioral health issues (being more aware)	…I am more aware of when I may need support with my behavioral health. (can also be part of the pathway to linkages)
INCREASED BEHAVIORAL HEALTH LITERACY Knowledge of where to go to seek support	… I know more about where to get help if I was having a hard time with my behavioral health.
REDUCED STIGMA Stigma discrimination reduction (San Mateo Indicator 5)	…I feel more comfortable talking about my mental health and/or substance use.”
LINKAGES TO BEHAVIORAL HEALTH SERVICES Openness to learning about and considering seeking behavioral health services	…I’m more open to learning more about behavioral health services.
LINKAGES TO BEHAVIORAL HEALTH SERVICES Openness to learning about and considering seeking behavioral health services	…I’m more open to considering behavioral health services for myself.
LINKAGES TO BEHAVIORAL HEALTH SERVICES Openness to learning about and considering seeking behavioral health services	…I have reached out to or been connected with behavioral health services, supports, or resources.
LINKAGES TO BEHAVIORAL HEALTH SERVICES Access to Treatment/Prevention Programs (Reducing Barriers) (San Mateo Indicator 4)	…I have learned knowledge and skills that I can use to access mental health and substance use health services.”

EXECUTIVE SUMMARY OF RECOMMENDATIONS

STRENGTHS FROM YEAR 1

Participants overwhelmingly reported having positive experiences with the Music Therapy for Asian Americans Program during Year 1. They particularly appreciated the social connection and teamwork experienced during the program, the quality of the teachers, the snacks provided, as well as the community experience of performing their music work across age groups in a large performance at the end of the program. Participants also reported positive behavioral health outcomes related to the program, such as being able to cope with stress, feeling better or less depressed, having a place to share feelings, or feeling pride in themselves and their music work. Survey data supported the idea that participants benefitted from enhancement of numerous protective factors (e.g., self esteem, community connection, emotional health, coping skills) and increased behavioral health literacy (e.g., more knowledge about music and its effects on one's behavioral health, awareness of feelings and the need for support, and knowing where to get support when needed).

AREAS FOR GROWTH AND/OR RECOMMENDATIONS FOR YEAR 2

Recommendations, areas for discussion, and areas for growth are summarized below.

Planning Ahead for/within Community Partnerships

1. **Plan ahead for community site partnerships.** Coordinate ahead of time and plan with particular attention to: a) the timing of sessions to match with any major scheduling conflicts for participants; b) a marketing strategy for recruitment; and c) the ability to recruit high school students given their busy schedules. Some participants desired having more people in the groups so that they could have more opportunities for social connection.

2. **Increase coordination between program staff and community site liaisons to select participants.** Have more discussion about how to recruit participants that match the targeted goals of the project and chosen approach, how involve parents as needed, and how to ensure that participants are motivated to participate.

Selection of Youth Participants

3. **Determine approach to selection of youth participants.** Determine whether the program will address more upstream prevention (i.e., which would include participants without behavioral health distress) versus inclusion of individuals at-risk or already experiencing signs of behavioral health distress. Coordinate with youth site coordinators accordingly, and recruit participants that match the targeted goals of the project and chosen approach.

Curriculum Planning

4. **Timing and content of performance pieces.** Pay attention to the timing of preparation for the performance to ensure that participants have sufficient time to prepare; consider sharing an outline or plan for the performance with participants. Attend to any needs for a balance of negativity with positivity / strengths within performance pieces, as needed/applicable.

5. Increase attention to coordination between music therapy and support group program components. Many elementary and middle school participants didn't remember the support group components, while others found the support groups disorganized or out of place. Potential suggestions for brainstorming improvements included: improving coordination between music and support group therapists by planning ahead, having music and support group therapists introducing themselves together as a team, or having more presence of support group therapists. Any attention to changes in support group approach should keep in mind that Year 1 support groups received particularly positive feedback from the older adult group as a critical component to social connections / friendships between participants.

Cultural Components of the Program

Determine approach to focusing on Asian American community needs. Determine the program's approach to targeting the goals of the grant related to reaching Asian American communities to decrease stigma and promote behavioral health, particularly among the elementary and middle school cohorts.

Determine approach to incorporating cultural content or other Asian American targeted needs into the music therapy and support group curriculum. Few participants in Year 1's cohort were able to recall cultural components in the program content. Consider developmentally appropriate attention to cultural identity across the cohort age groups.

Referrals or Resource Connection

Develop / implement the program's approach to detecting participants in distress and/or connecting them to resources or referrals. Learning knowledge, skills, or tools to access behavioral health services should they be needed was one of the lower-rated survey items, and staff stakeholders discussed uncertainty about how participants in distress might be detected and service/resource connected.

Evaluation Approach for Children

Determine an age-appropriate approach to evaluation for the elementary and middle school groups. Feedback from staff and site stakeholders pointed to the need for an approach to program evaluation that didn't involve written surveys and attended to developmentally appropriate vocabulary and reading levels. Consider the use of interview, focus group, or other approaches that can collect feedback through verbal interview.

Preferred Name for the Program

Discuss and determine a preferred name for the Music Therapy for Asian Americans Program, considering a few comments of concern about the word "therapy" activating stigma and potentially stymying recruitment.

RESULTS

The following section of the report discusses qualitatively coded themes in the two areas of strength and areas of growth, listed in order of how frequently they were mentioned by participants. Example quotes are provided for each theme, and a full list of qualitative data / comments are provided in the Appendix data tables. Note that the following coding key is used for example quotes.

Coding Key for Example Comments

- E-Elementary (N=9)
- M-Middle School (N=9)
- O-Older Adults (N=5)
- H-High school (N=2) Up to 7 participants; 2-3 regulars
- PS-Program staff (Support group)
- PM-Program staff (Music Therapy)
- PA-Program staff (Administration)
- SEM-Site contact for Elementary/Middle
- SO-Site contact for Older Adults

QUALITATIVE DATA: AREAS OF STRENGTH

1. Positive experiences with the program (59 comments; general comments about music and art)

The most frequently mentioned strengths were related to (overwhelmingly) positive experiences with the program (59 comments). These 59 comments included expressions of general appreciation and love of the program, and appreciation of the music and artistic components of the program. Example representative comments are provided below; a full list of qualitative data / comments from this theme are provided in the Appendix data tables.

Example Comments

- "Absolute W!" [It means good. A Win!] (E)
- They (seniors) loved it, it was well received, people want more. I'm blown away by how it went. (SO)
- Babies need music. Everyone needs music. It's in our DNA. It's better than laughter, it's medicine. (O)
- Just jamming with the group in general. Music makes me feel good, so having people to make Music with was a great way to unwind. (H)
- The album drawings were great. We got to draw our own album with our favorite songs. (E)
- I loved everything. Every aspect was absolutely great, I have no complaints. Other than it was too short. I would want it every day of the week. (E)

2. Social Connection / Teamwork (37 comments; linked to the outcomes of Protective Factors)

The second most frequently mentioned strength was the social connections made between participants within the groups (sometimes even lifelong friendships). The teamwork needed to put together the music therapy performance at the end of the program may have helped to facilitate these friendships. Example representative comments are provided below; a full list of qualitative data / comments from this theme are provided in the Appendix data tables.

Example Comments

- After the music program was completed, I find that our group became closer and I found a life long support group and good friends. (O)
- One immigrant teen was able to feel more comfortable and feel more connected to people. (PS)
- We weren't friends before [two kids]. We used to be *enemies* [joking] and now we're friends. (E)
- I liked the teamwork when we made the music. We each tried to come up with different words. There were different teams who did different things and then we put it together. (M)
- Felt a lot of growth, particularly for the younger students. Wasn't a lot of group cohesion in the beginning. At the final performance, there was a lot more group collaboration and openness to the different personalities. (PM)

3. Mental Health Outcomes (27 comments; linked to the outcomes of Behavioral Health Literacy and Stigma)

Consistent with program goals of increasing behavioral health literacy and decreasing stigma, the third most commonly mentioned strength pertained to improvements in mental health-related outcomes as a result of the Music Therapy for Asian Americans Program. Participants reported feeling more calm, less stressed, more proud, able to share their feelings, and others. Example representative comments are provided below; a full list of qualitative data / comments from this theme are provided in the Appendix data tables.

Example Comments

- [One of the participants] was very depressed – now he's the happiest guy. (SO)
- Music therapy helped me cope with stress. (M)
- *It [the performance] made me feel proud. (M)
- When we come in here, I feel less stressed. Coming here is like a break. (E)
- It was like therapy. Every time I sang, I feel better. I feel less stressed. (O)
- *[The high schoolers] had a space to share feelings in the group.
- [I liked] having a small group of people who can freely talk about feelings or someone else who can understand the things that we have a hard time understanding. (H)

4. Positive Experiences with the Performance (26 comments; supplementarily linked to the outcomes of Protective Factors)

A fourth strength mentioned by participants in qualitative comments were positive experiences with the group performance at the end of the program. Participants reported enjoying the performance, feeling proud and seen, and appreciating the opportunity to connect across generations (given that every age group gave a performance). Example representative comments are provided below; a full list of qualitative data / comments from this theme are provided in the Appendix data tables.

Example Comments

- *It [the performance] made me feel proud. (M)
- I loved each performance (from the different ages). I liked how there were elderly people. High school people. (E)
- I felt really good about myself. I felt like I accomplished something. It was a nice feeling, like oh wow, I performed in front of people. They applaud. (O)
- They felt seen. They were seen in a big way. We put them on the map. (SO)
- Was great to have the younger kids see the older adults so they can see what is their attitude in life. (PS / PA)
- It was good. I'd definitely do it again. (M)

5. Teachers (7 comments)

Participants reported that a notable strength of the program was the music therapy instructors. Seven comments highlighted appreciation for their competence and talent. Example representative comments are provided below; a full list of qualitative data / comments from this theme are provided in the Appendix data tables.

Example Comments

- I liked the [music therapy] teachers. They should get a higher raise. Have them do it again. (E)
- The teachers are all super talented. I'm impressed. (O)

6. Food for Youth (6 comments)

There were six comments of appreciation of the food and snacks provided by program staff throughout the program. These comments were predominant amongst youth participants.

Example Comments

- The food was good. Every time, they brought food. Our favorites were McDonalds and pizza. (M)
- The support group people - they brought food – KoolAid and granola bars. That was good. (M)

7. Addressing Stigma (2 comments; linked with the outcomes of Behavioral Health Literacy and Stigma)

Two comments noted strengths in having music therapy be an acceptable and destigmatizing approach to addressing behavioral health. For example, one program staff member commented that "It's been hard to work with AAPI boys. But adding music therapy destigmatized the topic for them. They were really active in the performance. They enjoyed the process."

8. Technology / Software (2 comments)

A final category of strengths from qualitative comments related to technology and software. Middle school participants enjoyed the integration of a music software application into the creation of their final performance (e.g, "They used an application / software. That was cool" and "I liked using the software. It was my idea to bring it in. They were going to use Music Lab, but we suggested Sound Trap and they agreed."

QUALITATIVE DATA: AREAS OF GROWTH

1. Organizational Improvements (24 comments)

The most frequently reported area of growth was the overarching theme of organizational improvements, mentioned by participants in 24 comments. This need for organizational improvement included requests for more streamlined scheduling of sessions to match availability of participants given other programming conflicts (13 comments), a suggestion to be strategic and intentional when selecting ideal site partners (6 comments), increasing efforts to market the program more widely to increase the volume of participant enrollment (6 comments), and improved organization of the session schedule, particularly to plan ahead for the end of program group performance (5 comments). Example representative comments are provided below; a full list of qualitative data / comments from this theme are provided in the Appendix data tables.

Example Comments

Logistics / Schedule of Sessions (13 comments)

- Something I'd want to change would be to move it to another day because sometimes I had a conflict with band. I'd move it to Mondays and Wednesdays. (M).
- Add additional time (i.e. 10 minutes). It would be fun to do twice a week. (M)
- It interfered with Zumba. Coordinate with the center to find a better time so that it doesn't interfere with other things… (O)
- Challenge – It was hard for everyone [the high schoolers] to get together. (PS)

Partnerships & Recruitment (6 comments)

- From the beginning, we need more care in selecting partners, and to clarify the expectations from each partners to have full commitment. (PS / PA)
- Next cycle – do more research on the high school sites to see if can improve commitment.

Marketing (6 comments)

- It wasn't advertised enough for people to know to do it. Get the word out more. (O)

- To market the program, maybe go to lunch and have everyone sing a song (i.e. Puff the Magic Dragon, Michael Row the Boat Ashore) for five to 10 minutes, so they may want to join the program. (O)

Organization Within the Curriculum (5 comments)

- Give them an outline of what the class involves. Something in writing more than the flier. (SO)
- I wish it were more organized. In the actual sessions, it felt a little disorganized. We were all doing our own activities. We all started as a group, and then everyone was doing different things, and then we ended up in two different groups for the performance. [The two groups wasn't necessarily a problem..] It would [just] be great if there was some kind of rubric or guidelines to follow. (M)
- Change the timing of the sessions so we can work on our songs faster. (M)

2. Musical Technique and Approach (18 comments)

With 18 comments, the second most common area for growth referred to the program's approach to music and its techniques. Feedback in this area differed between age groups; many of the older adults wanted to learn different music instruments skills and techniques rather than solely engaging in music therapy, while middle school and elementary students suggested making the music portions more interesting to keep participants more engaged. Feedback from two stakeholders of the elementary school group suggested that their "School Blues" song would be more representative and less embarrassing for administrators, if the song content balanced negative lyrics with more positive or strength-based content as well. Example representative comments are provided below; a full list of qualitative data / comments from this theme are provided in the Appendix data tables.

Example Comments

- I think we should get a different mix of beats. We were using the same rhythm, and it was getting kind of boring. (E)
- Maybe each week, introduce us to a different instrument. (O)
- Learn to read music and play guitar or piano. (O)
- Some (of the older adults) were concerned about the quality of the music they were creating. It was hard for some participants to come to terms with that. (PM)
- Make it more interesting for the students. (M)
- The School Blues song was all negative, and it was embarrassing. They should have balanced it out with more positives about school. It was embarrassing to bring the school staff and have the mayor there. (SEM)
- I'd maybe make [the School Blues song] not that mean – maybe put some good stuff in it. Cuz some parts of school are great. (E)

3. Social Connection Opportunities (4 comments)

Their third most frequently mentioned area of growth related to number of participants in each group. Participant reported that they would enjoy having more people in the groups, as opportunities to connect with and make more new friends.

Example Comments

- We want more people. Maximum capacity. At least 20 people. (M)
- I would want more people to be here. Everyone to have one buddy that could come. (E)
- The program should be more intense, more participation, more fun. More people, more interactions, more participation. (O)

4. The Performance (3 comments)

The fourth most frequently mentioned area for growth pertained to a desire for more time to prepare for the performance, along with one middle schooler suggesting that the performance be held at school because it is a more familiar environment.

Example Comments

- Start the song sooner so we get more time. I think I could have made a two minute song. We met 7 or 8 times before we made the song. (M)
- Do [the performance] in different places, like at our school. Because we're more used to our school. It would feel better here, because we already know it. (M)

5. Technology / Software (M; 3 comments)

Finally, the middle school group were mixed in their feedback about the use of technology and software within the Music Therapy for Asian Americans Program. Approximately half of the participants liked the integration of software, while the other half did not. One participant reported wishing that the therapist had more experience with the software (whose use was initiated by one of the middle school participants). Another middle school participant reported finding the online software so confusing that they quit engaging with it altogether.

Post-Program Survey: Participant Ratings on Targeted Program Outcomes

On average, survey respondents rated all outcome scores in the positive direction, agreeing that because of the Music Therapy for Asian Americans Program, the experienced improvements in outcomes ranging from feeling more proud or confident, to understanding their feelings more, to being more open to learning about behavioral health services. Means and standard deviations for each quantitative item are listed in Table 2 below.

Within these overall positive ratings of outcomes, there were relative areas of strength and growth. Relative areas of strength with average scores between 4.3-4.5 out of 5 are highlighted in green in the Figure 1 below, including: feeling more connected with others, learning how to listen to other people and/or their music, learning how to use music to feel better, feeling less stressed out and more calm, being more aware of how music makes them feel, and being more open to considering behavioral health services for themselves.

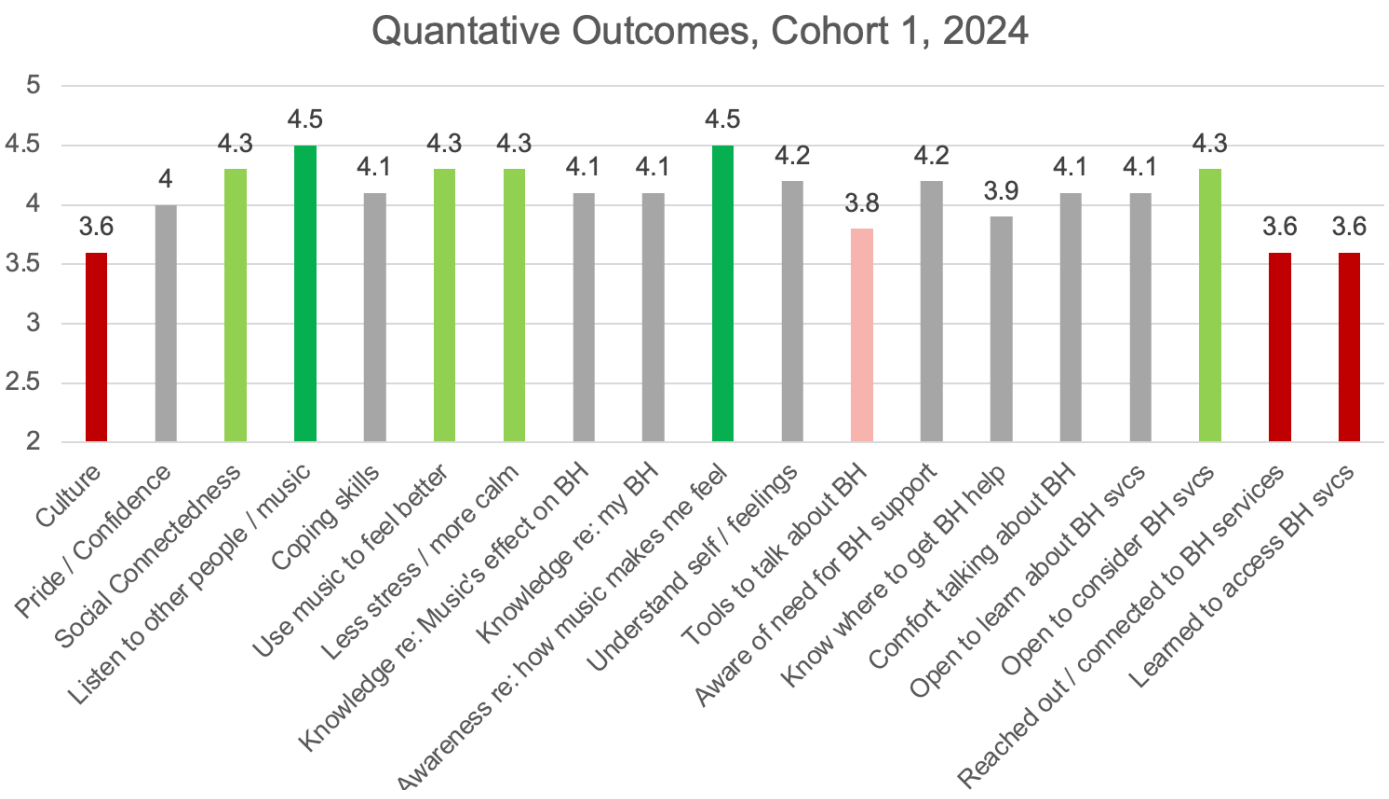
Relative areas for growth with average scores between 3.6 to 3.8 out of 5 are highlighted in shades of red in Figure 1, and included: feeling like they have more tools to talk about their behavioral health, feeling like their identity, cultural background, and experiences (race, ethnicity, gender, sexuality, religion, etc.) were affirmed by the program, learning knowledge and skills they can use to access behavioral health services, and actually reaching out / being connected with behavioral health services, supports, or resources.

Table 2: Quantitative Results on Targeted Program Outcomes

Because of the Music Therapy for Asian Americans Program…		N	Mean	Standard Deviation
1.	I feel like my identity, cultural background, and experiences (race, ethnicity, gender, sexuality, religion, etc.) were affirmed by the Music Therapy for Asian Americans Program.	15	3.6	1.1
2.	…I feel more proud or confident.	15	4.0	0.8
3.	…I feel more connected with other people.	15	4.3	0.6
4.	…I learned how to listen to other people and/or their music.	15	4.5	0.5
5.	…I learned new coping skills.	15	4.1	1.1
6.	…I learned how to use music to feel better.	15	4.3	0.7
7.	…I am less stressed out and more calm.	15	4.3	0.7
8.	…I know more about how music affects my behavioral health.*	15	4.1	0.7
9.	…I know more about my behavioral health.*	15	4.1	0.8
10.	…I am more aware of how music makes me feel.	15	4.5	0.5
11.	…I understand myself and my feelings more.	15	4.2	0.6
12.	…I feel like I have more tools to talk about my behavioral health.	15	3.8	1.1
13.	…I am more aware of when I may need support with my behavioral health.*	15	4.2	0.9
14.	… I know more about where to get help if I was having a hard time with my behavioral health.*	14	3.9	0.9
15.	…I feel more comfortable talking about my mental health and/or substance use.”	15	4.1	0.9
16.	…I’m more open to learning more about behavioral health* services.	15	4.1	0.9
17.	…I’m more open to considering behavioral health* services for myself.	15	4.3	0.8
18.	…I have reached out to or been connected with behavioral health* services, supports, or resources.	15	3.6	1.4
19.	…I have learned knowledge and skills that I can use to access mental health and substance use health services.	15	3.6	1.2

Note: Blue text denotes standard language from San Mateo County competency assessments. Red text indicates comparative/relative areas of growth. Green text indicates comparative/relative areas of strength.

Figure 1: Graph of Quantitative Results for Targeted Program Outcomes



Areas For Discussion

1. Evaluation Approach for Children

Site administrators suggested that program/evaluation staff reevaluate the use and wording of the evaluation surveys for the elementary and middle school students. Suggestions were to evaluate the survey for developmentally appropriate wording, non-stigmatizing content, and sensitivity to the relationship with and needs of participants' families.

Example Comments

- My issue has been the pre survey and the post survey, wanting aspects of it to be tailored to elementary school age and middle school families. (SEM)
- Asking questions that aren't appropriate to what the kids are doing is actually creating stigma in in those families. You're asking for the 5th grade family about substance use and mental health and that's not right for elementary school, it's stigmatizing. (SEM)

2. Upstream vs. Downstream Program Approach and Associated Minors and Confidentiality Considerations

The elementary and middle school site administrators raised issues for discussion related to the program's focus on upstream community building, prevention, and enhancement of protective factors, versus a more downstream intervention for children who are either at-risk or already-experiencing behavioral health issues. These different upstream vs. downstream approaches would yield a different process for the recruitment and selection of ideal program participants, and therefore would be ideally determined ahead of time.

Site administrators for the younger elementary and middle school children also commented that a focus on a more downstream programming approach for children with behavioral issues (i.e., actual "therapy" for behavioral health utilizing music and emotional support) would raise issues with regards to confidentiality and privacy of children at the end-of-program public intergenerational performance. Layered with this potential concern would be a need to think about security for children at the intergenerational performance, while they intermingle with adult strangers from the older adult group.

Example Comments

- Looking at the program as more of an opportunity for community building and connection versus problem emotional. (SEM)
- It didn't matter to me if they talked about their emotions. To me, the power of the program is the community building aspect of it. (SEM)
- But if we're doing real music therapy and having a more psychiatric approach then how is it that we're doing a community intergenerational party that would violate when therapy should be confidential. That would make no sense to me. (SEM)
- In my role of being in charge of kids, I have to think about how to mitigate harm. I don't normally have kids mingling with adult strangers, so there are a lot of different considerations to take into account. (SEM)

3. Approach to Selection of Participants

Qualitative data pointed to an area for discussion related to the process and strategy for selecting program participants, particularly for the youth groups from elementary school through high school. Comments suggest a need for program and site administrators to communicate explicitly and collaborate closely before the programs start to determine the best approach for identifying ideal participants and (for youth) working with families to ensure buy-in and motivation.

Example Comments

- I look at the dynamics of the kids and put together a group where some kids can lift up the others. Some had music experience, some kids barely say a word, some groups need a place to learn more social cues in a small group setting. (SEM)
- I selected kids who may be struggling socially or emotionally, i.e., because I know information from their teachers, from conflict resolution incidents…Some have a stutter and express himself through music…Some get angry easily and may need another way of coping. (SEM)

- [We] selected all boys for the middle school kids in order to have a place for boys only to connect. (SEM)
- They were pre-selected for not needing more intensive services (i.e., *the "Tier 3" kids with higher mental health needs were selected out)*…All these kids are "safe" kids…If I were choosing only tier 3 kids, I probably wouldn't have enough kids to fill the group. (SEM)
- Would like to be more involved with the selection of participants. Seemed like their parents wanted them to be in it, rather than them. (PM)
- More collaboration with the schools, the therapists. The counselor selected based on their behavioral management needs in school, but not based on their love or motivation for music. Would like to make sure they're motivated. (PM)

4. What the Program Should Be Called

Comments flagged an area of discussion related to the ideal title / name of the program; specifically, that having the word "therapy" in the name may have been a deterrent to recruitment of participants. For example, the elementary and middle school site coordinator reported that some families had a reaction to the word therapy in the name, and the older adult site coordinator reported a similar reaction from participants ("I don't need therapy").

Example comments

- The term "music therapy" do we really need to use that? Some of the families had a reaction, wanting to know why my kid needs to be in this program, whether they have a behavioral problem or not, and so it would help if the name didn't have the word therapy in it. Take the therapy name out. Tailor it to how it fit with our age group. [Suggestions:] music connections, community music intergenerational program. (SEM)
- The term mental health and therapy scare people away. It intimidates people. Music therapy. I think it would be bigger without the word there. "I don't need therapy" Suggestion about what to call it? Not sure. Maybe "Music Expressions"? (SO)

5. How to Find Individuals Who Need Referrals

Comments from elementary and middle school site administrators indicated an additional item for discussion: how to detect participants who may need a behavioral health referral, and a need to develop a process within the Music Therapy for Asian Americans program to connect individuals with additional behavioral health resources or referrals.

Example Comments

- …I already know which students in there need extra help. But the music therapy staff never gave me any feedback that any student in the group had depression or sadness; I never got any feedback about any kind of concern that they had. (SEM)
- This group of kids do have things like parent losses and other issues that they are dealing with. If the music therapists find out something that I should know about, then that would be great. (SEM)

6. Targeting the Asian American Community / Including Cultural Components

Few participants in Year 1's cohort were able to recall cultural components in the program content, though some participants commented that music was a good fit for culturally congruent ways to express themselves. Comments point to a need to determine the program's approach to incorporating cultural content or other Asian American targeted needs into the music therapy and support group curriculum – while recognizing that understanding of cultural identity differs across different age cohorts. Additionally, though all of the high school and older adult cohort participants identified as Asian or Asian American, there were few Asian or Asian American participants in the elementary and middle school groups. Program and site administrative staff at the elementary and middle schools may benefit from discussion of the program's approach to targeting the goals of the grant related to reaching Asian/Asian American communities to decrease stigma and promote behavioral health.

Example Comments

- I'm not sure that developmentally, the younger kids are at a place where they identify primarily through their race or ethnic identity. It might be more appropriate for high school students. In middle school, they are just starting to learn about ethnic studies, etc. (SEM)
- I don't think in our school, we have enough Asian kids to have a group that is only Asian. I ended up creating a mixed group because that meets them where they are at. (SEM)
- Something we could do better with: Recruiting participants, and have it more focused on Asian Americans so that they could outline their agenda more and focus more on Asian American. (PA)
- I originally thought the participants would be Asian American, so it was hard to incorporate Asian American experience. That's something we can potentially improve on? Can we emphasize more on focusing on the Asian American experience. (PM)

7. Changes to the Support Group Component

Comments from the older adult group showed that the support groups were largely perceived as a critical component to social connection between participants, with some sharing that the support groups served as a place to learn more about each other and form lasting friendships. In contrast, when queried, many elementary and middle school participants didn't recall / remember the support group components. Among those who did remember the support groups, some commented that they felt disorganized or out of place from the music therapy components. Stakeholders pointed to several potential suggestions for improvement, including: improving the coordination between music and support group therapists by planning ahead, having music and support group therapists introducing themselves together as a team, or having more presence of support group therapists throughout the program.

Example Comments

<u>Positive experiences</u>

- A couple people said the support group was interesting. (SO)

- Support group – got to express their emotions, reflect on their life stories. Nice juxtaposition in with the music therapy where we didn't see more of the life story. (PS / PA)
- We learned about each other, and maybe that's why we feel closer to each other. We were able to share more about our personal life and stories. (O)
- It helped to bring us together, and connect. (O)

<u>Don't remember the support group</u>

- No [I don't remember meeting with a therapist]. (E)
- There were two people watching, and then one other person talking to the teacher. Can't remember. (E)

<u>Need better organization / fit with music therapy</u>

- We just kind of talked about stuff. It was kind of "scuffed" – not really in place / rough. Unorganized. (M)
- It felt really last minute. (M)
- Think about how to coordinate the support vs. the music therapist role. (PS)
- It felt out of place. (M)
- It was unclear what the therapist was here for. (M)
- Support group was too abrupt; they were confused, they were looking for more music therapy. Without agenda or curriculum it was hard to orient them and center themselves. Either add more support groups or just integrate the curriculum. (PS)
- The NEMS therapists aren't there every session – so it's a bit confusing for participants – perhaps the session before, the therapists could be more involved with the music therapy so that the transition is more smooth. (PM)

APPENDIX

Music Therapy for Asian Americans Program, Cohort 1 2024, Qualitative Data (coded)

Coding Key

- E-Elementary (N=9)
- M-Middle School (N=9)
- O-Older Adults (N=5)
- H-High school (N=2) Up to 7 participants; 2-3 regulars
- PS-Program staff (Support group)
- PM-Program staff (Music Therapy)
- PA-Program staff (Administration)
- SEM-Site contact for Elementary/Middle
- SO-Site contact for Older Adults
- *-double coded
- **Overarching tertiary themes are in blue**
- **Secondary themes are in bolded black**
- <u>Primary themes are in underlined black</u>

Coordination / Program Coordination: Strengths

Strong Management

- Very friendly group, open to you know figuring out things like logistics, came on time (SEM)
- Great to work with the counselor (PS)

Coordination / Program Coordination: Areas of Discussion or Improvement

Evaluation Approach for Children

- My issue has been the pre survey and the post survey, wanting aspects of it to be tailored to elementary school age and middle school families (SEM)
- Asking questions that aren't appropriate to what the kids are doing is actually creating stigma in in those families. You're asking for the 5th grade family about substance use and mental health and that's not right for elementary school, it's stigmatizing. (SEM)

Upstream vs. Downstream Program Approach and Associated Minors and Confidentiality Considerations

- My perspective at school is everything we're doing is that we're not pointing out deficiencies; we're just meeting where they're at in building capacity (SEM)
- Looking at the program is more of an opportunity for community building and connection versus problem emotional (SEM)
    - We worked together on making the pamphlet and I pointed out that just like the way a couple things were phrased was pointing to a problem rather building

capacity and children and they responded to that and they changed it so I was like happy with that (SEM)

- It didn't matter to me if they talked about their emotions. To me, the power of the program is the community building aspect of it (SEM)
- But if we're doing real music therapy and having a more psychiatric approach then how is it that we're doing a community intergenerational party that would violate when therapy should be confidential. That would make no sense to me. (SEM)
- If this were therapy with "Tier 3" kids, there shouldn't be an intergenerational performance (SEM)
- In my role of being in charge of kids, I have to think about how to mitigate harm. I don't normally have kids mingling with adult strangers, so there are a lot of different considerations to take into account. (SEM)

Approach to Selection of Participants

- So I work with administration and teachers to select the students, rather than a table where we recruit and talk to parents. We selected kids who need a little bit more positivity or more connection with the school, more meaningful participation, more friendship, more relationship building. Kids who may need more recognition, to get involved with something fun (SEM)
- I look at the dynamics of the kids and put together a group where some kids can lift up the others. Some had music experience, some kids barely say a word, some groups need a place to learn more social cues in a small group setting (SEM)
- I selected kids who may be struggling socially or emotionally, i.e., because I know information from their teachers, from conflict resolution incidents (SEM)
    - Some have a stutter and express himself through music (SEM)
    - Some kids have say things that can be off putting to other kids, and the music may help him have another way of expressing himself (SEM)
    - Some get angry easily and may need another way of coping (SEM)
- She selected all boys for the middle school kids in order to have a place for boys only to connect (SEM)
- They were pre-selected for not needing more intensive services – *the "Tier 3" kids with higher mental health needs were selected out.* (SEM)
    - All these kids are "safe" kids (SEM)
    - If I were choosing only tier 3 kids, I probably wouldn't have enough kids to fill the group. Also, kids with social emotional needs, versus academic needs, don't have the same availability or schedule to be able to attend a group at the same time. (SEM)
- There was a big difference between the 6th and 8th graders. It was hard to combine the two grades together. Too different developmentally. Perhaps have 7th graders as well. (PS)
- Selection of participants can be improved. We usually do an assessment before we go to session (i.e they want to participate and are interested in music). One kid quit in the middle because he didn't want to do it. If some folks don't want to participate, it can interfere with willingness to participate. (PM)
- Would like to be more involved with the selection of participants. Seemed like their parents wanted them to be in it, rather than them. (PM)

- More collaboration with the schools, the therapists. The counselor selected based on their behavioral management needs in school, but not based on their love or motivation for music. Would like to make sure they're motivated (PM)
-

What the program should be called

- The term "music therapy" do we really need to use that? Some of the families had a reaction, wanting to know why my kid needs to be in this program, whether they have a behavioral problem or not, and so it would help if the name didn't have the word therapy in it. Take the therapy name out. Tailor it to how it fit with our age group (SEM)
    - Suggestions: music connections, community music intergenerational program (SEM)
- The term mental health and therapy scare people away. It intimidates people. Music therapy. I think it would be bigger without the word there. "I don't need therapy" Suggestion about what to call it? Not sure. Maybe "Music Expressions"? (SO)

How to find individuals who need referrals

- It's rare at this age for kids to have depression. But in these groups there were a few kids who had suicidal ideation. But I do believe this program is essentially planting the seed to show that we are working with mental health professionals, and they can be fun and not scary or intimidating. (SEM)
- Maybe the music therapy stuff could detect when kids needs referrals when they see the kids making their album covers, or choose their songs - kids could express that there. But, I already know which students in there need extra help. But the music therapy staff never gave me any feedback that any student in the group had depression or sadness; I never got any feedback about any kind of concern that they had. (SEM)
- I am using the program to fulfill a need I have for some of these kids to build connections, other ways to cope, etcetera. I already know which kids need help. [How would this program be able to identify kids in need in another school or system where a counselor is not as knowledgeable?] (SEM)
- This group of kids do have things like parent losses and other issues that they are dealing with. If the music therapists find out something that I should know about, then that would be great (SEM)

Targeting the Asian American Community

- I did try to take into account the fact that this was a program by an Asian American organization, but there were challenges. Most of our Asian identified kids are actually mixed, and some of the kids self identified race or ethnicity didn't actually match what is marked on their forms. (SEM)
- I'm not sure that developmentally, the younger kids are at a place where they identify primarily through their race or ethnic identity. It might be more appropriate for high school students. In middle school, they are just starting to learn about ethnic studies, etc. (SEM)
- I don't think in our school, we have enough Asian kids to have a group that is only Asian. I ended up creating a mixed group because that meets them where they are at. (SEM)
- *Something we could do better with: Recruiting participants, and have it more focused on Asian Americans so that they could outline their agenda more and focus more on Asian American (PA)

- I originally thought the participants would be Asian American, so it was hard to incorporate Asian American experience. That's something we can potentially improve on? Can we emphasize more on focusing on the Asian American experience (PM)
- The groups were very diverse (PM)

Program Strengths

General Comments (i.e., liking it)

- *[8 out of the 9 would do it again] (E)*
- I liked it. The music was fun. I liked it just the way it is (M)
- It was good (M)
- It was fun and funny (M)
- I liked every aspect of the program (i.e., before and after performance preparation) (M)
- I was good. I liked almost every aspect. (M)
- The program was supposed to be about music therapy but it turned into a fun time (M)
- It was fun – that was a good aspect (M)
- It was good (E)
- Good (E)
- Fun (E)
- "Absolute W!" It means good. A win. (E)
- It was fun! (E)
- I loved everything. Every aspect was absolutely great, I have no complaints. Other than it was too short. I would want it every day of the week. (E)
- It was so fun. It was kick back. (E)
- We're getting music instead of math [clap clap] (E)
- The program was good for seniors. (O)
- I'm grateful (O)
- I feel very grateful for the program (O)
- People are asking for it to come back. They want it to come back in the fall at Doelger (SO)
- *Some people came because son or daughter told them to go, and then they liked it (SO)
- Stress the fact that they loved it, it was well received, people want more. I'm blown away by how it went. (SO)
- *It's been hard to work with AAPI boys. But adding music therapy destigmatized the topic for them. They were really active in the performance. They enjoyed the process (PS)
- The seniors were the best group – they were so focused with each session date, really enjoyed it. (PA)
- *I learned how to adjust to my age and race I am 87 years old and so exciting to join the group (O)

<u>Music</u>

- The way they react to the music (M)
- It help me learn more about music (M)
- *Making a song with friends is fun (M)
- I liked the music part of it. I like listening to it (M)
- *I liked the music – making it together (M)

- I liked the music and how they do it (M)
- I had fun making the lyrics (E)
- *We can get together, talk about the music. (O)
- Babies need music. Everyone needs music. It's in our DNA. It's better than laughter, it's medicine. (O)
- I really enjoyed it. When I took this class, all of my music enjoyment from years ago just came out. (O)
- I'm almost 87 years old, and I enjoyed it. I was looking for a music outlet, and I could find one, and this did it! (O)
- Some discovered that they like music (SO)
- Everyone found a way for how to use music for themselves (PM)
- Got to understand more about the full process of music therapy. Seniors had more flexibility in time (PS / PA)
- *The performance was engaging, and more open to music therapy. Especially the seniors – they were more open to music therapy (PA)
- Just jamming with the group in general. Music makes me feel good, so having people to make Music with was a great way to unwind (H)
- The group singing, individual singing, the music, etc. (O)
-

<u>Art</u>

- The album drawings were great. We got to draw our own album with our favorite songs (E)
- *My favorite parts were…the party, the bus, the art we did, and the teachers (E)

<u>Flier</u>

- Feedback on the flier – it was good, gave a lot of information. People would come and ask questions about it and the flier answered all their questions

Wouldn't change anything – perfect the way it was

- I wouldn't change anything (M)
- I wouldn't change anything. It felt good the way it was. (O)

We want more of music therapy!

- We only met once a week. We want two times a week (M)
- I'd change the time – I want it more often, and longer (M)
- The time – more of it (M)
- *Add additional time (i.e. 10 minutes). It would be fun to do twice a week. (M)
- *I loved everything. Every aspect was absolutely great, I have no complaints. Other than it was too short. I would want it every day of the week. (E)
- I'd change thing to have more of it (E)
- I'd want to have more days to do it [I wanted more days to do the music] (E)
- I'd want to do it every day (E)
- I'd want more of it (E)
- Only thing I'd change is to do it every day. (E)
- One thing I'd change it to make the music therapy longer and every day. (E)
- *More time! I really enjoyed being able to go somewhere every week and have a safe space (H)

- Yes, what we completed, I hope it will continue to the second phase of the Music Therapy for Asian Americans Program, it will enhance our cultural learning more (O)

Teachers

- The teachers. They make it fun (E)
- I liked the teachers. They were really nice. (E)
- *My favorite parts were…the party, the bus, the art we did, and the teachers (E)
- I liked the teachers, Mai and Crystal. They should get a higher raise. Have them do it again. (E)
- The teachers are all super talented. I'm impressed. (O)
- Crystal and Mai – they're so talented (O)
- the teachers and facilators are absolutely capable mentors and coaches - fitting my needs. (O)

Technology / Software (M)

- They used an application / software. That was cool (M)
- I liked using the software. It was my idea to bring it in. They were going to use Music Lab, but we suggested SoundTrap and they agreed. (M)

Food

- The food was good. Every time, they brought food. Our favorites were McDonalds and pizza (M)
- The support group people - they brought food – KoolAid and granola bars. That was good. (M)
- Can you involve Westmore High School? Cuz I'm going there next year [and want to do it again there] (8th grader - M)
- Snacks. I like the snacks (E)
- *I liked the snacks the best, and the party. (E)
- [I also liked the snacks and the party] (E)

Social Connection / teamwork

- Grouping with students outside of social group and using skills to work together (M)
- *Making a song with friends is fun (M)
- Meeting new people (M)
- *I liked the music – making it together (M)
- I liked the teamwork when we made the music. We each tried to come up with different words. There were different teams who did different things and then we put it together. (M)
- The best part was making the song together, because it was really fun and nice. (M)
- The best part was making the song all together. We could put our minds all together depending on what songs we liked. (M)
- [We made new connections across grades] We kind of knew each other from before music therapy. Not really. 4 years ago I talked to that guy. I never met that guy before. We didn't know each other from different grades. (M)
- It's good for helping people make friends (E)
- It's good for helping people make friends (E)

- We weren't friends before [two kids]. We used to be *enemies* [joking] and now we're friends (E)
- It was good to hang out. We usually don't get to hang out with our friends, and our friends were here, so we got to hang out, by ourselves, and during school. (E)
- *We can get together, talk about the music. (O)
- Socialization – the music made that possible (O)
- I was just walking by, and they invited me in, to join for the performance. People enjoyed each other's company. (O)
- It's nice that we have a group where we can be friends. Before we didn't know each other, and now we're friends because of the music therapy group. (O)
- I really enjoyed going there. I got to know [other people in the group], and the community. (O)
- We all had a different type of music background that brought us together in the class. (O)
- The kids had friendships built up through this program (SEM)
- Smiles and laughter and the enjoyment and the fact that they were coordinating together to create this project (SO)
- They liked the sense of community that the program gave them. They didn't feel like they were alone. Felt like they had a common interest. It helped for the more quiet people to come out of their shell (SO)
- Reason to leave the house – people otherwise who wouldn't have anything to do. (SO)
- I saw friendships grow – now they have lunch together, they sit outside and talk together in the courtyard. Rather than sticking with their original folks / circles. They go with their little groups of people. Sometimes they're not as welcoming with a new person that sits there. (SO)
- They didn't have any competition like they have in Zumba, ping pong (SO)
- It's the fact that they had to work together to create this one performance. (SO)
- *Probably helped because they got to know one another and find common ground. Things that they were feeling, they found they weren't alone in how they felt. Feeling unseen. They felt seen. They were seen in a big way. We put them on the map. (SO)
- What did the kids get out of music therapy? They learned how to socialize (PM)
- *[The high schoolers] had a space to share feelings in the group (they shared positive feelings about family; also anxiety about how do I play and interact with other people)i.e. one immigrant teen was able to feel more comfortable and feel more connected to people (PS)
- Felt a lot of growth, particularly for the younger students. Wasn't a lot of group cohesion in the beginning. At the final performance, there was a lot more group collaboration and openness to the different personalities (PM)
- Older adults: With the performance – it was clear how much they loved bonding with each other (PS / PA)
- Participants in all groups were able to connect more (PM)
- *Having a small group of people who can freely talk about feelings or someone else who can understand the things that we have a hard time understanding (H)
- *More time! I really enjoyed being able to go somewhere every week and have a safe space (H)
- *Just having one hour to sing and play musical instruments relaxes me. Sitting down with the Dodger community. I got to know the people better. (O)
- I found how easy it was to find a wonderful, supportive group of friends I met in our group. (O)

- After the music program was completed, I find that our group became closer and I found a life long support group and good friends. (O)
-

Mental Health Outcomes *(better self-esteem, feeling connected to other people, Coping skills, Knowledge about behavioral health, Tackling any stigma about mental health, more aware of and comfortable talking about their feelings and mental health)*

- I felt the same before and after [didn't really make me feel better] (M)
- It made me feel the same.
- Didn't make me feel worse. About the same (M)

- Maybe it made me feel better? (M)
- It made me feel better, and more relaxed from the music (M)
- It made me feel *a little* better (M)
- *It [the performance] made me feel proud. (M)
- Music therapy helped me cope with stress (M)
- It was very calming. (E)
- When we come in here, I feel less stressed. Coming here is like a break. (E)
- I feel very happy when I come to class. Music is the best medicine. It makes your breathing better. (O)
- Before I felt invisible because I was the middle child. But then they gave me a solo. I had a good time [Pride] (O)
- It was like therapy. Every time I sang, I feel better. I feel less stressed. (O)
- It makes us feel like kids again (O)
- *The performance gave us the feeling of a high It felt really good. (O)
- 3 people said it made them feel less stress/more relaxed. (O)
- I felt better after the session. (O)
- I believe in anonymous counseling (i.e. Through social connection and other activities that may not be labeled therapy). And I think it worked, it made them feel good (SEM)
- All were welcome at every level. They got cheered on – even if they made a sound with an instrument. Everyone could participate, and everyone was given respect from the audience and from each other. No one felt criticized, even though I don't have a musical bone in my body. (SO)
- *Probably helped because they got to know one another and find common ground. Things that they were feeling, they found they weren't alone in how they felt. Feeling unseen. They felt seen. They were seen in a big way. We put them on the map. (SO)
- It helped people to handle stress in daily life. Some people sitting outside. He said "I'm stressed out" and started drumming on the table – I'm stressed out so I have to play something – he has no music background – then he was in the library laughing with people. (SO)
- The piano player was very depressed – now he's the happiest guy. (SO)
- Proud: Shy students were able to express themselves more. They were more comfortable to talk, they talked louder. One student who showed disruptive behavior, but at the end at the performance, he was there and he was one of the key performers, I believe he was able to change. 4th and and 5th grade (PS)
- Really like seeing how they use music to express themselves across all dimensions. (PM)

- 4th and 5th graders have strong opinions. They were able to express their feelings towards school in a song that was my favorite part of the program. They were able to express their emotions and thoughts properly. (PM)
- *[The high schoolers] had a space to share feelings in the group (they shared positive feelings about family; also anxiety about how do I play and interact with other people)i.e. one immigrant teen was able to feel more comfortable and feel more connected to people (PS)
- *Support group – got to express their emotions, reflect on their life stories. Nice juxtaposition in with the music therapy where we didn't see more of the life story (PS / PA)
- *Having a small group of people who can freely talk about feelings or someone else who can understand the things that we have a hard time understanding (H)
- *Just having one hour to sing and play musical instruments relaxes me. Sitting down with the Dodger community. I got to know the people better. (O)
- Perfectly compatible with relaxation needs, health needs. (O)

Elementary participants, stress level

- It made me feel less stressed (6 of 9) (E)
- None said it made them feel more stressed (E)
- 3 were unsure (E)

Addressing Stigma

- *It's been hard to work with AAPI boys. But adding music therapy destigmatized the topic for them. They were really active in the performance. They enjoyed the process (PS)
- For the seniors and older adults, they were already so open to the concept (of music therapy) (PM)
-

The Performance

- It was fun that we got two songs instead of one. That was cool (M)
- It was good. I'd definitely do it again. (M)
- *It [the performance] made me feel proud. (M)
- The party was the best (E)
- I liked the bus [to the performance]. It was cushiony. (E)
- The rap. That was good (E)
- The party was my favorite part (E)
- I liked the bus (E)
- *My favorite parts were…the party, the bus, the art we did, and the teachers (E)
- *I liked the snacks the best, and the party. (E)
- [I also liked the snacks and the party] (E)
- I liked the school blues song. I liked making the lyrics. It's like school rules, but school blues. (E)
- I loved each performance (from the different ages). I liked how there were elderly people. High school people. (E)
- I liked that it was recorded. I didn't want to go up there and speak. It would make me feel more stressed (E)

- I'm glad [the other participant] egged me to stay on. I'm glad I stuck with it and was able to perform. (O)
- We liked the performance. Getting up there and there was a good audience. (O)
- *The performance gave us the feeling of a high It felt really good. (O)
- I felt really good about myself. I felt like I accomplished something. It was a nice feeling, like oh wow, I performed in front of people. They applaud. (O)
- They loved the performance at the end (SO)
- They felt seen. They were seen in a big way. We put them on the map…It didn't matter who was there. Mayor and city council was there, lots of staff watching, few other seniors scattered about (SO)
- *It's been hard to work with AAPI boys. But adding music therapy destigmatized the topic for them. They were really active in the performance. They enjoyed the process (PS)
- Performance was awesome [for the high schoolers] (PS)
- Older adults: With the performance – it was clear how much they loved bonding with each other (PS / PA)
- Was great to have the younger kids see the older adults so they can see what is their attitude in life (PS / PA)
- *The performance was engaging, and more open to music therapy. Especially the seniors – they were more open to music therapy (PA)
- The performance was great in terms of it being intergenerational. They had fun and enjoyed it (PA)

Program Areas of Improvement / Recommendations

Organization

Logistics / Schedule of sessions

1 person thought the program was way too long, 3 thought it was just right, and 1 thought it was too short (O)

- *Deadline was too tight for the performance. We needed more time to prepare. [So I want] longer time in between sessions (M)
- I want longer time for each session (M)
- Something I'd want to change would be to move it to another day because sometimes I had a conflict with band. I'd move it to Mondays and Wednesdays.
- I'd change it to 4th period. Then we wouldn't have to miss stuff. Like right now, we were on a break and we had to come over. (M)
- *Add additional time (i.e. 10 minutes). It would be fun to do twice a week. (M)
- It interfered with Zumba. Coordinate with the center to find a better time so that it doesn't interfere with other things. How about Thursday. (O)
- Challenge – It was hard for everyone [the high schoolers] to get together. (PS)
- Longer times and more days (M)
- Different locations (M)
- More snacks (M)
- More class time (M)
- Longer periods (M)
- Better schedule. Ex: Monday, Wednesday, Period 4 (M)

Partnerships and recruitment

- A lot of time spent figuring out which partnerships would be the best. Perhaps we could meet with the counselor ahead of time (PA)
- Challenges with attendance with high schoolers – would like to find a group that would stay from beginning to end. (PA)
- See which sites are more eager to partner (PS / PA)
- From the beginning, we need more care in selecting partners, and to clarify the expectations from each partners to have full commitment (PS / PA)
- Next cycle – do more research on the high school sites to see if can improve commitment
- Was helpful to add the grant management meeting, to make sure we get the deliverables (PA)

Marketing

- It wasn't advertised enough for people to know to do it. Get the word out more. (O)
- To market the program, maybe go to lunch and have everyone sing a song (i.e. Puff the Magic Dragon, Michael Row the Boat Ashore) for five to 10 minutes, so they may want to join the program. (O)
- *The name doesn't apply. There was nothing to do with the skills of music, no lecture about the skill of music. The word "therapy" doesn't apply. Maybe use the word "enjoy," "relax" (O)

- Started off with 20 people and started to dwindle – they had a regular group of folks (SO)
- Some people came because son or daughter told them to go, and then they liked it (SO)
- Maybe better advertising, but other than that, the program was great as is. (H)

Organization within the curriculum

- *Give them an outline of what the class involves. Something in writing more than the flier (SO)
- I wish it were more organized. In the actual sessions, it felt a little disorganized. We were all doing our own activities. We all started as a group, and then everyone was doing different things, and then we ended up in two different groups for the performance. [The two groups wasn't necessarily a problem..] It would [just] be great if there was some kind of rubric or guidelines to follow. (M)
- Change the timing of the sessions so we can work on our songs faster (M)
- *Start the song sooner so we get more time. I think I could have made a two minute song. We met 7 or 8 times before we made the song. (M)
- For high schoolers: We did outline it with the number of sessions, but they had senior seminars, band, etc. But I guess we could reiterate. If we say there are X sessions, it might help with having them all come. (PA)

2. Music – Feedback on the approach, technique, etc.

- The School Blues song was all negative, and it was embarrassing. They should have balanced it out with more positives about school. It was embarrassing to bring the school staff and have the mayor there. (SEM)
- I'd maybe make [the School Blues song] not that mean – maybe put some good stuff in it. Cuz some parts of school are great. (E)
- I think we should get a different mix of beats. We were using the same rhythm, and it was getting kind of boring. (E)
- Maybe each week, introduce us to a different instrument (O).
- Let a different person each time do a solo so that they get used to doing solos. (O)
- Learn to read music and play guitar or piano. (O)
- Incorporate different instruments (O)
- The tambourine, and the different instruments. We got to use the different instruments, but we didn't know how to use it. It would have been great to learn how to use them. (O)
- *The name doesn't apply. There was nothing to do with the skills of music, no lecture about the skill of music. The word "therapy" doesn't apply. Maybe use the word "enjoy," "relax" Understanding Asian music. Rather than therapy. There were no instruments. It was percussion only. (O)
- Some (of the older adults) were concerned about the quality of the music they were creating. It was hard for some participants to come to terms with that (PM)
- Introduce more medicinal instrument, more music variety (O)
- We need more music/songs -- more variety we need it more intense. (O)
- For me it was almost no effect at all. Because I already played music before [piano]. But the program is good. (O)
- *The program should be more intense, more participation, more fun. (O)
- Some of us don't have that much music background; I'd be interested in learning how to read music and learn an instrument. (O)
- It what support better is you could also work individually not always as a group (M)
- Make it more interesting for the students. (M)

- Make it more interesting for the students who participate in music therapy then you will see the results (M – parent)

3. Social Connection Opportunities (4 comments)

- We want more people. Maximum capacity. At least 20 people (M)
- I would want more people to be here. Everyone to have one buddy that could come. (E)
- It was kind of small [in terms of number of people] (E)
- *The program should be more intense, more participation, more fun. More people, more interactions, more participation. (O)

4. The Performance (3 comments)

- *Deadline was too tight for the performance. We needed more time to prepare. [So I want] longer time in between sessions (M)
- *Start the song sooner so we get more time. I think I could have made a two minute song. We met 7 or 8 times before we made the song. (M)
- Do [the performance] in different places, like at our school. Because we're more used to our school. It would feel better here, because we already know it. (M)
    - [Some wanted it at school, most didn't care]

5. Technology / Software (M; 3 comments)

- None of them really had experience with music. It would have been helpful if the teachers (i.e., Mai and Crystal) had more experience with music making (i.e., with the software). It wasn't clear if they had experience until they started playing the guitar. They were musicians, but it would be great to have someone who had experience with the software or making music online. (M)
- The online stuff was really confusing so I just quit. It was too confusing. (M)
- [they were split down the middle; some liked the online components, and some liked the physical musical instruments. Conclusion: maybe they should have both] (M)

6. Need more work on making people more aware of / comfortable talking about feelings / mental health outcomes (1 comment)

- Not good [the program didn't do well in this area]. My child is the same. (M - parent)

Cultural Fit / Components

- The Kindergarten teacher (non-Asian woman). She came for a bit but then dropped out
- The group was almost all Asian Americans
    - It targeted who we were looking for, and the Doelger Senior Center is mostly Asian (Mostly Chinese, Korean, some Filipino). The fact that it was NEMS made Asian people go: The fact that NEMS was on it made them ask "Do I need to be Asian" and then they'd ask after going "Oh I need to be Asian"
    - The non-Asian Americans dropped off. 1 White person dropped out, she had early onset dementia – maybe the caregiver didn't want to bring here ("I don't want to be here. I need to shop for homes"). Most participants were Chinese.

- In the high school groups, we discussed some culture and immigration stuff. High schoolers were mostly from Filipino, Switzerland or Vienna, whereas others were born in us. Others have never been outside of here. Talked about the immigration experience in the support group (PS)
- *Something we could do better with: Recruiting participants, and have it more focused on Asian Americans so that they could outline their agenda more and focus more on Asian American (PA)
- I'm not sure if it fit my ethnica background but think it's appropriate for everyone. (O)
- It didn't fit we're not Asian (M)

Wasn't aware of cultural component / Program didn't address culture

- Didn't really go into culture (M)
- I didn't know it was Asian Americans. (O)
- Was there an Asian name on the flier? No, but the NEMS name was on it (O)
- There have been other events that are AAPI focused, and lots of people came who weren't non Asian [there may be a way to advertise for Asians but have everyone come] (O)

Did any of the programs speak to your cultural background?

- Filipinos are very musical people, so the program fit right up my alley (H)
- Fits well :) My family comes together for music / karaoke often. This was nice. :) (M)
- People support each other and try to understand one another, not judging about the things we talk about (H)
- No, not at all. (M)
- Not really. (M)
- Cultural background – that's risky. How would that be related? (M)
- That was supposed to be a feature? No, that wasn't in there. (M)
- [They didn't do anything about our culture / cultural background] (E)
- Did it do anything for you, to be in a group of all Asian Americans?
    - Yes of course. We liked connecting with other Asian friends. We want it to be open to everyone, but it was also nice to connect with other Asians.
- There was no Asian music. It was all American. (O)
- *I learned how to adjust to my age and race I am 87 years old and so exciting to join the group. It's excellent, I was able to adjust with of different cultures specially my age (O)
- it was great, [I] like[d it] (O)

Reluctance about recruiting just Asian Americans

- You need to focus on everybody not just Asian or Asian American. Every ethnic background should be included. Focus more on every ethnic background and communities, not only Asians (M - parent)
- Labeling it as cultural may be limiting. It should be more inclusive. There's a same equal need among non-Asian Americans (O)
- Are you just going to do it for Asian Americans? You should do it for everyone (O)
- We shouldn't exclude people who are non-Asians (O)
- It shouldn't say Asian Americans on the flier (O)
- Asian cultures are music oriented. But it's more of a general DNA thing across ethnicities. We don't want to be exclusive. (O)

Support Group

Informational only: Description of Support Group Content

- Elementary school: Planned to do drama and role play. One word to choose to express their feelings, and the other mirror them. Warm up, and then gave big art paper to draw their feelings. To be able to Express and support each other. Didn't want to ask too personal of questions. Create a space for them to know each other (PS)
- Middle school: Support group – came with an open agenda and see what they're interested in doing. used a process group model, and then do some psychoeducation based on what they say. Ended up talking about the music therapy and the relationship with wellness (PS)
- Emotion cards. There's a drawing on it depicting different emotions. I started with who are you and where are you from. High schoolers shared a lot of different things (PS)
- Older Adults: *Support group – got to express their emotions, reflect on their life stories. Nice juxtaposition in with the music therapy where we didn't see more of the life story (PS / PA)
- Older adults: Used the mental health bingo game – with each bingo item, how did they feel with certain emotions (i.e. what does anger and anxiety feel like – they provided psychoeducation with each other) (PS / PA)
-

Positive effects

- We played bingo. It was really nice to have the variety, to break up monotony (O)
- A couple people said the support group was interesting (SO)
- *Support group – got to express their emotions, reflect on their life stories. Nice juxtaposition in with the music therapy where we didn't see more of the life story (PS / PA)
-

<u>Helped to create social connections</u>

- We learned about each other, and maybe that's why we feel closer to each other. We were able to share more about our personal life and stories. (O)
- It helped to bring us together, and connect (O)

Awareness / Don't remember it

- No [I don't remember meeting with a therapist] (E)
- No [I don't remember meeting with a therapist] (E)
- No [I don't remember meeting with a therapist] (E)
- I remember another person just watching us, not saying anything. Maybe Jocelyn? (E)
- There were two people watching, and then one other person talking to the teacher. Can't remember (E)
- Did anyone ever ask about your feelings? Mai and Crystal did. We went around in a circle and talked about our day, and they asked how we were feeling. (E)
- Make sure that they're aware that it's also therapy, that there are group sessions. They didn't understand that (SO)

Need better organization

- We just kind of talked about stuff. It was kind of "scuffed" – not really in place / rough. Unorganized. (M)
- It felt really last minute. (M)
- We talked about music therapy, and taxes. It kind of got off topic. We talked about feelings for like the first part, maybe 5 minutes, and then it was a 180. We talked about taxes (we brought that part in). (M)
- *Give them an outline of what the class involves. Something in writing more than the flier (SO)
- *Think about how to coordinate the support vs. the music therapist role (PS)

<u>Need better fit between support group and music therapy</u>

- It felt out of place. (M)
- What was it like when you talked about the feelings? We forgot, honestly. We went around in a circle and talked about how we felt that day. That felt scuffed. (M)
- What should be changed? We should get money (haha). You should pay us to calm down. $1 per feeling (haha). (M)
- It was unclear what the therapist was here for. (M)
- So in conclusion nothing really happened. (M)
- Should they do it more often? No – unless they bring food. (M)
- Did it give you place to talk about feelings, get support for what you're going through?
    - It did somewhat
    - But we don't really have any problems [to address] (joking a little bit) (M)
- *Think about how to coordinate the support vs. the music therapist role (PS)
- Support group was too abrupt; they were confused, they were looking for more music therapy. Without agenda or curriculum it was hard to orient them and center themselves. Either add more support groups or just integrate the curriculum. (PS)
- Better coordination with the support therapists, so that we don't have as much coordination. We're both working towards mental health, but using different techniques. That would allow us to tell the kids and prep them more. (PM)
- The NEMS therapists aren't there every session – so it's a bit confusing for participants – perhaps the session before, the therapists could be more involved with the music therapy so that the transition is more smooth (PM)
- More coordination between music therapist and support therapists – to coordinate more. (PS / PA)
-

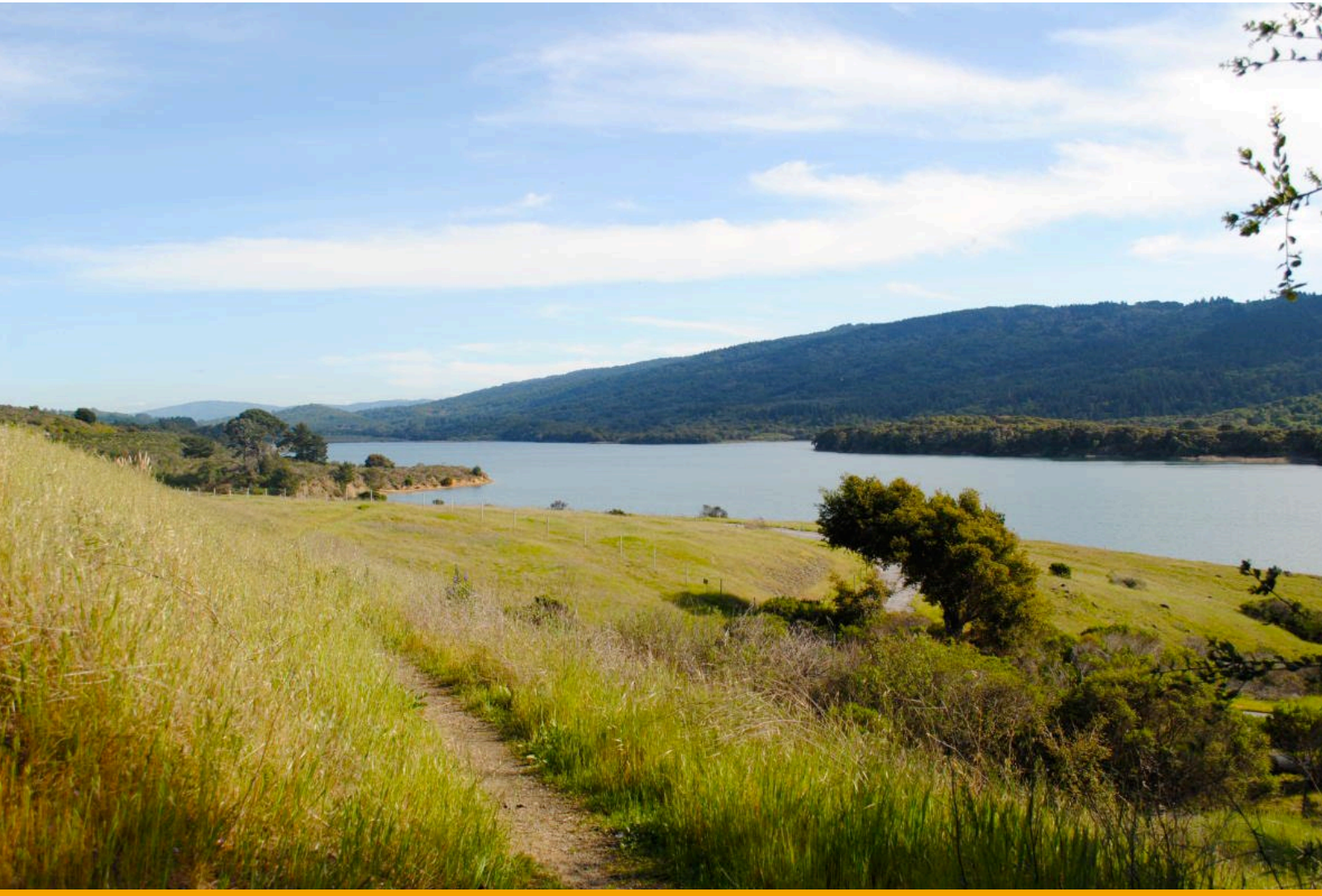
<u>Didn't think it should be included</u>

- There was one session where we talked about our personal life. It was nice, but I thought that was a little [strange]. I thought it was too deep, and too personal. It makes too many opportunities to compare with other people [and maybe feel bad about your own life situation – i.e. I can't travel, identity theft] (O)
- Suggestion: In the beginning, give permission to people to not share if they don't want to. They can just say "I pass." (O)
- 1 person said it was a waste of time (SO)

Referrals

- No comments

APPENDIX 13. PIONEERS PROGRAM INN EVALUATION REPORT, FY 2023–24



San Mateo County Behavioral Health & Recovery Services

Mental Health Services Act Innovation Evaluation

Pacific Islanders Organizing, Nurturing, and Empowering Everyone to Rise and Serve (PIONEERS) Annual Report

Fiscal Year 2023-2024

RDA CONSULTING | 40 YEARS of Systems Change | ASIAN AMERICAN RECOVERY SERVICES A PROGRAM OF HEALTHRIGHT 360 | SAN MATEO COUNTY HEALTH BEHAVIORAL HEALTH & RECOVERY SERVICES

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Fiscal Year 2023-2024

This report was developed by RDA Consulting under contract with the County of San Mateo Behavioral Health and Recovery Services.

The photo on the title page is of the Crystal Springs Regional Trail (Source: The San Francisco Peninsula)

RDA Consulting, 2024

RDA CONSULTING | 40 YEARS of Systems Change

ASIAN AMERICAN RECOVERY SERVICES
A PROGRAM OF HEALTHRIGHT 360

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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Acknowledgements

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Lastly, an acknowledgement to the RDA team who completed this evaluation: Alison Farringer, Caroline Calonge, Dina de Veer, and Vanessa Guerrero.

Introduction

In 2004, California passed Prop 63, the Mental Health Services Act (MHSA). The MHSA aims to expand and transform the public behavioral health system with the values of 1) Recovery, Wellness, and Resiliency; 2) Consumer and Family Driven; 3) Community Collaboration; 4) Cultural Competency; and 5) Integrated Services.

The purpose of the MHSA Innovation (INN) component is to pilot new and emerging behavioral health approaches to address the needs of underserved populations and contribute to learning across the state. MHSA INN funds provide an opportunity for counties to implement innovative behavioral health services and learn about practices that have the potential to transform the behavioral health system.

Pursuant to Welfare and Institutions Code Section 5830, all MHSA INN projects must meet the following requirements:

1. Address one of the following as its primary purpose:

- Increase access to underserved groups.
- Increase the quality of services, including measurable outcomes.
- Promote interagency and community collaboration.
- Increase access to services.

2. Support innovative approaches by doing one of the following:

- Introducing new behavioral health practices or approaches, including, but not limited to, prevention and early intervention.
- Making a change to an existing behavioral health practice or approach, including, but not limited to, adaptation for a new setting or community.
- Introducing a new application to the behavioral health system of a promising community-driven practice or an approach that has been successful in non-behavioral health contexts or settings.

In December 2022, San Mateo County (SMC) Behavioral Health and Recovery Services (BHRS) was awarded a four-year MHSA INN grant from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to implement the Pacific Islanders Organizing, Nurturing, and Empowering Everyone to Rise and Serve ("PIONEERS") Program. This report details the first fiscal year of implementation from July 1, 2023 to June 30, 2024 (FY23-24).

INNOVATION (INN)

INN projects are new, creative mental health practices/approaches that contribute to the learning process in the mental health field. INN projects must be developed in partnership with communities through a process that is inclusive and representative, especially of unserved and underserved, and inappropriately served individuals.

Program Overview

The PIONEERS program serves addresses the unique challenges faced by Native Hawaiian and Pacific Islander (NHPI) youths (ages 12 to 24 years old). Culturally responsive behavioral health services are urgently needed for NHPIs, as their cultural beliefs and practices often deter them from seeking professional help. The PIONEERS program offers culturally relevant behavioral health services for NHPI youths in SMC. Notably, there is currently no other behavioral health prevention program in SMC specifically tailored to NHPI youths, making this program an innovative and much-needed solution.

The program is implemented by the community-based behavioral health provider Asian American Recovery Services (AARS), a program of HealthRight360, and partners with SMC Community Colleges, area high schools and middle schools, BHRS, and other community-based behavioral health providers to establish essential services on campuses.

Below are the key program components of PIONEERS.

- **The Leaders in Training, or "LIT," Council.** The LIT Council is a youth advisory circle comprised of NHPI youths. Their input has guided the development of the program's design. LIT Council members engage in community engagement projects by leading workshops with the community. This enables participants to apply the knowledge and skills they acquire through the program to address the needs of their communities
- **PIONEERS Wellness Workshops.** The PIONEERS Wellness Workshops are a ten week, cohort-based cultural and mental health education program delivered directly to students in schools. Topics covered include the importance of cultural connectedness, migration stories, community memberships, and the power of resistance, among.
- **Mana Sessions.** These as-needed sessions provide a safe space for NHPI youths to decompress, engage in one-on-one or group discussions centered around behavioral health and wellness, and participate in skills-building workshops. These sessions are designed to promote emotional well-being and resilience.

For more information about the PIONEERS program design, see **Appendix A**.

Program Innovations & Adaptations

Figure 1. PIONEERS Program Innovation Timeline

Aug-Oct 2023

- Program fully staffed!
- Started building relationships with school staff and students
- Conducted outreach and responded to incidents in the community
- Began recruiting for LIT Council

Nov 2023-Jan 2024

- Held LIT Council Meet and Greet
- Continued school outreach and relationship building
- Planned for cohorts

Feb-Apr 2024

- Officially launched LIT Council and Mana Sessions
- Began cohort programming in Middle School and Community College
- Held AARS Grand Re-Opening

May-Jun 2024

- Completed cohorts
- Conducted outreach for fall cohorts
- LIT Council facilitated their first community engagement project
- Planned for LIT Council summer programming
- Tabled at San Mateo County Fair Pacific Island Day

Relationship Building and Outreach. Before the program officially launched, PIONEERS staff began building relationships with school staff and students. This allowed the program to scout potential locations for their in-school cohort programming. The team also conducted outreach in the community, attending and tabling at multiple events to gain trust of community leaders and begin to recruit for the LIT Council.

Cohorts in Middle Schools and Community Colleges. The original intention of the program was to provide programming in middle schools, high schools, and community colleges. However, high school administration was very challenging to connect with and PIONEERS ultimately made the decision to begin their cohort programming in middle schools and community colleges, where they had been building strong relationships with school staff.

LIT Council. The original design of the LIT Council was a youth advisory board intended to guide program design and evaluation decisions. But as the group continued to meet, PIONEERS staff saw that the true need for this group was to provide emotional wellness and community building services.

For a detailed description of program implementation updates by month, see **Appendix B**.

Evaluation Overview

In July 2023, SMC BHRS contracted RDA Consulting (RDA) to conduct a multi-year evaluation of the PIONEERS program, concluding in 2026. The purpose of this evaluation is to: (1) evaluate PIONEERS processes (implementation) and outcomes; (2) support continuous program improvement efforts; and (3) satisfy and comply with MHSA INN regulatory requirements, including annual and final evaluation reports to the MHSOAC.

Since starting the evaluation of the PIONEERS program in July 2023, RDA has worked closely with AARS and SMC BHRS to accomplish several key evaluation activities:

Developed an Evaluation Plan and Data Collection Tools. In partnership with AARS, RDA developed an evaluation plan that is intended to be used as a roadmap throughout the evaluation process. This plan is inclusive of the learning goals, evaluation questions, the proposed evaluation methodology and analytic framework, potential limitations, and reporting requirements. Using the evaluation plan, RDA collaborated with AARS to develop data collection tools including focus group protocols, a youth service log, and a youth survey.

Data Collection. RDA facilitated focus groups with both PIONEERS staff as well as youth participants in the LIT Council. AARS administered the youth surveys and inputted data into the youth service log.

Data Analysis. To inform this report, RDA analyzed the data collected in the first FY of the program. This includes data gathered from the focus groups, youth surveys, and youth service logs. Together, RDA and AARS made sense of the findings during a virtual data party. During the data party, AARS provided RDA with additional insights to help inform data interpretation.

Throughout this partnership, RDA also held regular monthly meetings with AARS and SMC BHRS to stay updated on the program's progress, discuss any new developments, and share evaluation progress. These ongoing meetings will continue to ensure the evaluation remains on track and that the findings are used to support the program's growth and success. Collectively, these efforts have laid the groundwork for an evaluation that will help to answer key questions about how the program is working and the impact it is having on the program participants. The following section outlines the specific evaluation questions guiding this work.

Evaluation Questions

In alignment with the program's learning goals, RDA and PIONEERS program leadership developed a set of evaluation questions to guide the assessment of the PIONEERS program. The evaluation questions aim to serve as a framework for assessing the program's ongoing implementation, its impact on access and utilization of behavioral health services, and the behavioral health and quality of life outcomes it generates for the NHPI youth community. By exploring these four questions in Table 1 below, RDA aims to capture a holistic view of the PIONEERS program and its contributions to NHPI youths' behavioral health and well-being.

Table 1. Evaluation Questions and Associated Learning Goals

Evaluation Questions and Learning Goals	
Q1	How is the PIONEERS **program being implemented** over time?
	Learning Goal To assess and improve the implementation of the PIONEERS program to ensure it effectively meets participant needs, fosters collaboration, and delivers quality services.
Q2	To what extent does the PIONEERS program **improve wellness outcomes** for NHPI youth participants?
	Learning Goal To determine the extent to which the PIONEERS program enhances wellness outcomes for NHPI youth participants, focusing on the engagement and satisfaction with services and emotional wellbeing.
Q3	To what extent does PIONEERS, a culturally relevant youth and community focused program, **improve access to behavioral health services** for NHPI youth participants?
	Learning Goal To examine the extent to which the PIONEERS program improves access to culturally relevant behavioral health services for NHPI youth participants and cultivates emotional well-being, cultural pride, and a sense of belonging.
Q4	To what extent does the integration of leadership and community advocacy **improve quality of life outcomes** for NHPI youths who participate in the PIONEERS program?
	Learning Goal To evaluate the extent to which the integration of leadership and community advocacy within the PIONEERS program contributes to improved quality of life outcomes for NHPI youth participants, including their awareness, engagement, educational attainment, and wellbeing.

Methodology

RDA used a mixed-methods approach in this evaluation, combining both quantitative and qualitative data to provide a holistic view of the program. This method ensured that the evaluation team addressed SMC BHRS and PIONEERS priorities, answered key evaluation questions, and met MHSA INN reporting requirements. The annual evaluation report includes information about how the program was put into action, how participants engaged with services, and the short-term outcomes achieved during FY23-24.

Data Collection

As part of the evaluation planning process, RDA, SMC BHRS, and PIONEERS collaborated to identify and discuss qualitative and quantitative data sources that could be used to address the evaluation questions for FY23-24 reporting. Data was collected from December 2023 through May 2024. RDA provided incentives for all survey respondents and LIT Council focus group participants. **Appendix C** provides a detailed overview of the learning goals, evaluation questions, the indicators and measures, and the data sources used for this evaluation.

Table 2 below outlines specific data sources and collection methods RDA used to gather information for the evaluation, further described in the following sections.

Table 2. Data Sources and Collection Methods

Data Source	Participants	Sample (N)	Collection Timeline
Focus Group	LIT Council	7	April 2024
Focus Group	PIONEERS Staff	6	May 2024
Youth Survey	Cohort Participants	47	Feb-May 2024
Youth Service Log	Cohort Participants and LIT Council	40	Dec 2023-June 2024

Quantitative Data

Youth Survey. In collaboration with the PIONEERS team, RDA developed a confidential, voluntary survey for cohort participants. The survey measured participant engagement in the program, satisfaction with services, and impact of the program on participant mental health, cultural identity, and stigma. Items used to measure mental health and stigma were adapted from Generalized Anxiety Disorder-2 (GAD-2)[1], Patient Health Questionnaire-2

[1] Sapra, A., Bhandari, P., Sharma, S., Chanpura, T., & Lopp, L. (2020). Using generalized anxiety disorder-2 (GAD-2) and GAD-7 in a primary care setting. *Cureus*, 12(5), e8224. https://doi.org/10.7759/cureus.8224

(PHQ-2)[2], Ask Suicide-Screening Questions (ASQ)[3], and the Attitudes Toward Serious Mental Illness Scale–Adolescent Version (ATSMI-AV).[4] PIONEERS staff administered a total of 47 surveys: 39 pre-surveys in February and 16 post-surveys in May. Paper surveys were scanned and uploaded to a secure file transfer protocol (SFTP) site, where they were then saved to a protected folder for analysis.

Youth Service Log. RDA developed an Excel tracking tool for PIONEERS staff to log LIT Council and cohort participant information. The tool was adapted from an existing service log from a similar program.[5] This included information about client demographics, program enrollment, referrals provided, and activity participation. Staff entered information for 40 LIT Council and cohort participants. The youth service log was uploaded to a secure file transfer protocol (SFTP) site, where it was then saved to a protected folder for analysis.

Qualitative Data

Focus Groups. RDA facilitated two focus groups, one with LIT Council members and one with staff. Each focus group was tailored to gather unique insights from each group based on their position within the context of the PIONEERS program. All focus groups were virtually for approximately 1 hour each. RDA developed the protocol for the LIT Council focus group with input from PIONEERS staff.

The focus group with LIT Council members involved discussions of participants' experiences with activities and services and the impact on their wellbeing, access to behavioral health services, and quality of life. There were seven LIT Council members who participated in the focus group.

The focus groups with PIONEERS staff included discussions of program implementation and adaptations, service delivery, collaboration with partners and staff, and client engagement and outcomes. There were six staff members who participated in the focus group.

Monthly Evaluation Meeting Documentation. RDA used virtual, monthly evaluation meetings with PIONEERS as an opportunity to make additional observations about how the program was being implemented over time and to what extent the program was identifying needs and best practices to support participants. RDA documented these additional observations

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[2] Arroll, B., Goodyear-Smith, F., Crengle, S., Gunn, J., Kerse, N., Fishman, T., Falloon, K., & Hatcher, S. (2010). Validation of PHQ-2 and PHQ-9 to screen for major depression in the primary care population. *Annals of Family Medicine*, *8*(4), 348–353. https://doi.org/10.1370/afm.1139

[3] National Institute of Mental Health. (2024). *Ask suicide-screening questions (ASQ) toolkit.* Retrieved from https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

[4] Watson, A. C., Miller, F. E., & Lyons, J. S. (2005). Adolescent attitudes toward serious mental illness: *The Journal of Nervous and Mental Disease*, *193*(11), 769–772. https://doi.org/10.1097/01.nmd.0000185885.04349.99

[5] ALAS Cariño Project.

through meeting notes and used a portion of these meetings to gather program updates from PIONEERS. These meetings were held for up to one hour.

Data Analysis

RDA conducted a mixed-methods evaluation using qualitative and quantitative analysis techniques, triangulating findings from multiple data sources and types to produce a more robust set of findings.

To analyze quantitative data, RDA used Stata to calculate descriptive statistics such as basic frequencies and averages for survey and service log data. RDA excluded non-response or missing data from analysis at the item level. Per recommendations from The California Department of Social Services (CDSS), RDA de-identified data that represented fewer than 11 individuals to protect client confidentiality.[6]

Qualitative data were analyzed using a systematic approach. RDA transcribed, reviewed, and thematically analyzed responses to identify recurring themes and key takeaways.

To further bolster the findings, RDA hosted a virtual data party with the PIONEERS team. This data party provided a platform to present the initial findings, encouraging open discussion and feedback. PIONEERS staff shared their perspectives, offered additional context, and ensured that the interpretations were both accurate and culturally appropriate. These discussions were crucial, as they not only validated the findings but also added depth and nuance to the analysis. The insights gathered from this engagement were directly incorporated into the final findings and this report, ensuring that the results were reflective of the PIONEERS team's and program participants' expertise and experience.

Limitations

Small Sample Sizes. Not every participant completed the survey or joined the focus group, meaning only a portion of feedback was gathered from those engaged with the program. RDA was unable to schedule a focus group with cohort participants, leaving only survey data to draw on. Additionally, RDA was unable to match much data from the pre- and post-surveys, making it challenging to understand participants' trajectory throughout the program.

It is also important to note that throughout the findings, frequencies are used to present most of the quantitative data, such as demographic characteristics and services accessed.

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[6] California Department of Social Services. (2019). *Data de-Identification reference guide.* Retrieved from https://www.cdss.ca.gov/portals/9/Data%20De-Identification%20Guidelines%20DSS%20Reference%20Guide_FINAL.pdf

This approach was chosen to provide a clear, accurate interpretation of the results given the small sample size, avoiding percentages to prevent any potential misrepresentation.

Participant Challenges Completing the Survey. PIONEERS staff shared that youth had several questions about the way certain survey items were worded. At the time of the pre-survey, participants had a difficult time answering cultural identity questions as they had not yet learned about it. Some youth, particularly middle school students, had challenges with reading comprehension. Staff shared that they observed many participants rushing through the survey without reading the items, particularly those with multiple choice or Likert scales. Several survey items, including many demographic options, were skipped, potentially introducing **item nonresponse bias**. Those who completed each item on the survey may have different perspectives and experiences from those who skipped items. This may impact the validity of the participant survey findings.

Self-Report Bias and Social Desirability Bias. Participants may unintentionally misrepresent their experiences, either by exaggerating or downplaying them. Respondents might also have felt the need to provide responses they believed were more favorable or acceptable, rather than being fully candid. For example, some participants may have spoken more positively about the program than they truly felt, especially if they were reluctant to express criticism.

Despite these limitations, the feedback collected can help guide PIONEERS in refining its programming to better serve youth, their families, and the broader community moving forward.

Evaluation Findings

The following sections share key findings in response to each evaluation question: program implementation, impact on emotional wellness and cultural awareness, impact on access to services, and impact on quality of life. Findings presented are for the first fiscal year of implementation (FY23-24) and should be interpreted as the baseline.

Q1. How is the PIONEERS program being implemented over time?

This section highlights the PIONEERS program's first year of implementation, showcasing its depth of services provided and high levels of client satisfaction. It also details key challenges and successes related to implementing this new program.

Clients Served

In the first year of implementation, PIONEERS served 40 youth through the cohorts and LIT council. Overall, most were heterosexual or straight (31 of 31), identified as Native Hawaiian/Pacific Islander (31 of 40), primarily speak English, had no known disability (30 of 30), and were not a veteran (39 of 39). Additionally, approximately half were female (22 of 39). Nearly all live in either San Bruno (17 of 40) or San Mateo (15 of 40). Table 3 below shows the full demographic breakdown of all participants served.

40

youth served

Table 3. Participant Demographics, FY23-24[7,8]

Category	Count[9]
Age groups	**31**
10-19 years old	12
20+ years old	19
Sex assigned at birth	**39**
Female	22
Male	17
Sexual orientation[10]	**31**

[7] Data Source: Service Log

[8] Hispanic/Latinx identity is not reported to protect client confidentiality since n<11

[9] Subgroup counts may add up to more than the total category count as participants could select more than one response for some questions

[10] Categories excluded from this count to protect client confidentiality when n<11 includes prefer not to answer, unknown/not reported, and Vakasalewalewa (a third gender identity in Fiji).

Category	Count[9]
Heterosexual or straight	31
Gender identity[11]	**39**
Female	22
Male	17
Race	**40**
Native Hawaiian/Pacific Islander	31
Other[12]	18
Ethnicity	**39**
Fijian, Samoan, or Tongan	27
Other[13]	39
Primary Language[14]	**40**
English	27
Tongan or Samoan	16
Disability[15]	**30**
No known disability	30
Veteran Status	**39**
Not a veteran	39
City of Residence	**40**
San Bruno	17
San Mateo	15
Other[16]	19

Most participants heard about the program through PIONEERS staff or other programs (15 of 27 survey respondents), while the rest (12 of 27) heard about the program through school or friends and family. When asked what they were hoping to get out of their experience in the program, youth shared they were hoping to get community and friendship, an opportunity to understand their own culture and other cultures, build leadership skills and empowerment, find a place to do good, grow their mental health skills, build self-awareness, and get out of their comfort zone.

[11] The category Vakasalewalewa was excluded from this count to protect client confidentiality when n<11.
[12] Other races include Asian, American Indian or Alaska Native, Black or African American, White, and Other.
[13] Other ethnicities include African, American Indian/South Asian, Central American, Eastern European, European, Filipino, Italian, Mexican/Mexican-American/Chicano, Nicaraguan, Salvadorian, and White.
[14] Other primary languages include Hindi, Spanish, and Tagalog.
[15] Categories excluded from this count to protect client confidentiality when n<11 include learning disability, difficulty seeing, and chronic health condition, unknown/not reported, and prefer not to answer.
[16] Other cities of residence include Burlingame, Daly City, East Palo Alto, Hayward, Pacifica, Redwood City, San Carlos, and San Francisco.

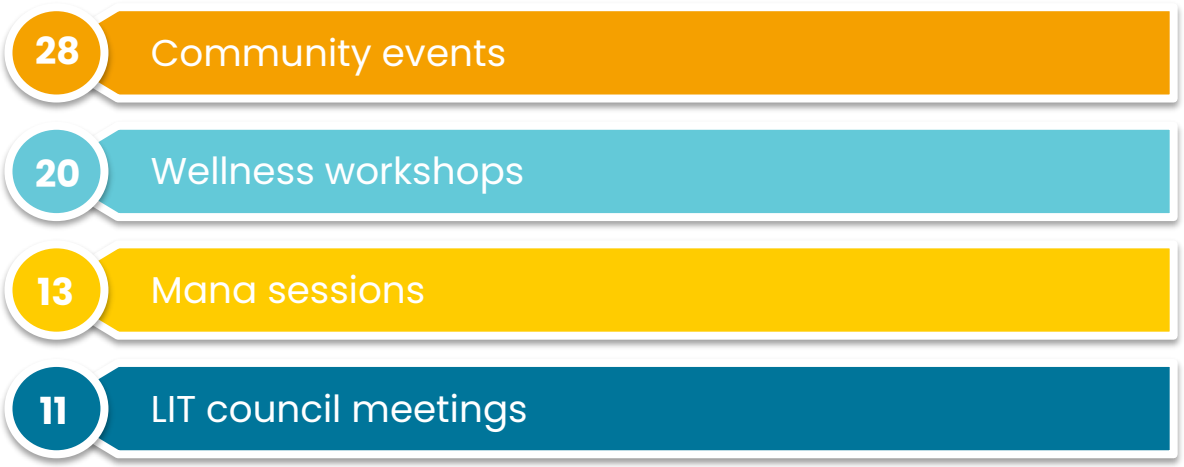
Services Provided

The PIONEERS program provided a total of 72 services to 58 youth.[17] Participants attended community events including Wellness Wednesday, a weekly wellness-focused event hosted by the Samoan Community Development Center, and the Pacific Islander Day at the San Mateo County Fair. Staff held wellness workshops for cohort participants on topics ranging from regulating emotions, introduction to mental health, healthy communication, and setting boundaries. PIONEERS staff provided Mana sessions to participants, offering them a safe space to share their stories and receive support from staff. The program also held biweekly meetings with the LIT Council. Some LIT Council members facilitated activities during their meetings and at community events, further building leadership skills among members. Figure 2 below shows the number of services provided by type.

72

services provided

Figure 2. PIONEERS Key Services, FY23-24, N=72 services[18]



[17] Some youth in the community were provided services, but their information was not tracked with other participants in the service log. This is why the number of youth who received services (n=58) is higher than the number of program participants (n=40).

[18] Data Source: Service Log

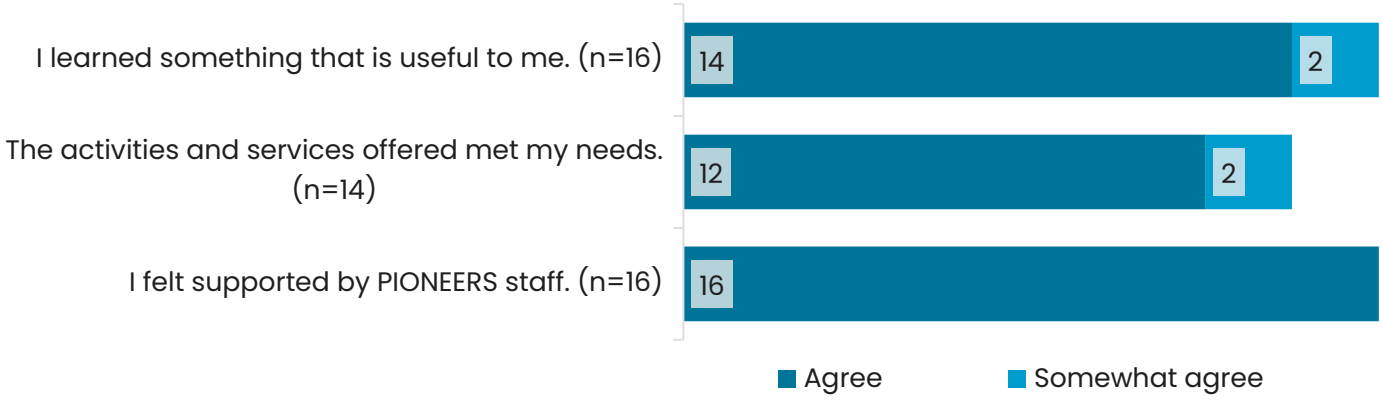
Client Satisfaction

16 out of 16

of youth were satisfied

Of those who completed the post-survey, **100% (16 of 16) were satisfied with their experience in the program.** Most (14 of 16) did not have any suggestions for improvement. The two participants who did have suggestions for improvement expressed the desire to learn more and have the program reach more people. Overall, participants felt support by staff, felt the program met their needs, and they learned something useful (Figure 3).

Figure 3. Participant Satisfaction, FY23-24[19]



Program Implementation Strengths

PIONEERS has built strong relationships with youth participants. LIT Council members shared in focus groups that they had built very strong connections with each other and PIONEERS staff. Several youth shared that it "feels like a second family." These relationships contributed to a sense of overall satisfaction with their involvement in the program. Staff members echoed these sentiments, sharing that the consistent quality time spent with youth has allowed participants to really open up to staff and ask for help. Staff also shared the importance of youth "seeing someone that looks like them on campus and in the community."

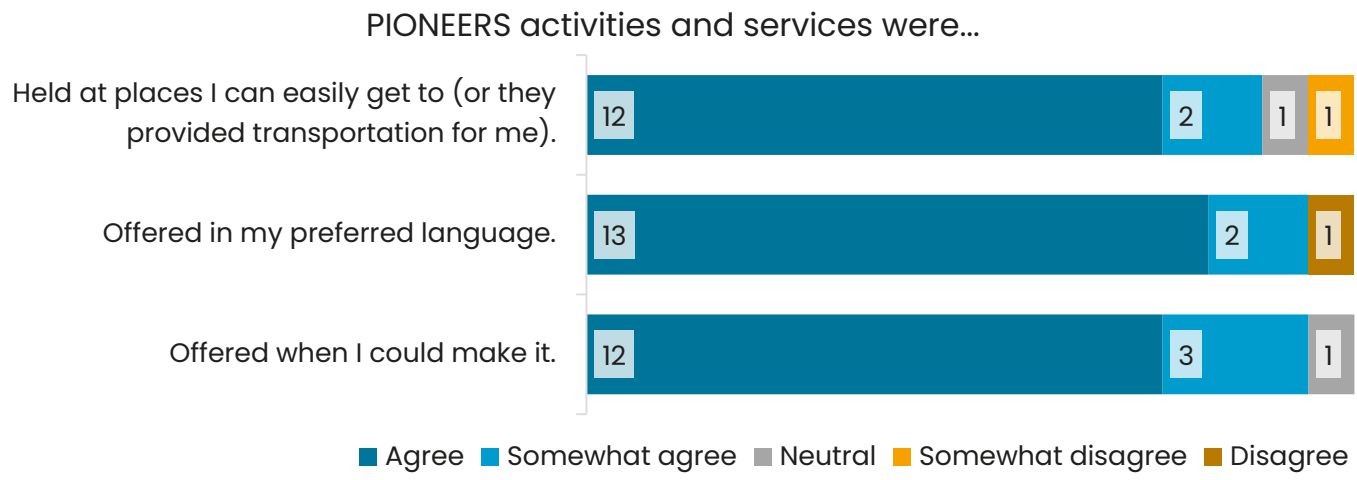
[19] Data Source: Participant Survey

Staff have growing relationships with schools and partner organizations. PIONEERS staff shared that they have been able to build strong relationships with several area schools where they are holding their cohorts. Staff are planning to do additional outreach to high schools to grow their cohort programming and continue building relationships with organizations at the College of San Mateo (CSM), including the Wellness Center. Staff also have strong relationships with other HealthRight360 programs and other Pacific Islander-focused agencies. This has allowed them to offer warm handoffs to clients who need external services as well as build visibility in the community.

The program has worked to minimize barriers for participant engagement. Cohort programming was offered directly in schools so participants could more easily attend workshops. Several LIT Council members mentioned that the transportation provided by the program enhanced their accessibility. Staff coordinate pick ups and drop offs with the youth directly. These messages also serve as a reminder to youth about attending the events. Survey respondents shared that in general, services were offered at times, locations, and in a language that worked best for them (Figure 4).

> "They really helped me out getting here and taking me to all these events that I wouldn't be able to attend on my own."
> -LIT Council Member

Figure 4. Elements that Impacted Program Engagement, FY23-24, N=16 participants[20]



[20] Data Source: Participant Survey

Attendance at cultural events increased participants' connection to their culture and communities. During the LIT Council focus group, multiple participants shared how activities and events impacted their understanding of their culture. Youth shared stories about connecting through dance, understanding the values in the community, and increases in cultural pride. They talked about meeting a lot of community members at the events and often seeing people they know. This helped them feel a greater sense of family with the larger community.

Program Implementation Opportunities for Growth

Youth are not always able to consistently attend programming. Staff shared that the cohorts had consistent attendance at the beginning of programming. But the youth have many other commitments and as the school year went on, attendance became more sporadic for some.

Staff have encountered some challenges working with school staff. Staff shared that in order to offer cohorts in schools, PIONEERS needs to be invited on campus. Staff have had to build connections with administration, but there has been some turnover in local schools. When this happens, staff must restart the relationship building process. Additionally, PIONEERS staff have heard from teachers who want them to offer programming in their classrooms. But because the program is primarily oriented towards Pacific Islander youth, they are unable to work in all classes.

> "Heart work is not cheap […] they need additional funding to do the deep engagement work in the community."
> -LIT Council Member

Both staff and youth have limited capacity for additional commitments, limiting the potential reach of the program. There are only two staff members dedicated to the PIONEERS program. Given the geographical reach of San Mateo County, they are unable to provide programming in all the schools who express interest. Youth also have limited availability outside of school and other commitments, so getting participants to regularly attend activities has been challenging.

Q2. To what extent does the PIONEERS program improve wellness outcomes for NHPI youth participants?

This section assesses the wellness impacts that the PIONEERS program has had on participants in its first year of implementation. This includes emotional impacts such as overall emotional wellness, anxiety, depression, and suicidal ideation as well as cultural impacts like cultural awareness, a sense of cultural pride, and a sense of belonging. Findings should be understood in context of the small sample sizes, as less than half of participants completed a post-participation survey.

Emotional Wellness[21]

Overall Emotional Wellness

Participants did not experience a significant difference in overall emotional wellness as a result of participating in the program. Many participants experienced mental health symptoms before and after participating in the program.[22] Of the participants who fully completed all mental health items on both the pre- and post-surveys, most reported fewer mental health symptoms after participating in the program.

When asked how the PIONEERS program improved their life, **several survey respondents described the positive impact the program had on their emotional wellbeing**. Youth shared that the program made them "feel comfortable with issues I'm facing," while others talked about how the program helped with their overall mental health. One participant shared that the program helped them "be a little positive."

> "PIONEERS was my steppingstone to learning more and being aware that it's okay not to be okay."
> -LIT Council Member

> "The one-on-ones really helped me. Most of the time I don't like putting my problems out to other people or talking about my mental health. [PIONEERS staff] said it's okay to express my emotions. They really helped me a lot."
> -LIT Council Member

Participants shared an increased awareness of what mental health is, how to express emotions, and what resources are available. Participants and staff shared examples of successful referrals to behavioral health resources. LIT Council members described how the workshops and Mana sessions helped them understand their emotions and how to express them.

[21] Emotional wellness data points are not reported to protect client confidentiality; n<11 for most post-survey results.
[22] There was not a statistically significant difference at the 95% confidence level

Anxiety

Participants did not experience a significant difference in anxiety symptoms after participating in the program. Similar proportions of participants experienced anxiety symptoms before participating in the program and after participating in the program.[23] Of the participants who fully completed all anxiety items on both the pre- and post-surveys, most reported fewer anxiety symptoms after participating in the program.

Depression

Participants did not experience a significant difference in symptoms of depression after participating in the program. Nearly three fourths of participants experienced depression symptoms before participating in the program, while just over half of participants were experiencing depression symptoms after participating in the program.[24] Of the participants who fully completed all depression items on both the pre- and post-surveys, most reported fewer depression symptoms after participating in the program.

Suicidal Ideation

Participants did not experience a significant difference in symptoms of suicidal ideation after participating in the program. Nearly a third of participants experienced thoughts of suicide before participating in the program, while just one participant was experiencing thoughts of suicide after participating in the program.[25] Of the participants who fully completed all suicide items on both the pre- and post-surveys, none reported any suicidal ideation on either survey.

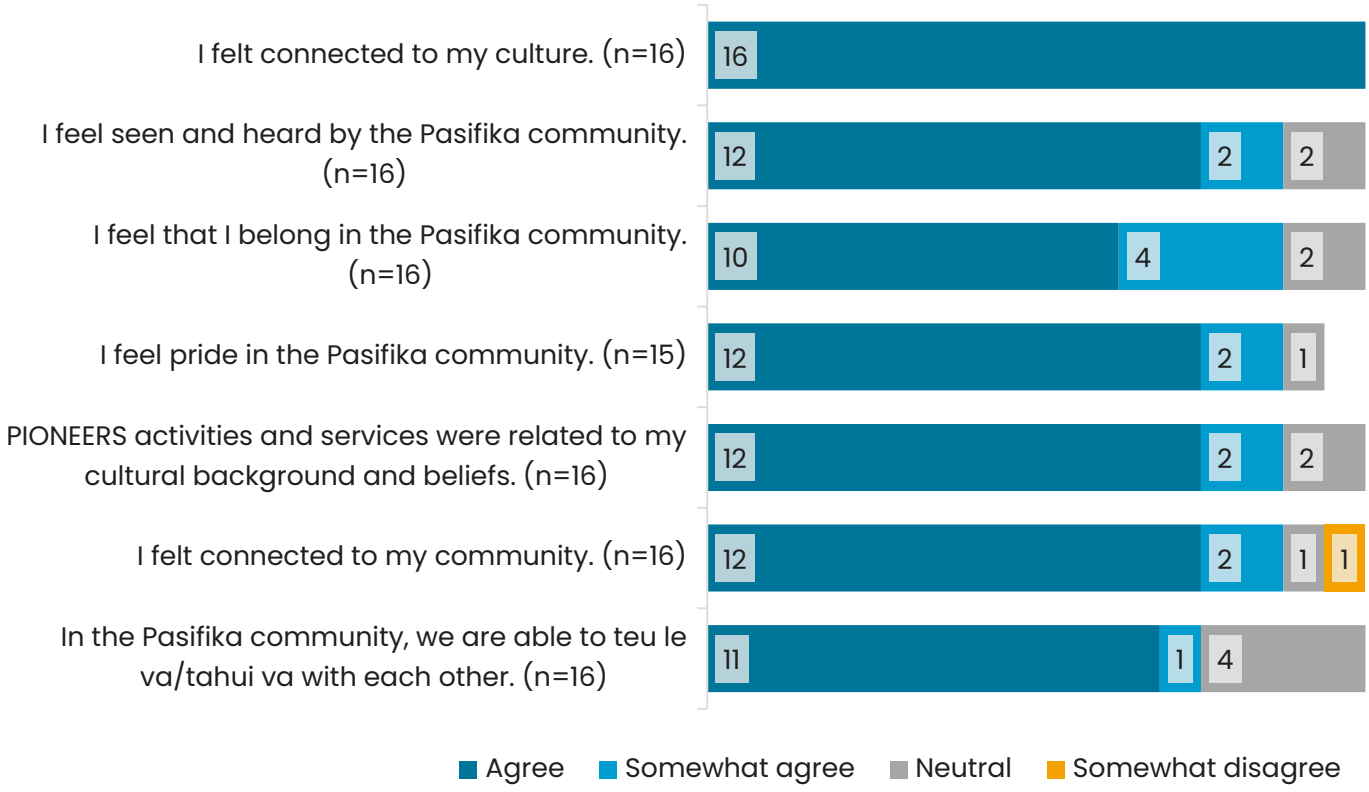
Cultural Awareness

Participants felt that the activities and services were culturally relevant and helped them feel connected to their culture and community. Overall, participants felt connected to their culture, felt seen and heard, felt like they belong, felt a sense of cultural pride, felt like the program was related to their cultural background and beliefs, felt connected to their community, and felt like the Pasifika[26] community is able to teu le va/tahui va[27] with each other (Figure 5). Of the participants who

[23] This is not a statistically significant difference at the 95% confidence level.
[24] This is not a statistically significant difference at the 95% confidence level.
[25] This is not a statistically significant difference at the 95% confidence level.
[26] Pasifika is a term adopted from Aotearoa (New Zealand) that describes Pacific Islanders who live outside their homelands.
[27] Teu le va or tahui va is the Pacific Islander value of nurturing relationships and community.

fully completed all cultural items on both the pre- and post-surveys, several reported more cultural awareness after participating in the program.[28] When asked how the PIONEERS program improved their life, a few survey respondents shared the program helped them learn more about their culture. One LIT Council member shared that the program helped them understand the different perspectives and values in their community.

Figure 5. Cultural Awareness, FY23-24[29]



[28] This is not a statistically significant difference at the 95% confidence level.

[29] Data Source: Participant Survey

Q3. To what extent does PIONEERS, a culturally relevant youth and community focused program, improve access to behavioral health services for NHPI youth participants?

This section describes how the PIONEERS impacted youth access to behavioral health services through connection to resources and addressing stigma.

Connection to Services

In its first year of implementation, **PIONEERS staff provided eleven behavioral health referrals to youth** (Table 4), a few of whom received more than one referral. Youth were referred to other AARS programs (like Essence of Mana), the Pioneer Court Outpatient Program, and Daly City Youth Health Center.

Table 4. Behavioral Health Referrals, FY23-24[30]

Type of Behavioral Health Referral	Count
Mental health	6
Substance use	1
Other behavioral health referral	4
TOTAL	**11**

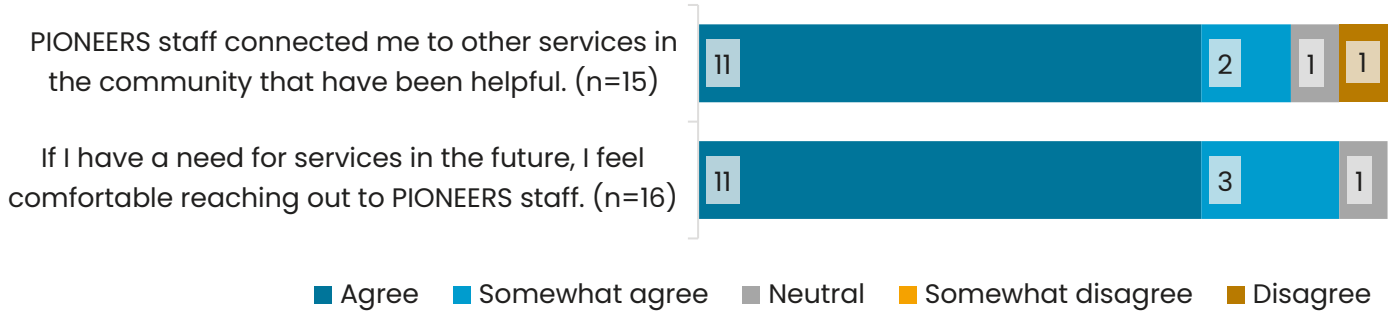
PIONEERS staff shared stories of providing referrals to youth in programming, families of youth, or participants at outreach events who express a need for services. **Community members often approach PIONEERS staff about resources**, and they provide referrals whenever possible. These referrals are not always tracked and therefore may not be reflected in Table 4.

PIONEERS staff shared that their strong relationships with youth, particularly LIT Council members, has allowed youth to show vulnerability and ask for help. This has opened the door for staff to provide behavioral health referrals to those who share a need. Multiple LIT Council members shared being connected to therapy services by PIONEERS staff. In one instance, **staff referred a participant to therapy services, and the youth is still receiving those services to this day**. Staff have shared that they have seen enormous personal growth from this individual since they began receiving therapy services.

[30] Data Source: Service Log

When asked about being connected to other services in the community, **participants shared that they were connected to helpful services and would feel comfortable reaching out to staff if they needed services in the future** (Figure 6).

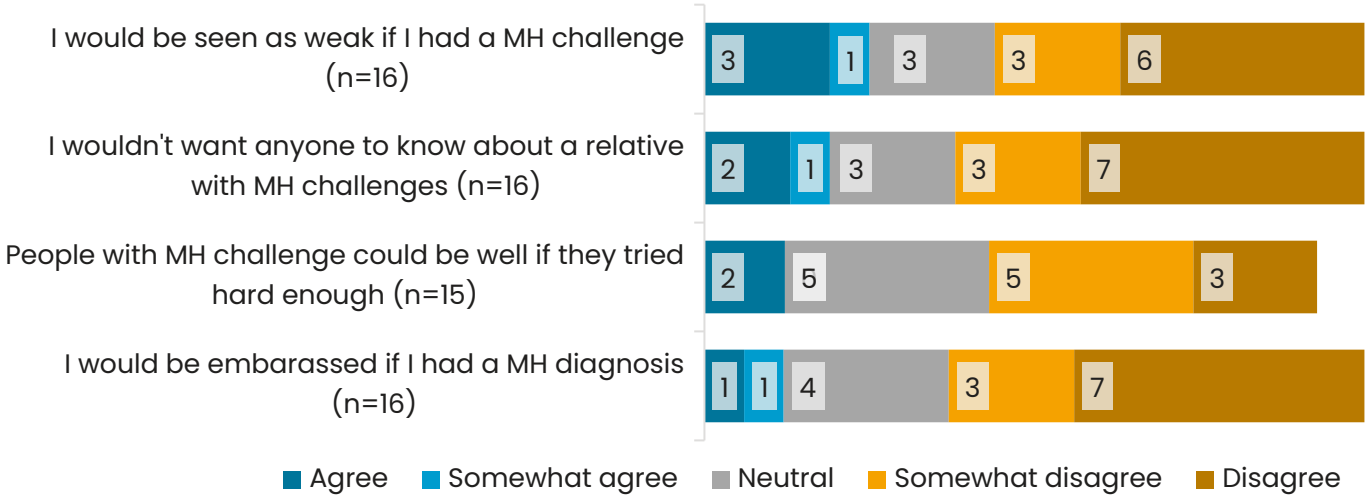
Figure 6. Participant Connection to Services, FY23-24[31]



Stigma

Most participants reported stigma around behavioral health and treatment seeking before and after participating in the program. Of the participants who fully completed all stigma items on both pre- and post- surveys, most reported the same amount or a slight increase in stigma after participating in the program.[32] Several participants shared that they would be seen as weak if they had a mental health challenge, and that they wouldn't want anyone to know about a relative with mental health challenges (Figure 7).

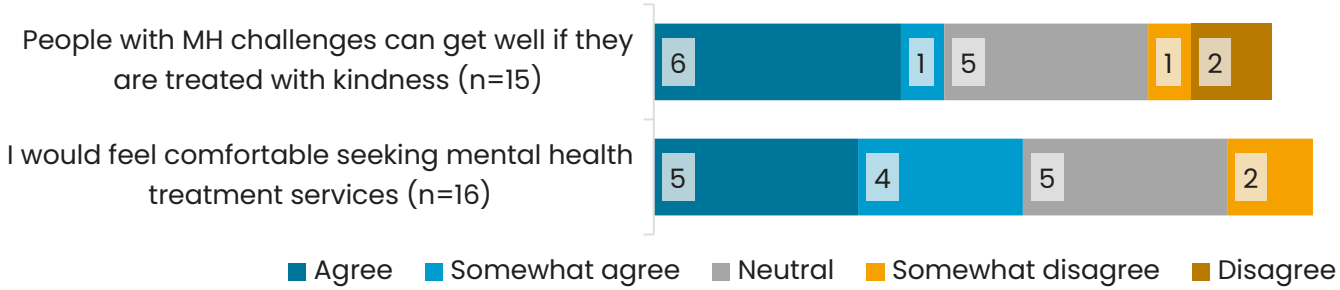
Figure 7. Mental Health Stigma, negative wording, FY23-24[33]



[31] Data Source: Participant Survey
[32] This is not a statistically significant difference at the 95% confidence level
[33] Data Source: Participant Survey

When asked about stigma with positively worded questions, most participants shared that they would be comfortable seeking mental health services and that people with mental health challenges can get well if they are treated with kindness (Figure 8).

Figure 8. Mental Health Stigma, positive wording, FY23-24[34]



PIONEERS staff shared that many of the participants know about the services that are available and understand that it is okay to use the services, but still carry a sense of stigma and fear around seeking treatment for themselves. Staff suggested multiple reasons for this continued stigma including limited family support for seeking treatment and the idea that you need to "wait until things are really bad" before connecting with a therapist. Staff shared that youth view therapy as "the very last option." Staff are continuing to work towards breaking down this stigma, but these issues show that there is still a long way to go.

LIT Council members shared similar sentiments; when they first entered the program they still had a lot of stigma around going to therapy. One participant shared feelings of fear and a family environment that did not support seeking treatment for mental health.

> "My stigma was with therapy. [… PIONEERS staff] have taken down that wall. They helped me see that my stigma came from a place of fear. […] I asked myself, 'what could go wrong with healing?'"
> -LIT Council Member

Knowledge of Resources

Participants did not report a significant increase in knowledge about available behavioral health resources after participating in the program. Just under half of youth reported being knowledgeable about behavioral health resources before participating in the program (17 of 37), while just over half reported being knowledgeable about behavioral health resources after participating in the program (9 of 16) (Figure 9).[35] Of the participants who responded to

[34] Data Source: Participant Survey
[35] This is not a statistically significant difference at the 95% confidence level

this item on both pre- and post-surveys, most reported the same or increased knowledge about behavioral health resources available to them after participating in the program.

Figure 9. Knowledge of Behavioral Health Resources, FY23-24, N=16 participants[36]

When asked about how PIONEERS services has helped them, **several participants shared how the program increased their knowledge about mental health in general as well as the resources available to them**. Youth shared that PIONEERS introduced them to new ideas, helped them put words to things they experience, understand how to have healthy communication, and how to navigate their emotions. Several youth shared that the PIONEERS program was a safe space to talk about mental health, a sentiment that was echoed in the LIT Council focus group.

[36] Data Source: Participant Survey

Q4. To what extent does the integration of leadership and community advocacy improve quality of life outcomes for NHPI youths who participate in the PIONEERS program?

This section described the impact that the leadership and community advocacy components had on quality-of-life outcomes for youth. That includes connection to social services, impact on confidence levels, and impact on independence.

Connection to Social Services

PIONEERS staff provided seven social service referrals to youth (Table 5), a few of whom received more than one social service referral. Youth were referred to housing resources, housing case management, and a nonprofit legal aid resource. Staff also talked about building relationships with youth's parents and providing referrals to AARS parenting classes.

Table 5. Social Service Referrals, FY23-24[37]

Type of Social Service Referral	Count
Housing/shelter	4
Cultural	1
Family	1
Legal assistance	1
TOTAL	**7**

Social Support

A key theme mentioned by both youth and staff was the **social support provided by the PIONEERS program and participants**. Youth participants, particularly LIT Council members, shared stories about feeling connected with each other on a deeper level after participating in workshops. One member phrased it as "nurturing the space between each other." Members describe a safe and comfortable place to be themselves. Youth really enjoy going into the community and attending events, feeling like they are building a "second family."

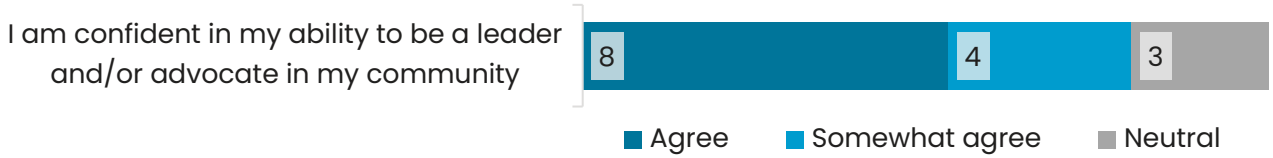
Confidence and Independence

Youth confidence to be a leader in their community did not change significantly after participating in the program. A slightly higher proportion of participants reported that they were confident in their ability to be a leader and/or advocate in the community after

[37] Data Source: Service Log

participating in the program (12 of 15) (Figure 11) compared to before participating in the program (26 of 27).[38] Of those who responded to this item on both the pre- and post-surveys, most reported an increase in confidence in their ability to be a leader.

Figure 10. Confidence in Ability to be a Leader, FY23-24, N=15 participants[39]



When asked how the PIONEERS activities and services helped them, **youth described an increased connection to others, the confidence to share their feelings and speak up for themselves, and a stronger sense of independence and drive to follow their dreams**.

PIONEERS staff described seeing significant leadership growth in youth, particularly the LIT Council members. One staff member shared that they are seeing leaders come out of the group, describing how youth have come out of their shell and engaged in community activities. Some have been able to help facilitate workshops when staff capacity is limited.

LIT Council members have also noticed this growth within themselves, sharing their goals for the future and the program has increased their confidence to achieve those goals. One shared that they want to start a community organization geared toward Fijian Americans; another shared that they want to be a therapist who offers free services to the Pacific Islander community; another student shared that they felt encouraged to attend a four year college and pursue their education. LIT Council members shared that the program provided them with positive role models, opportunities to facilitate and lead sessions, and other opportunities to build their confidence and leadership skills.

[38] This is not a statistically significant difference at the 95% confidence level

[39] Data Source: Participant Survey

Recommendations

Based on the lessons learned from the first year of PIONEERS implementation, RDA has lifted up a few recommendations that can help improve participant outcomes and program impact. These recommendations mainly focus on expanding current program successes as well as advocating for additional funding to expand services.

- **Continue to build strong relationships with youth participants.** Much of the successes in program engagement, connection to services, mental health outcomes, and quality of life outcomes are due to the deep relationships that staff have built with the participants. Continue putting quality time into these relationships, as this trust is at the heart of the program.
- **Continue to remove barriers to engagement.** Several participants mentioned that the program was easily accessible, offered at times and locations that were easy for them to attend. Offering transportation, food, and communication with parents are all critical for ensuring program attendance. Due to limited staff capacity, consider additional resources to fill in some of these roles, particularly transportation.
- **Continue to show up in the community and build relationships with schools.** Because cohort programming is conducted in schools, it is important to continue to be present in the community and build relationships with school staff. This could help bring programming to more schools in the area. Additionally, attending community events with youth participants has had a powerful impact on their leadership skills and sense of cultural identity and belonging. Continue bringing youth to these events as part of the program activities.
- **Continue to work to address stigma**. As shown in the surveys and focus groups, there is still a lot of stigma surrounding mental health in the Pacific Islander community in San Mateo County. Ensure that anti-stigma activities are being built into the curriculum for future programming. Activities could include storytelling, peer-led sessions, and diving deep into the roots of generational stigma.
- **Advocate for supplementary funding to hire additional staff**. There is a clear need for more programs like PIONEERS in the community, and the impact of the program has been detailed in this report. Consider advocating for additional funding to hire more staff members dedicated to PIONEERS so the program can expand to more school sites and current staff can spend more time building relationships with participants and community members.

Appendices

Appendix A. Program Design

PIONEERS is designed to offer culturally relevant behavioral health services for NHPI youths in SMC. This program places a strong emphasis on prioritizing the well-being of both students and their respective communities through empowerment, leadership, and advocacy. Notably, there is currently no other behavioral health prevention program in SMC specifically tailored to NHPI youths, making this program an innovative and much-needed solution.

The primary goals of the PIONEERS program are to 1) enhance access to behavioral health services for NHPI youths by addressing mental health and substance use challenges, 2) increase awareness of emotional health, 3) empower NHPI advocates for behavioral health, and 4) improve culturally responsive services on local school campuses. The program is implemented by the community-based behavioral health provider, Asian American Recovery Services (AARS), and will foster partnerships between SMC Community Colleges, BHRS, and other community-based behavioral health providers to establish essential services on campuses.

Service Offerings

The program encompasses three key components:

- **The Leaders in Training, or "LIT," Council.** The LIT Council is a youth advisory circle comprised of NHPI youths. Their input has guided the development of the program's curriculum, activities, and outreach strategies. LIT Council members also engage in community engagement projects by leading workshops and discussions with middle- and high school students and the broader community. It enables PIONEERS participants to apply the knowledge and skills they acquire through the program to address the specific needs of their communities
- **PIONEERS Wellness Workshops.** The PIONEERS Wellness Workshops are a ten week, cohort-based cultural and mental health education program delivered directly to students in schools. Topics covered include the importance of cultural connectedness, migration stories, community memberships, and the power of resistance, among others.
- **Mana Sessions.** These as-needed sessions provide a safe space for NHPI youths to decompress, engage in one-on-one and group discussions centered around behavioral health and wellness, and participate in skills-building workshops. These sessions are designed to promote emotional well-being and resilience.

By focusing on cultural relevance, empowerment, leadership, and advocacy, the program aims to improve behavioral health outcomes and foster a sense of community support among NHPI youths, ultimately benefiting both the individuals and their broader communities.

Program Staff

The PIONEERS program has a small but mighty two-person team. A brief description of program staff's roles is below:

- **Program Coordinator** is responsible for the oversight of the identified work plan activities of the program to ensure the goals, objectives, and other deliverables are satisfactorily met in a timely manner.
- **Case Manager** assists the Program Coordinator in the implementation of the PIONEERS Project identified work plan and is responsible for outreach, recruitment and case management.

Target Population

The PIONEERS program has a specific focus on addressing the needs of NHPI youths, ages 12 to 24 years old, a population that often faces significant health disparities. While comprehensive data on this community is limited, available information highlights the notable disparities experienced by NHPI individuals in various health indicators. For instance, according to data from the Census Bureau, a substantial 17.6% of the NHPI community lives below the poverty line. This figure stands in stark contrast to the national poverty rate of 11.7% for Asians and 11.6% for Whites. These economic disparities underscore the pressing need for targeted support and intervention within the NHPI youth demographic.

Annually, the PIONEERS program aims to make a meaningful impact by engaging with 45 NHPI youths through its various program services. Additionally, the program seeks to extend its reach to benefit 30 NHPI community youth through its community advocacy component. By targeting these specific demographics, the PIONEERS program endeavors to address the unique challenges and disparities faced by NHPI youths, working towards improving their overall well-being and contributing to the betterment of the NHPI community as a whole.

Appendix B. Program Implementation Updates

Month and Year	PIONEERS Implementation Updates
July 2023	• Work with RDA and PIONEERS officially kicked off this month
August 2023	• Hired the project coordinator role • Began attending community events to share about PIONEERS
September 2023	• Began visiting with schools to meet with staff and inform them of PIONEERS • Started recruiting for the LIT Council (then known as the Youth Advisory Board)
October 2023	• Continued to build relationships with schools • Supported the community through losses due to violence and suicide • Reviewed the LIT Council applications
November 2023	• Convened a community call to action meeting to respond to recent events • Continued supporting community through incidents of violence • Began planning for LIT Council programming
December 2023	• Held a meet and greet for the LIT Council • Continued to outreach to schools, including building a relationship with the Wellness Center at CSM • Attended CSM research showcase to present to the community
January 2024	• Scheduled the start of the workshops • Continued planning for cohort and LIT Council programming
February 2024	• Launched cohort programming at Parkside Middle School and CSM • Began biweekly LIT Council meetings
March 2024	• AARS and HealthRight360 Grand Re-Opening • Working to administer surveys in the cohorts
April 2024	*No meeting held this month*
May 2024	• Held focus groups with LIT Council and staff • LIT Council facilitated their first community workshop • Wrapped up programming with cohorts and LIT Council
June 2024	• Started reaching out to schools to set up the cohorts for the next academic year • Participated in professional development trainings • Attended San Mateo County Fair Pacific Island Day

Appendix C. Learning Goals, Evaluation Questions, Data Measures & Sources

Learning Goal	Evaluation Question	Data Measures	Data Sources
To assess and improve the implementation of the PIONEERS program to ensure it effectively meets participant needs, fosters collaboration, and delivers quality services.	**PROCESS EVALUATION**		
	Q1. How is the PIONEERS program being **implemented over time**?	• Successes and/or challenges to implementation • Adaptations to implementation in response to participant needs • Count and proportion of participants served, including demographics • Type, count, and proportion of services provided • Collaboration • Staff support • Program elements that contributed to participant engagement & outcomes	• Youth service log • PIONEERS staff focus groups • Youth focus groups • Evaluation meeting notes • Youth survey

Learning Goal	Evaluation Question	Data Measures	Data Sources
To determine the extent to which the PIONEERS program enhances wellness outcomes for NHPI youth participants, focusing on the engagement and satisfaction with services and their emotional wellbeing.	**OUTCOME EVALUATION**		
	Q2. To what extent does the PIONEERS program **improve wellness outcomes** for NHPI youth participants?	• Count and proportion of NHPI youths that engage in PIONEERS program services • Count and proportion of NHPI youths whose emotional wellness improves (suicidal ideation, anxiety, depression) • Level of satisfaction with services • Self-reported impact on NHPI youths' overall emotional wellbeing • Count and proportion of NHPI youths who develop cultural pride and sense of belonging • Level of cultural awareness	• Youth service log • Youth survey • Youth focus groups • PIONEERS staff focus groups

Learning Goal	Evaluation Question	Data Measures	Data Sources
To examine the extent to which the PIONEERS program improves access to culturally relevant behavioral health services for NHPI youth participants and cultivates emotional wellness, cultural pride, and a sense of belonging.	Q3. To what extent does PIONEERS, a culturally relevant youth and community focused program, **improve access** to behavioral health services for NHPI youth participants?	• Count and proportion of NHPI youths referred to behavioral health services • Count and proportion of NHPI youths that engage in services • Count and proportion of NHPI youths who decrease stigma and increase knowledge about behavioral health resources • Impact on NHPI youths' attitudes and behaviors toward emotional wellness and service utilization • Count, proportion, and description of NHPI youths' perception of behavioral health services • Count, proportion, and description of NHPI youths' willingness to talk about emotional wellness	• Youth service log • Youth survey • Youth focus groups • PIONEERS staff focus groups

Learning Goal	Evaluation Question	Data Measures	Data Sources
To evaluate the extent to which the integration of leadership and community advocacy within the PIONEERS program contributes to improved quality of life outcomes for NHPI youth participants, including their awareness, engagement, educational attainment, and wellbeing.	Q4. To what extent does the integration of leadership and community advocacy **improve quality of life outcomes** for NHPI youths who participate in the PIONEERS program?	• NHPI youths' awareness of data and storytelling • NHPI youths' level of engagement in advocacy • Count, proportion, and description of NHPI youths' interest in higher education • NHPI youths' community trust and movement building • Count, proportion, and description of improved cultural and emotional wellness awareness, self-identity and coping skills • Count and proportion, and description of improved leadership skills • Count and proportion, and description of improved educational outcomes	• Youth service log • Youth survey • Youth focus groups • PIONEERS staff focus groups

APPENDIX 14. RECOVERY CONNECTION CENTER INN EVALUATION REPORT, FY 2023–24

San Mateo County Behavioral Health and Recovery Services

Mental Health Services Act Innovation Evaluation

Recovery Connection Center Annual Report

Fiscal Year 2023-2024

RDA CONSULTING | 40 YEARS of Systems Change

Voices of Recovery SAN MATEO COUNTY

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

San Mateo County Behavioral Health and Recovery Services

Mental Health Services Act Innovation Evaluation

Recovery Connection Center Annual Report

Fiscal Year 2023-2024

This report was developed by RDA Consulting under contract with the County of San Mateo Behavioral Health and Recovery Services.

RDA Consulting, 2024

RDA CONSULTING | 40 YEARS of Systems Change

Voices of Recovery SAN MATEO COUNTY

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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Acknowledgements

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Thank you to Voices of Recovery San Mateo County staff ShaRon Heath, James Young, and Rubi Garcia for supporting this project and being consistent thought partners throughout this evaluation.

Thank you to SMC BHRS leadership, including Doris Estremera, and the Behavioral Health Advisory Board along with the MHSA Ongoing Planning Council for their commitment to the success of this program. This program would not have been possible without MHSA Innovation funds.

Lastly, an acknowledgement to the RDA team who completed this evaluation: Caroline Calonge, Dina de Veer, Paulina Hatfield, and Vanessa Guerrero.

Introduction

In 2004, California passed Prop 63, the Mental Health Services Act (MHSA). The MHSA aims to expand and transform the public behavioral health system with the values of 1) Recovery, Wellness, and Resiliency; 2) Consumer and Family Driven; 3) Community Collaboration; 4) Cultural Competency; and 5) Integrated Services.

The purpose of the MHSA Innovation (INN) component is to pilot new and emerging behavioral health approaches to address the needs of underserved populations and contribute to learning across the state. MHSA INN funds provide an opportunity for counties to implement innovative behavioral health services and learn about practices that have the potential to transform the behavioral health system.

Pursuant to Welfare and Institutions Code Section 5830, all MHSA INN projects must meet the following requirements:

1. Address one of the following as its primary purpose:

- Increase access to underserved groups.
- Increase the quality of services, including measurable outcomes.
- Promote interagency and community collaboration.
- Increase access to services.

2. Support innovative approaches by doing one of the following:

- Introducing new behavioral health practices or approaches, including, but not limited to, prevention and early intervention.
- Making a change to an existing behavioral health practice or approach, including, but not limited to, adaptation for a new setting or community.
- Introducing a new application to the behavioral health system of a promising community-driven practice or an approach that has been successful in non-behavioral health contexts or settings.

In December 2022, San Mateo County (SMC) Behavioral Health and Recovery Services (BHRS) was awarded a five-year MHSA INN grant from the MHSOAC to implement the Recovery Connection Center ("Recovery Connection"). This report details the first fiscal year[1] (FY) of program implementation from July 1, 2023 to June 30, 2024.

INNOVATION (INN)

INN projects are new, creative mental health practices/approaches that contribute to the learning process in the mental health field. INN projects must be developed in partnership with communities through a process that is inclusive and representative, especially of unserved and underserved, and inappropriately served individuals.

[1] Fiscal year goes from July 1st of the previous year to June 30th of the following year.

Program Overview

Recovery Connection is a one-stop drop-in center for individuals with substance use challenges and/or mental health challenges. Recovery Connection utilizes a peer-support model and provides linkages to services and resources. According to SAMHSA, a peer-support model improves relationships between providers and participants, increases services retention, reduces substance use, and decreases criminal justice involvement. Recovery Connection centers around Wellness Recovery Action Plan (WRAP) programming, which includes an eight-week WRAP group that helps participants acquire tools to support recovery, build positive social networks, increase self-awareness and accountability, and improve mental health while increasing a sense of hope and purpose. SMC BHRS contracted with Voices of Recovery San Mateo County (VOR SMC) to deliver Recovery Connection program services.

In addition to WRAP groups, Recovery Connection offers the following services:

- **Peer Mentoring and Coaching**. Peers provide one-on-one mentoring and coaching to support participants on their road to recovery. This includes setting goals, developing WRAP plans, finding sober housing, and developing healthy relationships.
- **Linkages to Mental Health, Substance Use, and Other Services**. Staff are trained to identify participants who would benefit from treatment, connecting them to behavioral health services as needed. Staff also provide referrals to outside resources like housing, job training, and basic needs resources.
- **Health and Wellness Classes**. Staff offer classes with discussions on health topics.
- **Job Readiness and Employment Services**. Staff and partners assist with resume writing, improving computer skills, and connecting participants to job opportunities.
- **Volunteer Opportunities**. There are opportunities for participants to volunteer at the Recovery Connection center, such as tabling and setting up for events as well as assisting with WRAP groups and health and wellness classes.
- **WRAP Training**. The center provides ongoing training in WRAP to peers, clinicians, and paraprofessionals to increase the number of certified WRAP providers.

For more information about Recovery Connection, see **Appendix A**.

Program Innovations and Adaptations

Aug - Oct 2023	Nov 2023 - Jan 2024	Feb - Apr 2024	May – Jun 2024
• Program launched • Hired staff • Found a new building • Secured a designer for the building • Hosted first public event at new location	• Fully moved into new building • Onboarded volunteers • Started to deliver services, running groups 3x/week	• Some staff turnover & hiring paused • Trained 10 new advanced-level WRAP facilitators • Launched Advisory Group	• Lift fully installed • Building fully furnished • Started inviting organizations to give presentations

Establishing Program Operations. When the program launched, Recovery Connection leadership set out to assemble a team of passionate staff of recovery coaches, an executive assistant, and outreach workers. Despite some staff turnover, the team continued to grow. The program secured a new building and upon move-in, leadership quickly brought on a designer to furnish the building and worked to enhance accessibility by installing a lift. Establishing program operations set a firm foundation for Recovery Connection to deliver services.

Recovery Connection Center Grand Opening

Launching Community Events and Services. As program operations were being established, Recovery Connection began engaging with and serving the community. The program hosted community events open to the public that brought together the recovery community to learn about resources available, have thoughtful discussion, and socialize with others. Within the walls of the Recovery Connection Center, the program began delivering services, including WRAP groups and trainings. There was an increase in participation over time, with new clients visiting the Center after attending community events. Recovery Connection also launched their Advisory Group, bringing community and client voice into program planning.

For a detailed description of program implementation updates, see **Appendix B**.

Evaluation Overview

In July 2023, SMC BHRS contracted RDA Consulting (RDA) to conduct a multi-year evaluation of the Recovery Connection program. The purpose of this evaluation is to: (1) evaluate Recovery Connection processes (implementation) and outcomes; (2) support continuous program improvement efforts; and (3) satisfy and comply with MHSA INN regulatory requirements, including annual and final evaluation reports to the MHSOAC.

Since starting the evaluation of the Recovery Connection program in July 2023, RDA has worked closely with VOR SMC and SMC BHRS to accomplish several key evaluation activities:

Developed an Evaluation Plan and Data Collection Tools. In partnership with VOR SMC, RDA developed an evaluation plan that is intended to be used as a roadmap throughout the evaluation process. This plan includes learning goals, evaluation questions, the proposed evaluation methodology and analytic framework, potential limitations, and reporting requirements. RDA also developed data collection tools including focus group protocols, a participant intake form, participant surveys, and WRAP surveys.

Data Collection. RDA facilitated focus groups with both Recovery Connection staff as well as participants. RDA solicited feedback from community partners and WRAP facilitators via email and survey. VOR SMC administered the participant intake form, recovery management plans, referrals, WRAP sign-in sheets, and applications. SMC BHRS administered WRAP post-training surveys.

Data Analysis. To inform this report, RDA analyzed the data collected in the first FY of the program. This includes data gathered from the focus groups, intake forms, recovery management plans, referral data, WRAP sign-in sheets, WRAP applications, and WRAP post-training surveys. Together, RDA and VOR SMC made sense of the findings during a virtual data party. During the data party, VOR SMC provided RDA with additional insights to help inform data interpretation.

Throughout this partnership, RDA held monthly meetings with VOR SMC and SMC BHRS to stay updated on the program's progress, discuss any new developments, and share evaluation progress. Collectively, these efforts have laid the groundwork for an evaluation that will help to answer key questions about how the program is working and the impact it is having on the program participants. The following section outlines the specific evaluation questions guiding this work.

Evaluation Questions

RDA and VOR SMC program leadership developed a set of evaluation questions to guide the assessment of the Recovery Connection program. The evaluation questions serve as a framework for assessing the program's implementation, its impact on access and utilization of recovery services, participant outcomes, and program adaptability.

Table 1. Evaluation Questions and Associated Learning Goals

Evaluations Questions and Learning Goals	
Q1	How is the Recovery Connection **program being implemented** over time?
	Leaning Goal To assess and improve the implementation of the Recovery Connection program to ensure it effectively meets participant needs, fosters collaboration, and delivers quality services.
Q2	To what extent does the Recovery Connection program **increase access to recovery services and mental health services and supports** for individuals who were not previously engaged in services?
	Learning Goal To determine the extent to which the Recovery Connection program enhances access to recovery and mental health services for individuals who were not previously engaged in such services, with a focus on participation, barriers to access, service delivery to underserved populations, and the identification of co-occurring disorders.
Q3	To what extent do individuals who participate in WRAP and other drop-in recovery center services through the Recovery Connection program **experience in their long-term recovery**, including recovery time, number of relapses, mental wellness indicators and economic mobility?
	Learning Goal To examine the extent to which the Recovery Connection program improves long-term recovery outcomes for participants, with a focus on recovery time, relapse rates, mental wellness, economic mobility, and overall quality of life.
Q4	To what extent does training peer workers, clinicians, and paraprofessionals in WRAP through the Recovery Connection program **increase capacity in San Mateo County to use WRAP** with individuals with substance use and mental health challenges?
	Learning Goal To evaluate the extent to which the Recovery Connection program enhances capacity in San Mateo County for using WRAP with individuals facing substance use and mental health challenges, focusing on the number of trainings, trained individuals, their knowledge and skills, readiness to use WRAP, and satisfaction with training.

Methodology

RDA used a mixed-methods approach in this evaluation, combining both quantitative and qualitative data to provide a holistic view of the program. This method ensured that the evaluation team addressed SMC BHRS and Recovery Connection priorities, answered key evaluation questions, and met MHSA INN reporting requirements.

Data Collection

As part of the evaluation planning process, RDA, SMC BHRS, and Recovery Connection collaborated to identify and discuss qualitative and quantitative data sources that could be used to address the evaluation questions for FY23-24 reporting. Data was collected from July 2023 through October 2024.

Appendix C provides a detailed overview of the learning goals, evaluation questions, the indicators and measures, and the data sources used for this evaluation. Table 2 below outlines specific data sources and collection methods RDA used to gather information for the evaluation, further described in the following sections.

Table 2. Data Sources and Collection Methods

Data Source	Participants	Sample (N)	Collection Timeline
Focus Group	Participants	8	August 2024
Focus Group	Staff	11	August 2024
Survey	WRAP Facilitators	11	October 2024
Email Communications	Community Partners	1	October 2024
Participant Intake Form	Participants	134	July 2023-June 2024
Recovery Management Plans	Participants	70	July 2023-June 2024
Referrals	Participants	22	July 2023-June 2024
WRAP sign in sheets	WRAP Participants	252	July 2023-June 2024
WRAP daily surveys	WRAP Participants	381[2]	January-June 2024
WRAP training applications	WRAP Facilitators	27	July 2023-April 2024
WRAP training sign in sheets	WRAP Facilitators	2	July 2023-April 2024
WRAP training survey	WRAP Facilitators	4	October 2024

[2] RDA reviewed a subset of six months of daily surveys

Quantitative Data

Participant Intake Form & Recovery Management Plan. Recovery Connection program staff provided RDA with data captured in the participant intake form and recovery management plan that are administered to all program participants at intake or once they elect to participate in services. The intake form primarily gathers participants' demographic characteristics (e.g., race, language, etc.). and the recovery management plan assesses their satisfaction with specific life domains (e.g., transportation, employment, finances, housing, etc.). In addition, in the recovery management plan, participants are prompted to elaborate on the life domains they deem most critical, the highest priority, or both. The data from the intake forms and recovery management plan are inputted into program's database, FAVOR, which can produce reports in the form of Excel spreadsheets. These reports and others capturing data on participant referrals were provided to RDA for this evaluation. In early 2024 (February and March 2024), RDA collaborated with Recovery Connection program leadership to modify this form to meet the needs of the evaluation by including additional demographic questions and questions screening for substance use and co-occurring mental health and substance use needs. The updated intake form was not fully implemented until the end of the fiscal year (May or June 2024). More data from the revised intake form will be available for FY24-25 and will be presented in the next annual report.

Daily Evaluation Forms. Recovery Connection program staff provided RDA with scanned copies of Daily Evaluation Forms completed by program participants. The Daily Evaluation Forms are administered to community group participants after participation in the group and are completed on paper. The form gathers information on participant satisfaction and feedback, utility of the information provided, and participant perceptions related to hope, personal responsibility, and self-advocacy. Similar to the intake form, RDA adapted the existing Daily Evaluation Form in early 2024 to create a pre- and post-survey that include questions related to program engagement, recovery service access, referrals, and perceived outcomes related to recovery and other aspects of wellness (e.g., housing and employment status, income, relationships, etc.). However, the new pre- and post-surveys were not implemented until after FY23-24 and as a result, this data is not available and data from the Daily Evaluation Forms was used for this evaluation. Data from the pre- and post-surveys will be available for the next reporting period (FY24-25).

WRAP Training Sign-in Sheets, Applications, & Surveys. Recovery Connection program staff provided RDA with all data available from the WRAP trainings, including scans of the paper sign-in sheets, copies of completed training applications, and the results of the WRAP Seminar surveys. There is one paper sign-in sheet per training and along with signatures, participants indicate with a check mark whether they attended one or multiple

days of training. The sign-in sheets also include information on the training itself, such as the date, duration of the training, name of facilitators, and the level of the training. The application is administered to all individuals interested in participating in WRAP training via the online platform Survey Monkey. The application gathers participant contact information and some demographic data, including race/ethnicity and primary language. In addition, the application confirms the training commitment, assesses training interests and expected benefits, and asks participants to report if they identify as a person with lived experience or if they are a family member of someone with lived experience. Lastly, the WRAP training survey is administered after the training via Survey Monkey by SMC BHRS to capture a data related to participants' experiences and insights, such as satisfaction, applicability and relevance of the training, and supports needed to apply learnings. Participants are also asked to share the specific aspects of the training that were most useful and suggestions for training improvement.

Qualitative Data Sources

All data collection for the qualitative data sources utilized **convenience sampling**. Convenience sampling is a sampling method where participants are selected or included in the sample because they are readily accessible or available to participate. Through this approach, RDA relied on Recovery Connection program leadership to identify potential participants to invite for the focus groups rather than employing a more randomized approach. Convenience sampling was ideal to accommodate the timeline of the evaluation and reduce barriers or restrictions to participating.

Focus Groups. RDA facilitated two focus groups, one with program participants and one with staff. Each focus group was tailored to gather unique insights from each group based on their position within the context of the Recovery Connection program. To ensure that questions were appropriately tailored for each group, RDA developed both focus group protocols with input from Recovery Connection program leadership who also helped with scheduling and coordinating the focus groups. The program participant focus group was approximately one-hour and in-person at the Recovery Connection Center. To thank participants for their time and contributions, RDA provided incentives for those that participated in the focus group in the form of $25 gift cards to Amazon and Target. The staff focus group was also one-hour but was facilitated virtually where RDA attended via Zoom and Recovery Connection staff attended together by streaming the Zoom call at the Recovery Connection Center. Incentives were not provided to staff due to MHSA regulations prohibiting incentives for individuals representing an agency in a paid position.

The participant focus group involved discussions of program access, engagement, and impact; program satisfaction and perceived responsiveness; mental health and recovery/long-term recovery service access; as well as the nature of outcomes

experienced, including those related to housing status, employment status, income, family and peer relationships, criminal legal system involvement, quality of life, social support, and sense of belonging.

The staff focus group included discussions of Recovery Connection program implementation, successes, challenges, and adaptations; internal and external collaborations; staff support and satisfaction; program responsivity; perceptions of program access and impact; service adoption and outcomes; and participants' long-term recovery experiences.

WRAP Facilitator Survey. RDA solicited feedback from WRAP facilitators via a survey on Google Forms after attempting to schedule a focus group. The survey included six questions that were all open-ended (requiring text responses) and the survey was voluntary and anonymous. The survey was available for five days and was sent to all WRAP facilitators whose contact information was shared by Recovery Connection program leadership. In the survey, participants were asked to describe how they got involved with VORSMC, their experience becoming a WRAP facilitator and providing WRAP workshops, any supports needed, and their perceptions on WRAP impacts in the community. Through these questions, RDA was hoping to gain insight into the processes, satisfaction, and outcomes of WRAP trainings and workshops. Similar to the staff focus group, incentives were not provided to WRAP facilitators who participated in the survey because most facilitators were also program staff. This was done to comply with MHSA regulations prohibiting incentives for individuals representing an agency in a paid position

Community Partner Email Communications. RDA solicited feedback from community partners via email after attempting to schedule a focus group. The names and contact information of community partners were originally provided by Recovery Connection leadership staff to RDA for the purposes of the focus group and the same individuals were then contacted to provide feedback asynchronously. When outreaching to community partners via email, RDA sent a list of three questions for them to respond to. The questions ask partners to describe their organization's relationship with Recovery Connection, how they collaborate, and where they see strengths or areas for improvement related to implementation, collaboration, and impact. Community partners were asked to respond directly to RDA via email with their responses. Responding to the questions was voluntary and RDA encouraged community partners to provide as much or as little feedback as they would like.

Evaluation Meeting Documentation. RDA utilized monthly evaluation meetings with Recovery Connection program leadership as an opportunity to make additional observations of the Recovery Connection program. The documentation of these meetings

allowed RDA to document how the program was being implemented over time and to what extent the program was identifying needs and best practices to support clients. RDA documented these additional observations through meeting notes. RDA used a portion of these meetings to gather program updates from Recovery Connection program leadership which yielded information on program implementation, its successes, challenges, adaptations, as well as best practices and lessons learned. These meetings were held virtually for up to one hour. While RDA captured meeting notes monthly, analysis of the program updates from the notes took place after the end of the fiscal year to be included in this report.

Data Analysis

RDA conducted a mixed-methods evaluation using qualitative and quantitative analysis techniques, triangulating findings from multiple data sources and types to produce a more robust set of findings.

Different analytic approaches were used to analyze the quantitative and qualitative data. To assess measures from the quantitative data sources listed above, RDA used Stata to calculate descriptive statistics such as basic frequencies and averages for survey and service log data. Data gathered from the qualitative data sources were analyzed using a systematic approach. RDA transcribed, reviewed, and thematically analyzed responses to identify recurring themes and key takeaways.

To further bolster the findings, RDA took a collaborative approach by hosting a virtual data party with the Recovery Connection team. This data party provided a platform to present the initial findings, encouraging open discussion and feedback. Recovery Connection staff shared their perspectives, offered additional context, and ensured that the interpretations were both accurate and culturally appropriate. Moreover, the data party revealed data issues that were quickly and easily resolved with collaboration among RDA, Recovery Connection leadership staff, and SMC BHRS. These discussions were crucial, as they not only validated the findings but also added depth and nuance to the analysis. The insights gathered from this engagement were directly incorporated into the final findings and this report, ensuring that the results were reflective of the Recovery Connection team's and program participants' expertise and experience.

Limitations

Data Accessibility Challenges. Due to the program being in the initial implementation phase during the reporting period, there were some process changes and capacity constraints that impacted data availability. Throughout the first year of implementation, Recovery Connection continued to utilize forms and surveys from existing VORSMC programming. The process to update those tools to align with the evaluation questions and

MHSA requirements and to then subsequently implement them took longer than expected and did not take place until after the FY23-24 reporting period. As a result, certain data that was anticipated for FY23-24 is not available but will be in the next evaluation report (FY24-25). Most notably, pre- and post-surveys were not yet implemented, making it difficult to assess outcomes.

Selection Bias and Small Sample Size. With Convenience Sampling, there is the risk of selection bias because there is an opportunity for self-selection or the choice to opt into data collection activities. When this occurs, specific groups of people may be more interested or motivated to take part in data collection activities, such as surveys, focus groups, etc., than others. As a result, not every individual invited to participate in data collection activities chose to engage and that reduced our overall number of participants, especially when trying to engage community partners. This can lead to results that are not representative of the whole population and are not generalizable.

Recall Bias and Nonresponse Bias. In addition to selection bias, there is also risk of recall bias and nonresponse bias as data is being gathered. Because the evaluation relies heavily on self-reported data from participants and staff, respondents may not recall certain experiences, or they are unwilling or unwilling to respond to certain questions. Recall bias may lead to incomplete or inaccurate data and nonresponse bias can reduce the generalizability of the results because there may be something unique or different about those who do or do not respond to certain questions.

Self-Report Bias and Social Desirability Bias. Participants may unintentionally misrepresent their experiences, either by exaggerating or downplaying them. Respondents might also have felt the need to provide responses they believed were more favorable or acceptable, rather than being fully candid. For example, some participants may have spoken more positively about the program than they truly felt, especially if they were reluctant to express criticism.

Despite these limitations, the feedback collected can help guide Recovery Connection in refining its programming to better serve youth, their families, and the broader community moving forward.

Evaluation Findings

The following sections share key findings in response to each evaluation question: program implementation, impact on access to services, impact on recovery, and impact WRAP capacity in the County. Findings presented are for the first fiscal year of implementation (FY23-24) and should be interpreted as the baseline.

Q1. How is the Recovery Connection program being implemented over time?

This section highlights the Recovery Connection program's first year of implementation, showcasing its depth of services provided and high levels of client satisfaction. It also details key challenges and successes related to implementing this new program.

Overall, clients were very satisfied with the services provided by Recovery Connection. The new location has allowed the program to serve more people and connect with new organizations. However, as the number of participants has increased, staff capacity has become more limited.

Clients Served

Participants Served and Demographics

In the first year of implementation, the Recovery Connection program served 134 participants. All were cisgender (123 of 123), most primarily speak English (50 of 65), and more than half live in the southern half of San Mateo County (69 of 119). Participants were otherwise quite diverse, with varying representation from a range of age groups, sexual orientations, gender identities, races, and ethnicities (Table 3).

134

clients served

Staff and participants enjoying events at the Recovery Connection Center

Table 3. Participant Demographics, FY23-24[3,4]

Category[5]	Count	Percent[6]
Age groups	**97**	
Under 34	28	29%
35-44	33	34%
45-54	14	14%
55+	22	23%
Sexual orientation	*	
Straight	65	*
LGBQ+[7]	*	*
Gender identity	*	
Male	65	*
Female	57	*
Other[8]	*	*
Transgender	**123**	
No	123	100%
Race and Ethnicity	**126**	
Hispanic, Latino, or Spanish Origin	38	30%
White	34	27%
Other[9]	35	28%
Black or African American	12	10%
Asian/Pacific Islander	12	10%
Primary Language	**65**	
English	50	77%
Other[10]	15	23%
City of Residence	**129**	
Redwood City	50	39%
Other[11]	26	20%
Belmont	20	16%
San Mateo	14	11%

[3] Data Source: Participant Intake Form

[4] Items marked with an asterisk have been masked to protect client confidentiality when n<11

[5] Sex assigned at birth and disability status were added to the intake form at the end of June 2024. Data will be available during subsequent reporting periods.

[6] Percentages may not add up to 100% due to rounding and the option to select more than one choice for demographic items.

[7] LGBQ+ includes Bisexual, Gay, Lesbian, Other, and Pansexual

[8] Other gender identity includes Nonbinary and Other

[9] Other race includes Indigenous/Alaska Native, Middle Eastern or North African, and Other

[10] Other primary languages include Other, Spanish, and Tongan

[11] Other city includes Burlingame, Castro Valley, Colma, Daly City, Emerald Hills, Fremont, Gilroy, Meadow Vista, Menlo Park, Millbrae, Milpitas, Montara, Newark, Oakland, Pacifica, Palo Alto, San Bruno, San Carlos, San Francisco, San Jose, and South San Francisco

Category[5]	Count	Percent[6]
East Palo Alto	13	10%
Part of the County	**119**	
North San Mateo County[12]	50	42%
South San Mateo County[13]	69	58%

Most participants were referred to Recovery Connection by a treatment program or a specific individual. Since some WRAP groups are held directly at treatment centers, many participants are first introduced to the program while in treatment.

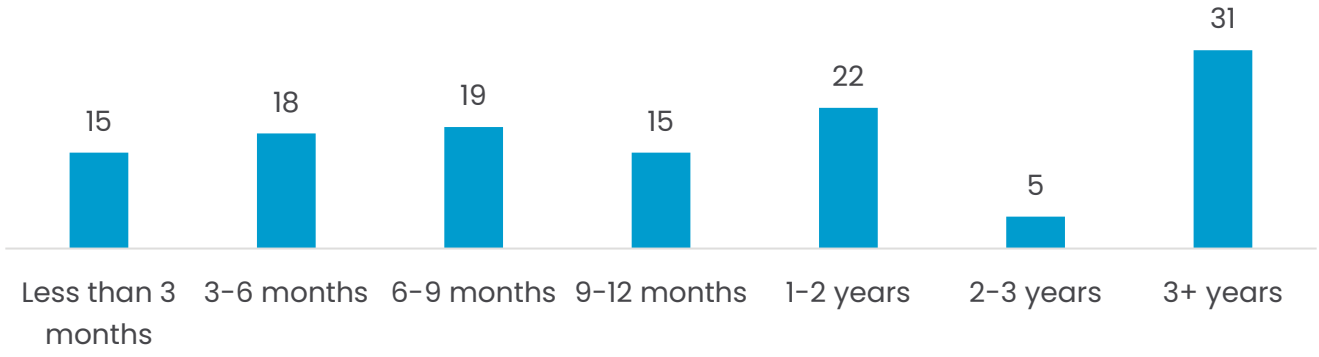
Table 4. Participant Referral Source, FY23-24[14]

Referral source	Count
SUD treatment program	17
Specific individual	12
Self or walk-in	5
Friend	2
Other[15]	2
VORSMC staff and programs	2
TOTAL	**40**

Intake Date

Some participants are new, but many have been participating for years. Around a quarter of participants started the program less than 6 months (33 of 125), while almost half have been participating since before Recovery Connection started last year (58 of 125).

Figure 1. Length of Time from When Participant Started the Program, FY23-24, N=125[16]



[12] North San Mateo County includes Belmont, Burlingame, Colma, Daly City, Millbrae, Montara, San Bruno, San Mateo, and South San Francisco

[13] South San Mateo County includes East Palo Alto, Emerald Hills, Menlo Park, Palo Alto, Redwood City, and San Carlos

[14] Data Source: Referrals

[15] Other referral source includes self , friend, VORSMC staff and programs, justice-related referrals, or a residential program

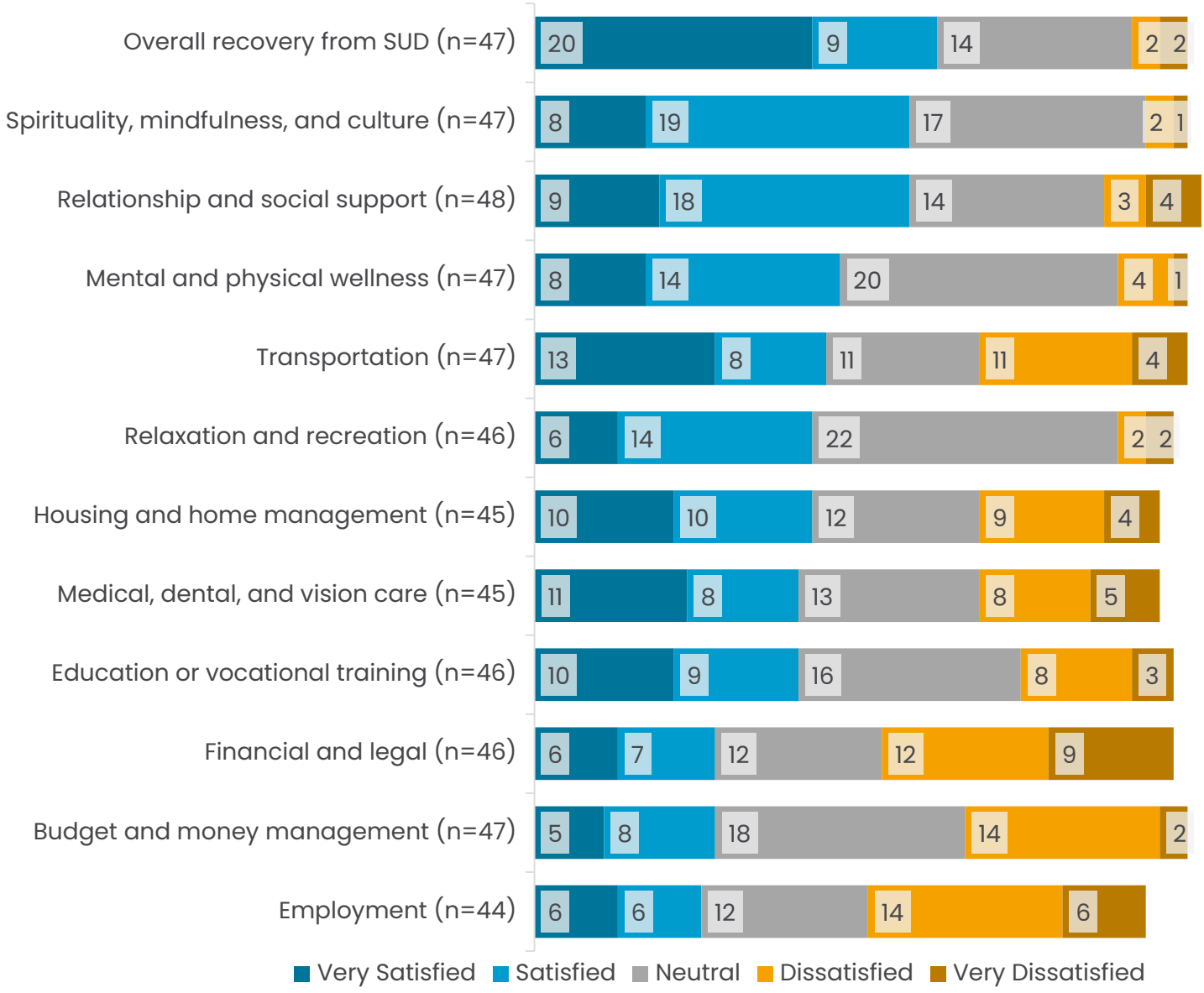
[16] Data Source: Participant Intake Form

Client Needs at Intake

Most participants enter the program seeking services for behavioral health challenges.[17]

At intake, most participants were satisfied with their overall recovery from SUD (29 of 47); spirituality, mindfulness, and culture (27 of 47); and relationships and social support (27 of 48). Some were satisfied with their mental and physical wellness (22 of 27); transportation (21 of 47); recreation and relaxation (20 of 46); housing and home management (20 of 45); medical, dental, and vision care (19 of 45); and education or vocational training (19 of 46). Fewer were satisfied with their financial and legal situation (13 of 46), budget and money management (13 of 47), and employment (12 of 44).

Figure 2. Client Needs at Intake, FY23-24[18]



[17] The presence of a mental health and/or substance use challenge was added to the intake form at the end of June 2024. Data will be available during subsequent reporting periods.

[18] Data Source: Participant Intake Form

Services Provided

252 WRAP and other support groups

7 events

70 recovery management plans

22 referrals

Recovery Connection held a total of 252 WRAP groups and other support groups for 162 participants. Staff held most groups in English (234 of 252) and some in Spanish (18 of 252). Once the program moved to their new location, all groups were in-person or hybrid (190 of 252); pre-move, groups were held virtually on Zoom (62 of 252).

Voices of Recovery hosted 7 events at the Recovery Connection Center. These events ranged from financial wellness workshops, holiday events, community planning meetings, and a meditation workshop. These events reached a total of 140 community members.[19]

Recovery Thanksgiving Event

Staff worked with participants to develop 70 recovery management plans. Over a third of participants had a recovery management plan on file (50 of 134). Most participants had only one plan (37 of 50), but some had between two and four plans (13 of 50).

Staff provided at least 22 referrals to behavioral health and social service programs. There were five participants who received between one and three referrals. However, staff noted that not all referrals are consistently tracked in the FAVOR database. This is likely an underestimate of the number of referrals and number of participants who received referrals.

WRAP Training

The Recovery Connection program held five WRAP facilitator trainings in FY23-24. Two of these trainings were Seminar I trainings and three were Seminar II trainings.

[19] Since community members could attend multiple events, this is a duplicated count.

Over 29 people attended the WRAP facilitator trainings, adding WRAP capacity to San Mateo County.[20] Of the attendees with demographics on-file, nearly all identified as a person with lived experience as a consumer of San Mateo County Behavioral Health services or as a family member of a consumer (25 of 26). Almost half of applicants reported Redwood City as their city of residence (12 of 26). Race or ethnicity and primary language was unknown for a majority of applicants (19 of 26), and applications for trainings taking place before April 2024 did not ask about race/ethnicity or language.

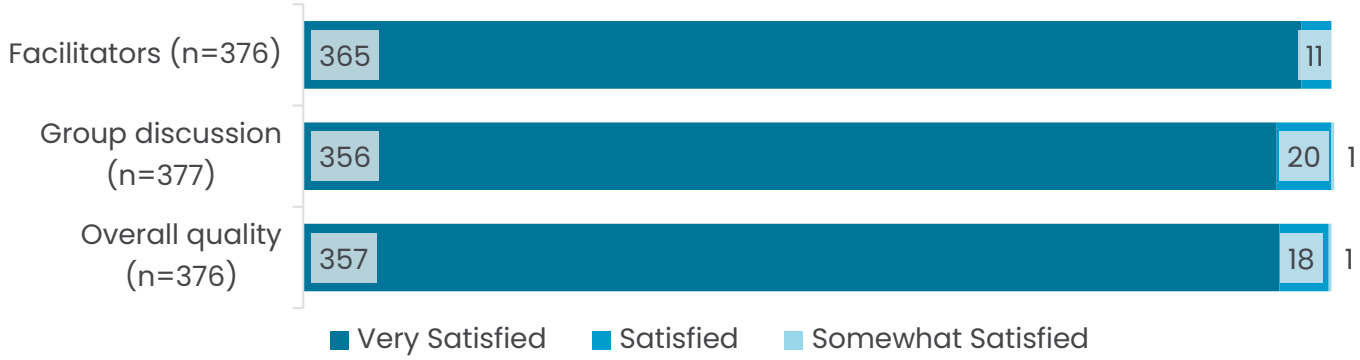
Client Satisfaction

100%

of clients were satisfied

Of participants whose daily evaluations were in the subset that RDA analyzed, **100% of clients were satisfied with the overall quality of the sessions, group discussions, and facilitators (376 of 376)**. All shared that they expect to use the information gained by the support group (377 of 377) and that they would recommend it to another person (378 of 378).

Figure 3. Participant Satisfaction, FY23-24[21]



Clients are very satisfied with Recovery Connection services. Participants expressed feeling welcomed and respected by staff when they come to the center. They mentioned a spirit of trust and openness with staff and other participants. Because of how welcome they feel, they look forward to coming to WRAP groups and choose to come back time after time.

> *"I feel I come here, and I feel okay without judgment. I was anxious at first, but they really embraced me, and I look forward to coming."*
> *- Program Participant*

[20] Two out of the five trainings in FY23-24 did not have applications available (VOR could not locate), and three out of the five trainings in FY23-24 did not have sign-in sheets available to confirm attendance (VOR could not locate). This has resulted in a likely undercount of WRAP training participants.

[21] Data Source: WRAP Daily Surveys

Program Implementation Strengths

One of the biggest successes of implementation was finding and moving to a new, larger location. The new building has increased program participation and provides enough space to carry out programming, such as staff meeting with clients one-on-one, hosting presentations with community partners, and facilitating WRAP groups in-person. Staff reported more participants walking into the center due to its central location. Staff have also been able to make modifications at the new location, including adding a lift, to make the space more accessible for participants with disabilities.

Program staff noted that there has been an increase in partnerships since launching the program and there are now more opportunities to collaborate with community partners. Through collaboration, there is a bi-directional relationship between Recovery Connection and its partners by supporting one another and clients in different ways. For example, VOR engages and provides services to clients of community partners, such as WRAP groups and offering them volunteer opportunities. In addition, VOR has hosted focus and other types of groups for partners in Recovery Connection's new space. Similarly, partners support VOR by promoting VOR services and events, and partners have come to VOR to do presentations for staff and participants.

"We're a big family here and we work through differences. I feel comfortable speaking up and sharing my opinion. At the end of the day, I'm here to support everyone. People are here to support each other with any circumstance that arises." – Program Staff

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Staff expressed feeling very supported while working at Recovery Connection. Staff shared that Recovery Connection fosters a supportive working environment, where staff feel comfortable to be themselves and are very collaborative. Staff have professional development opportunities through Recovery Connection and feel they have grown professionally. Many staff started out as clients, then began volunteering, after which they were hired full time. Additionally, staff appreciate that leadership has an "open door" policy and is always open to providing support. Finally, staff shared that the improved operation supports, like new policies and the creation of committees, has improved processes and infrastructure at the program.

Program Implementation Opportunities for Growth

It has been challenging to accommodate the needs of new and existing clients as the program grows. Staff noted that there's a "new crowd of people with new needs," including

clients who are unhoused. In addition, staff expressed challenges figuring out how to appropriately adapt to the changing needs.

> *"[There are] more people than we've ever had before, [it's] challenging to figure out what's best for us." – Program Staff*

As the program has grown, staff capacity has gotten more limited. Staff shared that it has been challenging to balance all the work as the number of participants increased and the scope of services expanded. Some participants shared that it has been more difficult to meet people and learn how things worked at VOR. Participants also shared that as the program has gotten busier, fewer people are getting a one-on-one, personalized welcome and orientation to the program. Overall, staff expressed a need for additional funding to meet the growing needs of clients.

Q2. To what extent does the Recovery Connection program increase access to recovery services and mental health services and supports for individuals who were not previously engaged in services?

This section describes how the Recovery Connection program impacted access to behavioral health resources. This includes participant access to behavioral health services prior to participating in the program, participant engagement in recovery services through the program, and the extent to which participants were able to access behavioral health services outside of Recovery Connection.

While many participants were previously engaged in behavioral health services before entering the program, several participants shared that Recovery Connection fills a gap in their existing services. Additionally, staff have been able to provide referrals to behavioral health services to participants who were not previously engaged in recovery services.

Access to Behavioral Health Services Pre-Program

Some participants learn about Recovery Connection while receiving services in the County, suggesting that some participants are accessing recovery and mental health services prior to being in the program. When asked to describe how they first heard about Recovery Connection, several participants reported being involved in different programs, such as outpatient services at places like StarVista and treatment programs including Our Common Ground and Serenity House, before visiting Recovery Connection.

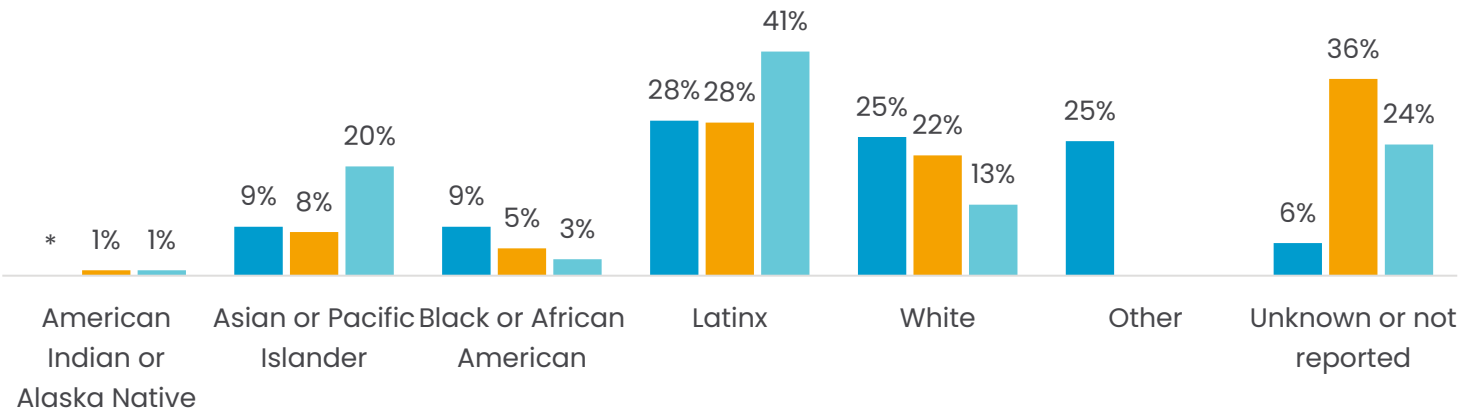
Program Engagement

Penetration Rates

Recovery Connection serves a diverse group of community members in San Mateo County, with participants representing historically underserved populations. As displayed in Figure 4, the racial and ethnic makeup of Recovery Connection participants is generally similar to that of BHRS. Similar to Recovery Connection, most clients served by BHRS (28%) and those eligible for Medi-Cal (41%) identify as Latinx and a slightly smaller portion identify as White (22% and 13%, respectively). In addition, Recovery Connection and BHRS serve very similar proportions of clients identifying as Asian/Pacific Islander (9% and 8%, respectively) but this population represents a much larger portion of Medi-Cal eligibles (20%), doubling what we see for both Recovery Connection and BHRS. Lastly, Recovery Connection serves a slightly larger population of clients who identify as Black or African American (9%) than BHRS (5%), as well as Medi-Cal eligibles (3%), but is still aligned with

overall trends. B**oth Recovery Connection and BHRS are under-serving the Asian or Pacific Islander population as well as the Latinx population, while over-serving the White population.** This may be, in part, due to the limited number of bilingual staff and services offered in languages other than English at Recovery Connection.

Figure 4. County Medi-Cal Penetration Rates, FY23-24[22,23]



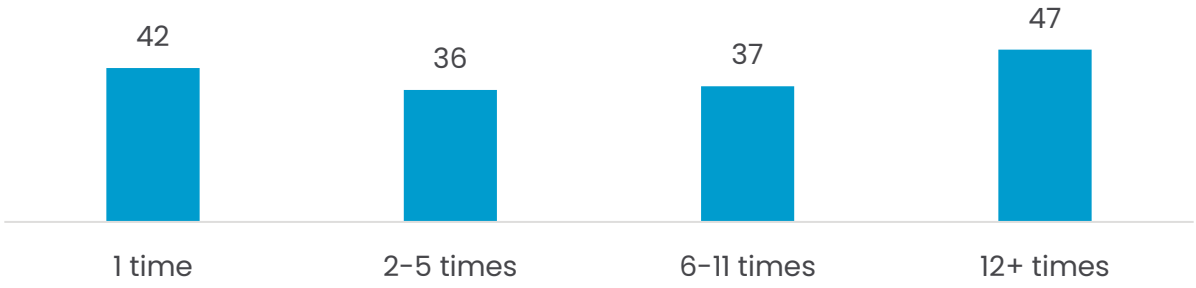
Participant Engagement

162

participants attended WRAP and other support groups

There were 162 individuals who attended Recovery Connection WRAP and other support groups. Most participants attended less than once a month (115 of 162). However, many participants attended at least 12 WRAP groups (47 of 116), with some attending more than 50 WRAP groups (16 of 116). This shows how many participants choose to keep coming back to Recovery Connection again and again.

Figure 5. WRAP and Support Group Attendance, FY23-24, N=162[24]



[22] Data Source: BHRS Adult Medi-Cal Penetration Rate by Race, FY23-24. Retrieved from https://performance.smcgov.org/
[23] Items marked with an asterisk have been masked to protect client confidentiality when n<11
[24] Data Source: WRAP Sign-In Sheets

The program culture, physical space, accessibility, and peer-led programming promote active and continued participation. Participants return to Recovery Connection time after time because of the accepting, warm environment that makes them feel welcomed and that they belong. A key contributor to this culture at Recovery Connection is the program staff, who participants describe as approachable and supportive. The new location offers more space and opportunity for participants to connect with staff and others, fostering social connection and relationship building.

"[I] came once a week, then twice a week, and they started to become my family. They showed up. It felt good to know someone was there for me."
-Program Participant

There are multiple drivers of engagement related to how Recovery Connection structures and delivers their services. Firstly, there is a focus on peer-led programming that resonates well with participants. WRAP facilitators noted that participants are drawn to the peer-to-peer format of groups and the diversity of facilitators available at Recovery Connection. This allows participants to engage with facilitators that they connect with the most and may align with their own identities and experiences. Lastly, participants engage highly with services because they are accessible. For example, there is a lift available for participants with physical disabilities, the WRAP groups are free, and the new building is in a central location that is walkable from other services and organizations nearby.

"People that come to WRAP do so because it is in a fantastic location…People also come to WRAP groups for a free space to feel like they can speak on anything and just to check in." – WRAP Facilitator

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Staff and participants celebrating the Grand Opening of the Recovery Connection Center

Participants, staff, and WRAP facilitators all voiced recommendations on how Recovery Connection can enhance accessibility and strengthen the delivery of WRAP groups to increase engagement. One of the primary areas for improvement noted by participants and staff was linguistic accessibility of services. Particularly, participants and staff noted there is a lack of services available in Spanish. Notably, Recovery Connect program leadership have since communicated recent hiring efforts focused on recruiting more Spanish-speaking staff.

In addition to hiring more Spanish-speaking staff, participants feel there is a need to implement additional supports and resources to enhance accessibility and engagement, such as:

- Hosting groups more days per week
- Implementing an in-house hotline or crisis line
- Offering transportation to and from the Center
- Improving procedures when someone visits the Center by providing a more in-depth program overview & welcome to new participants
- Offering childcare during groups
- Promoting WRAP groups to more individuals and organizations

When asked about their experience providing WRAP workshops and what resources would be supportive, WRAP facilitators voiced needs around upgrading technology and implementing additional facilitation supports. Namely, WRAP facilitators recommend that Recovery Connection update technology available for hybrid WRAP groups to better support those joining virtually. Facilitators also expressed other ways WRAP groups can be improved to increase engagement, such as adding new topics (e.g., finances, spirituality, parenting, etc.) and creating presentation slides to enhance visual learning. For WRAP facilitators specifically, they expressed a need for more support from program staff and leadership on administering paperwork and forms to WRAP group participants. Program leadership have since discussed the idea of developing an in-house training for WRAP Facilitators on how to administer the paperwork, which fields are required, and how to effectively help participants in filling out the forms to reduce administrative burden and enhance accessibility.

Access to Behavioral Health Services Post-Program

Recovery Connection provides referrals to participants for services and resources across the county, including recovery and mental health resources. In FY23-24, there were 22 recorded referrals across five participants. Four of those referrals on file were for substance use and mental health services, including peer support, sober social events, and 12-step groups. For the first year of program implementation, referral documentation was not yet

integrated into existing processes. Referrals are a natural byproduct of Recovery Connection services, especially peer mentoring. Recovery Connection leadership agree that this is an area for improvement and plan to provide the guidance and support needed to help staff track referrals in the future.

Table 5. Participant Referral Types, FY23-24, N=5[25]

Referral Type	Count
Other	18
Substance Use	3
Mental Health	1
TOTAL	**22**

[25] Data Source: Participant Intake Form

Q3. To what extent do individuals who participate in WRAP and other drop-in recovery center services through the Recovery Connection program experience in their long-term recovery, including recovery time, number of relapses, mental wellness indicators and economic mobility?

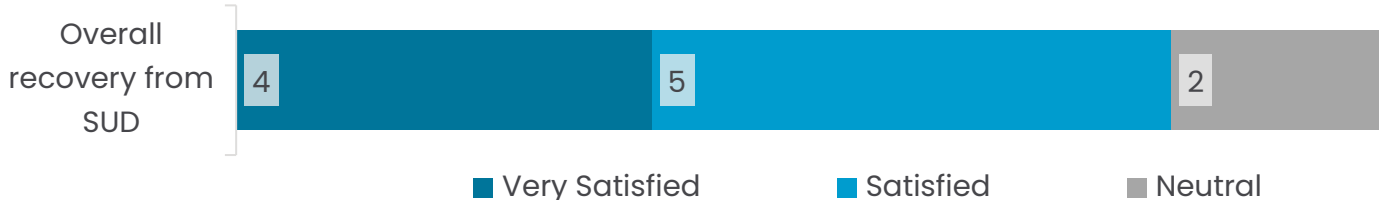
This section describes participant outcomes related to substance use, social support, and others, and what program and service aspects of Recovery Connection influence these outcomes.

Overall, the program has had a positive impact on participants' recovery, their sense of social support, and quality of life. Participants could still use additional support with their financial and legal situations, budget and money management, employment, and education and vocational training.

Substance Use

Participants report satisfaction with their recovery from SUD, with some participants maintaining or increasing in satisfaction overtime. For participants with more than one recovery management plan, most were satisfied or very satisfied with their recovery at the time of their most recent recovery management plan (9 of 11) (Figure 6).

Figure 6. Overall Recovery from SUD Satisfaction, FY23-24, N=11[26]



For participants who rated this domain on their first and most recent recovery management plan, some increased their satisfaction with their recovery from SUD (4 of 11), some reported the same level of satisfaction (5 of 11), and fewer reported a decrease in satisfaction (2 of 11).

Recovery Connection has a very positive influence on participant recovery by instituting a sense of accountability, being a safe space to go when in crisis, and providing new, unique tools and approaches to recovery. Participants like that Recovery Connection

[26] Data Source: Participant Survey

provides a sense of accountability, knowing that they have somewhere to go and that they should not use substances before arriving at the Center. Nevertheless, participants see Recovery Connection as a safe place to go to if they do relapse and need support. Participants appreciate that Recovery Connection staff are welcoming and accepting, never shaming people if they make mistakes but rather embrace them. Lastly, participants identify that Recovery Connection offers new, unique tools and approaches to recovery that are different from other, traditional programs and interventions, such as Alcoholics Anonymous (AA). Particularly, participants appreciate that Recovery Connection bridges substance use with mental health, acknowledging that both are interconnected.

"Here, addiction bridges mental health, which 12 steps doesn't do for me."
- Program Participant

WRAP facilitators also talked about the program's impact on substance use, describing that WRAP trainings and workshops have a positive impact on the community by supporting recovery, encouraging introspection, and meeting unmet needs in these areas. Through WRAP trainings and workshops, people receive positive support, build confidence, increase knowledge on forms of recovery, and have an opportunity to improve their lives.

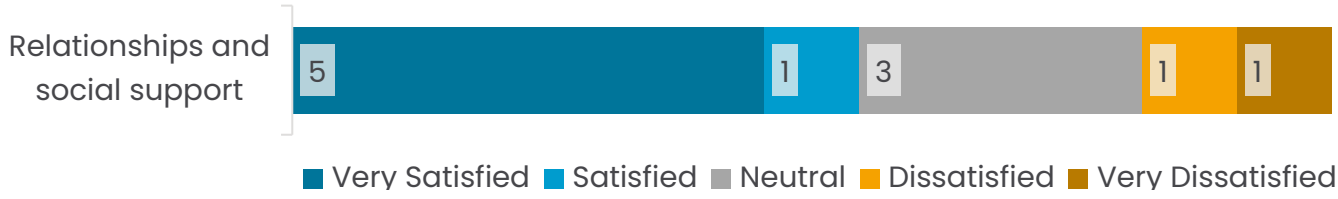
"WRAP fixes and fills the cracks in the sidewalks we often just step over. Metaphor for what other similar programs do not address. Or do so in a less 'planning' type of way which works for a lot of the participants that I have come across."
- WRAP Facilitator

"WRAP is an effective program and is changing lives for the better."
- WRAP Facilitator

Social Support

Most program participants have high satisfaction with their relationships and the level of social support received and some experienced increased satisfaction overtime. For participants with more than one recovery management plan, over half were satisfied or very satisfied with their relationships and social support at the time of their most recent recovery management plan (6 of 11) (Figure 7).

Figure 7. Relationship and Social Support Satisfaction, FY23-24, N=11[27]



Of participants who rated this domain on their first and most recent recovery management plan, more than half increased their satisfaction with their relationships and social support (6 of 11), some reported the same level of satisfaction (3 of 11), and fewer reported a decrease in satisfaction (2 of 11).

Participant satisfaction with the level of social support they experience is influenced by Recovery Connection's culture of acceptance and the physical space available to connect with others regularly. Program participants and staff both expressed that Recovery Connection fosters a sense of belonging by encouraging connection and establishing a culture where participants feel welcomed and accepted. Notably, the new location bolsters this sense of belonging by creating a physical space where participants can be in community with one another. Participants see Recovery Connection as a family, they feel open to talking to others, and are eager to meet others and learn their stories. Participants and staff also note that social connection extends beyond the walls of the Center and many participants will see each other outside of the program.

> *"Having this space makes it a more inviting place to come and hang out…people know that there will be a bunch of people here willing to talk with them. The space has all these separate rooms so we can talk one-on-one, can go outside with them. A lot of people will come here at 3:00 and stay here until 7:30. Participants get a lot out of groups and get a lot out of connecting with people outside of the groups." – Program Staff*

Other Outcomes

An aspect of Recovery Connection that is impacting client outcomes and contributing to growth in client wellness is linkage to resources. In FY23-24, there were 18 recorded referrals on file across three participants for other services outside of mental health and recovery services. About a third of referrals were for legal services (5 of 18), slightly fewer were for housing services (4 of 18), and a few were for employment/financial services (3 of

[27] Data Source: Participant Survey

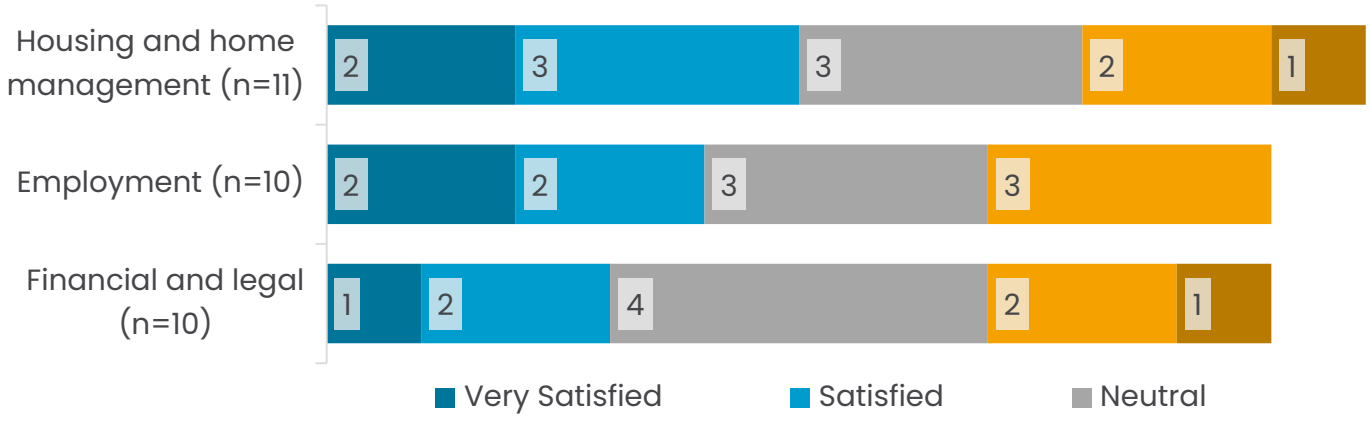
18). A third of referrals were identified as "Other" and included referrals to services that assist with food, healthcare navigation, insurance, transportation, among others (6 of 18).

Table 6. Other Referral Types, FY23-24, N=18[28]

Other Referral Type	Count
Legal	5
Housing	4
Employment/Financial Services	3
Other	6
TOTAL	**18**

For outcomes related to legal support, housing, employment, and finances, there were mixed feelings and varying levels of satisfaction among participants, however there was more consistent satisfaction around overall quality of life. For outcomes related to legal support, housing, employment, and finances, less than half of participants with more than one recovery management plan were satisfied with these areas at the time of their most recent recovery management plan (Figure 8). When comparing their initial and most recent recovery management plans, there was almost an even split amongst those that increased, decreased, or maintained their level of satisfaction in these areas. When assessing indicators related to quality of life, such as mindfulness and mental and physical wellness, participants expressed higher levels of satisfaction that were mostly sustained overtime across all indicators in this domain.

Figure 8. Housing, Employment, and Financial Satisfaction, FY23-24[29]



[28] Data Source: Participant Intake Form
[29] Data Source: Participant Survey

Housing and Home Management

For participants with more than one recovery management plan, less than half were satisfied or very satisfied with their housing and home management at the time of their most recent recovery management plan (5 of 11). For participants who rated this domain on their first and most recent recovery management plan, some increased their satisfaction with their housing and home management (3 of 10), some reported the same level of satisfaction (3 of 10), and a similar proportion reported a decrease in satisfaction (4 of 10).

Financial and Legal

For participants with more than one recovery management plan, less than a third (3 of 10) were satisfied or very satisfied with their financial and legal situation at the time of their most recent recovery management plan**.** For participants who rated this domain on their first and most recent recovery management plan, some increased their satisfaction with their financial and legal situation (3 of 9), a similar proportion reported the same level of satisfaction (4 of 9), and a couple reported a decrease in satisfaction (2 of 9).

Employment

For participants with more than one recovery management plan, less than half were satisfied or very satisfied with their employment at the time of their most recent recovery management plan (4 of 10)**.** For participants who rated this domain on their first and most recent recovery management plan, a third increased their satisfaction with their employment (3 of 9), a third reported the same level of satisfaction (3 of 9), and another third reported a decrease in satisfaction (3 of 9).

Recovery Connection provides opportunities and pathways to employment for participants engaging in the program. Firstly, program staff and participants both spoke of the opportunity to volunteer at Recovery Connection, one of the program's many service offerings. Staff and participants went on to say that many volunteers are hired and given paid positions, such as recovery coaches, and this is true for many of the current staff members who started as volunteers initially. However, staff also noted that the program is not able to hire everybody who volunteers. Fortunately, Recovery Connection has many partnerships across the county and knows of places where volunteers can find work.

"[I] started as a volunteer and [was] able to get hired on…nice path for training. Amazing that an organization functions in that way." – Program Staff

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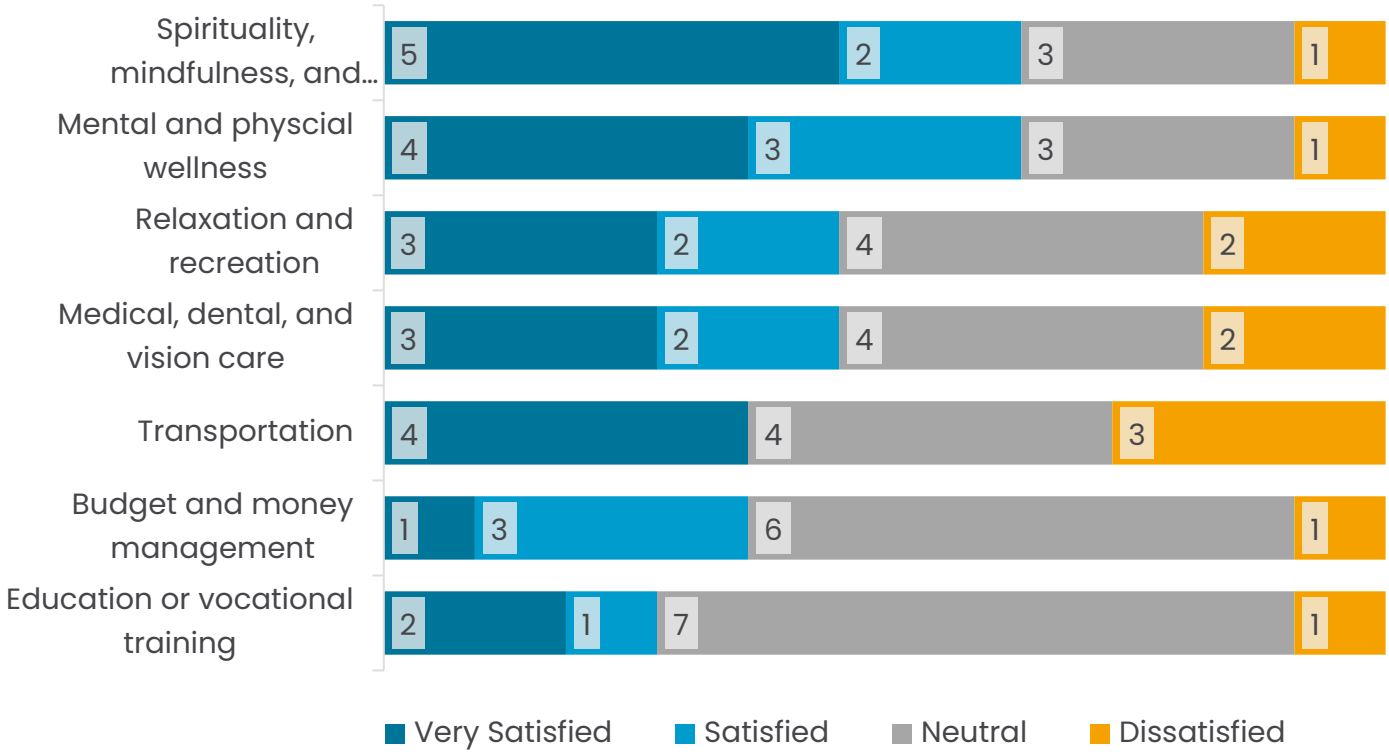
Quality of Life

Overall, participants expressed high levels of satisfaction around most quality of life indicators, but indicators related to social factors and skills (e.g., transportation, budget management, and education) brought about mixed feelings and lower satisfaction.

Recovery management plans assessed satisfaction across quality of life indicators such as spirituality, mindfulness, recreation, and mental and physical wellness, as well as social factors like transportation, money management, and education. As displayed in Figure 9, for participants with more than one recovery management plan, more than half were satisfied or very satisfied with their spirituality, mindfulness, and culture (7 of 11) and mental and physical wellness (7 of 11). Approximately half were satisfied or very satisfied with their relaxation and recreation (5 of 11) and medical, dental, and vision care (5 of 11). A smaller number of participants were satisfied with their transportation (4 of 11), budget and money management (4 of 11), and education or vocational training (3 of 11).

Figure 9. Indicators of Quality of Life Satisfaction, FY23-24, N=11[30]



For participants who rated all aspects of this domain on their first and most recent recovery management plan, most increased their satisfaction with their quality of life (5 out of 8), while a few reported the same or decreased satisfaction (3 of 8).

[30] Data Source: Participant Survey

Satisfaction and improvements in quality of life seen through the Recovery Management Plans were consistent with what was expressed by program participants in the focus group and through the WRAP daily surveys. Participants highlighted that through participation in Recovery Connection, they have experienced a greater sense of purpose and hope, with one program participant saying, *"[The program] installed hope and life in me. [I] feel like I am living life."* Similar sentiments were expressed through the WRAP Daily Surveys.

Figure 10. Impact of WRAP and Other Support Groups, FY23-24[31]

[31] Data Source: WRAP Daily Surveys

Q4. To what extent does training peer workers, clinicians, and paraprofessionals in WRAP through the Recovery Connection program increase capacity in San Mateo County to use WRAP with individuals with substance use and mental health challenges?

This section describes the implementation and impact of the WRAP Seminars facilitated by the Recovery Connection program. Implementation of the Seminars is understood through trainee satisfaction, barriers and facilitators to attending the training, and resources and support most helpful to trainees.

Individuals who participated in the WRAP training were satisfied with the training, found it to be accessible, and felt like they had enough resources and support from the program. Trainees increased their understanding of the material and improved confidence in their skills, increasing the likelihood that they would apply what they learned in their work.

Training Implementation

Satisfaction

Overall, trainees were satisfied with the process to become certified WRAP facilitators and found the training to be enjoyable, engaging, and informative. Trainees enjoyed the training and especially appreciated that the training was engaging, offering ample space for trainees to "role play" scenarios and practice skills, such public speaking. Many trainees noted that the experiential nature of the training was most helpful for them, and some expressed a desire for additional interactive training components, such as more opportunities to practice facilitating and more breakout sessions. Trainees felt the training provided a large amount of information in a way that was understandable and straightforward, and, according to the WRAP training survey, all respondents found the instructors to be "Extremely" or "Very" knowledgeable on the topic (8 of 8).

Seminar I – Develop Your Own WRAP Facilitators, Staff, Volunteers, and Trainees

Trainees shared that the training was motivational, applicable to their practice, and affirming of their identities and experiences. According to the WRAP training survey, all respondents found the training to be "Extremely" or "Very" applicable to their practice (8 of 8), and most felt the training did "Extremely" or "Very" well in addressing needs related to working in a multicultural context and agreed that their identity, culture, and experiences were affirmed by this training (6 of 7).

"The seminars were very good & provided lots of information about WRAP."

"Being trained as a facilitator was motivational."

- WRAP Facilitators

Accessibility

The unique pathways to becoming a WRAP facilitator as well as the shortened training duration and in-person format all positively influenced training attendance. Trainees reported hearing about VORSMC through various channels, such as existing WRAP facilitators, family members, treatment facilities, community partners/organizations, and events. After hearing about VORSMC, trainees typically become involved through volunteering, regularly attending WRAP groups, sitting on committees, and/or becoming full-time staff, before deciding to be trained as a WRAP facilitator. Having multiple avenues in which someone can learn of and decide to become a facilitator speaks to the accessibility of WRAP trainings and that there is not just one way to become a facilitator.

Most facilitators are trained in less than two weeks, and trainees noted that the process has shortened over time, especially after the COVID-19 pandemic. Currently, Seminar I is a two- or three-day training and Seminar II for Advanced Level WRAP Facilitators is three- or five-days. The duration is dependent on the number of trainees, with more trainees requiring more time to get through the material and practice skills. Trainees made multiple remarks that the training experience is simple and easy to follow along. Most WRAP training survey respondents reported that their training was in person (6 of 7), and they preferred it that way. This indicates that the training format matched most participant preferences.

"At this time, I think our process has improved and we can train staff more quickly than we did after returning from the COVID lockdown."
- WRAP Facilitator

Resources and Support

Trainees receive ample support throughout their training experience from VORSMC, the training facilitators, and other staff members. More specifically, trainees expressed appreciation for the support provided by the VORSMC Facilitator Support Group, as well as the workbook and binder provided to them upon starting the training. In addition, some trainees felt supported by being given the opportunity to scribe at a WRAP group before facilitating their own, which allowed them to ease into WRAP facilitation. Through the WRAP training survey, when asked what support they might need to apply what they learned moving forward, most respondents indicated they might need hands-on practical experience (6 of 7), and a smaller portion expressed a need for support from their supervisor and/or additional resources or materials on the topic (4 of 7).

Impact of Training

Through the training, trainees increased their understanding of the material and gained a heightened sense of confidence in their skills, increasing the likelihood that they would apply what they learned in their work. As mentioned earlier, the training provides a large amount of information about WRAP and many trainees affirmed this by self-reporting increased knowledge and understanding on the topic. Many trainees linked knowledge with confidence, noting that their increased understanding fosters confidence. Specifically, many trainees noted building confidence in public speaking and all WRAP training survey respondents reported feeling more confidence in their ability to create change in their community or workplace (7 of 7). All WRAP training survey respondents also reported that they are likely to apply something they learned in the training in their thinking, behavior, or practice (7 of 7), and multiple participants plan to facilitate WRAP groups at their jobs and/or will encourage their clients to set up their own WRAP. In addition, some participants indicated that they would apply communication skills and techniques learned from the training, such as reflective listening.

"[The] training was helpful to give me the confidence I needed for public speaking and engaging with community members."

"The training to become a facilitator has allowed me the opportunity to learn and to understand the material at a level which I can feel confident."

-WRAP Facilitators

Recommendations

Based on the lessons learned from the first year of Recovery Connection implementation, RDA has made recommendations that can help improve participant outcomes and program impact.

- **Enhance data collection processes.** Data collection processes can be strengthened to better capture program outcomes and impact. To do this, the updated data collection tools created in FY23-24 should be fully implemented in FY24-25 to gather the data needed to answer the evaluation questions and meet MHSA requirements. Data should be captured on client participation in recovery and mental health services before Recovery Connection. This data will provide insight into the accessibility of services before and after program engagement. Additionally, consistent tracking of referrals would enhance client outcomes and reporting.
- **Implement additional support and resources to enhance accessibility.** Program stakeholders voiced accessibility needs. Notably, there is a need for more Spanish-speaking staff to better serve participants whose primary language is Spanish. Other strategies to enhance accessibility include hosting WRAP groups more frequently and providing services, such as childcare and transportation, to support in-person participation. WRAP groups would also benefit from improved technology to better engage those participating virtually, as well as instituting more visual aids.
- **Continue to provide WRAP facilitation support.** WRAP facilitators experience a great amount of support throughout their training experience. As an integral part of developing strong facilitators, Recovery Connection should continue to implement resources and processes that further support facilitators beyond the training process. Notably, there is a need among facilitators for more support in administering paperwork/forms to WRAP participants. Hosting in-house training on this process has been voiced by program leadership as a potential way to meet this need.
- **Continue to leverage the new location.** The new building was the most notable strength of the program in its first year of implementation. Moving forward, Recovery Connection should continue to intentionally use the space to increase participation, as well as foster relationships with community partners by inviting them to use the space and encouraging their clients to visit the Center. There may be value in establishing satellite offices in other parts of the county to increase accessibility and participation.

All the above recommendations would benefit from additional funding. Recovery Connection should continue to seek additional funding that can support program growth and sustainability. This would support the program in instituting the above recommendations and enhancing existing program services, such as hiring more volunteers and bolstering community-wide events.

Appendices

Appendix A. Program Design

Access to Services

To ensure that Recovery Connection services are easily accessible to the community, the organization has strategically chosen a central location in Redwood City, situated between East Palo Alto and Belmont. This location was carefully selected for its convenience, particularly in terms of public transportation options, with a special focus on accessibility during non-traditional hours. The center's operational hours are from approximately 9am to 7:30pm, Monday through Friday, as many individuals seek support beyond regular business hours.

Moreover, Recovery Connection is committed to staying closely attuned to the evolving needs of the community it serves. Annual focus groups and surveys with program participants will be conducted to gauge the effectiveness of the current operating hours in meeting their requirements. If it is found that extended evening and weekend hours would better cater to the population's needs, the organization is prepared to adjust its schedule accordingly.

Additionally, the center is dedicated to fostering collaboration within the community. It will actively partner with local organizations and existing substance use treatment providers to promote awareness of its drop-in center services and reach out to potential participants. This collaborative approach underscores Recovery Connection's commitment to ensuring its services are both accessible and responsive to the dynamic needs of the community it serves.

Assessment and Service Planning

When individuals visit Recovery Connection, they are extended an invitation to attend an informative session led by a peer coach. This session is designed to acquaint them with the center and its comprehensive range of services. Once a decision to engage with the program is made, participants are guided through the completion of an intake form, which includes the development of a personalized recovery management plan. The intake form serves as a vital tool in this process, as it prompts individuals to provide information about their substance use and includes a straightforward co-occurring screening component. This screening helps facilitate appropriate referrals and seamless transitions to other services, all while ensuring compliance with the MHSA Substance Use Disorder (SUD) reporting requirements. Subsequently, the recovery management plan is carefully crafted to determine the specific services that best suit everyone’s unique needs and preferences.

These services may encompass various aspects such as mentoring and job skill development. All participants begin their services with a WRAP group, which also help inform additional services that would further meet their needs. This initial step not only fosters personal growth but also assists in identifying additional services that align with their unique needs.

If it is determined that a participant would benefit from services beyond the scope of what Recovery Connection offers, Recovery Connection staff assist with making these referrals and establishing essential connections. This holistic approach underscores Recovery Connection's commitment to ensuring that everyone receives the comprehensive care and support they need on their path to recovery.

Program Staff and Advisory Group

The Recovery Connection program consists of a diverse team of professionals, including a program manager (to be filled), four full-time peer staff, four full-time outreach staff, and one full-time administrative staff. A brief description of program staff's roles is below:

- **Program Manager** (once filled) will design, develop, and oversee program implementation, as well as manage day-to-day operations. In addition, the Program Manager will provide supervision and guidance to program staff.[32]
- **Peer Staff**, including peer support specialists, are actively engaged in delivering direct services to program participants such as facilitating WRAP workshops, offering guidance on job readiness and employment opportunities, providing housing referrals, conducting health and wellness classes, and identifying volunteer opportunities.
- **Outreach Staff** lead outreach efforts aimed at reaching the program's target populations.
- **Administrative Staff**, including leadership staff and an executive assistant, ensure a smooth intake process and support administrative tasks as well as data collection.

In the early stages of program initiation, a small and diverse **advisory group** was formed, consisting of program participants, family members, and esteemed community leaders. This advisory group also includes representatives from partner agencies who share a vested interest in the program's success. The primary purpose of this advisory group is to actively shape all facets of the Recovery Connection program. They contribute their insights and expertise to influence the program's structure, service offerings, outreach strategies, evaluation processes, and the dissemination of innovative findings. Stakeholders maintain

[32] A Program Manager will be hired in the future once funds are secured for this position. The Executive Director will carry out the roles of the Program Manager in the interim.

an ongoing and pivotal role in guiding the continuous development and evolution of this program, ensuring that it remains responsive to the needs of the community it serves.

Target Population

The Recovery Connection program is open to all people over the age of 18 who are experiencing a substance use challenge or co-occurring substance use and mental health challenges. Recovery Connection accepts people at all stages of recovery, and, unlike the RCC model, participants do not need to be clean and sober to receive services. Annually, the program aims to serve 200 to 300 new participants, for a total of 940 to 1,110 participants through WRAP and health and wellness groups.

Compared to the population at large, communities that are historically marginalized are often underserved and do not have equitable access to substance use supports. In response to this, the Recovery Connection program specifically seeks to reach individuals in the Latinx community, particularly immigrants whose second language is English and are very low- to low-income, male, under- or unemployed, and involved in the justice system. The program also seeks to reach other populations that are historically underserved, including Asian/Pacific Islander, African American, low-income, LGBTQIA+, unhoused, chronically unemployed, and justice-involved populations.

Appendix B. Program Implementation Updates

Month/Year	Recovery Connection Implementation Updates
Aug 2023	• Recovery Connection launched the program • Recovery Connection and RDA completed the first evaluation planning session
Sep 2023	• Recovery Connection hired two peer staff who were slated to go through a training process to become facilitators and assist in outreach • Recovery Connection hired an Executive Assistant • Recovery Connection found a building but there were some accessibility concerns • Recovery Connection in the discovery phase of convening a project advisory group • Recovery Connection and RDA completed the second evaluation planning session
Oct 2023	• Recovery Connection moved into the new building • Recovery Connection worked on securing a designer for the building as well as addressing other infrastructure needs, such as security, signage, internet, computers, etc. • Recovery Connection had their "soft" opening at the new building but are planning a larger grand opening in 2024 • Recovery Connection hosted a Halloween event in the new building • Recovery Connection and RDA completed the third evaluation planning session this month • Recovery Connection identified community members and other stakeholders for the advisory board. In October 2023, RDA engaged in discussions and shared a resource guide with Recovery Connection to help support the development of their advisory group.
Nov 2023	• Recovery Connection hired two outreach workers that are also certified WRAP facilitators • Recovery Connection was fully moved into the new building • The building was furnished for staff work and Recovery Connection continued searching for a designer • RDA completed the evaluation plan and shared it with Recovery Connection
Dec 2023	N/A – meeting canceled
Jan 2024	• Recovery Connection started major renovations to the building and plans to have a lift installed • Recovery Connection got their signage installed and are still looking to secure a designer

	• Recovery Connection running hybrid groups out of the new building three times per week • The drop-in space is now open at Recovery Connection's new building • Recovery Connection starting to get a lot of volunteers
Feb 2024	• Recovery Connection working with designers to design and furnish building • Program participation increased tremendously, especially after installing signage outside of the building • Recovery Connection interviewing for the Program Manager role • Recovery Connection began planning for the Advisory Group and RDA provided technical assistance
Mar 2024	• Hiring for a Program Manager was paused due to a shift in funding • Staff member left and Recovery Connection working to hire two more people for the position • Recovery Connection planning for more community events, such as a Cesar Chavez event and an open mic • Recovery Connection trained 10 new advanced-level WRAP facilitators • Three staff in the process of becoming certified peer specialists
Apr 2024	• Recovery Connection hosted the first Advisory Group meeting in-person at the Center with eight attendees (not including Recovery Connection program leadership and RDA) (with hybrid option available)
May 2024	• Recovery Connection hosted the second Advisory Group meeting in-person at the Center with eight attendees (not including Recovery Connection program leadership and RDA) (with hybrid option available)
Jun 2024	• The lift was installed at the Recovery Connection Center • Recovery Connection outreach workers are shadowing an outreach team from Life Moves to get a better understanding of what it is like to be out in the field • Recovery Connection hosted and participated in community events, such as San Mateo Pride and Juneteenth • Recovery Connection started creating new MOUs to invite other organizations to come to the Center and give presentations (e.g., NAMI, East Palo Alto Legal) • Recovery Connection Planning a recovery movie night open to the public (community-wide event) • Recovery Connection planning to hire another staff person who speaks Spanish

Appendix C. Learning Goals, Evaluation Questions, Data Indicators and Measures, and Data Sources

LEARNING GOAL	PROCESS EVALUATION		
	Evaluation Question	**Data Measures**	**Data Sources**
To assess and improve the implementation of the Recovery Connection program to ensure it effectively meets participant needs, fosters collaboration, and delivers quality services.	How is the Recovery Connection program being **implemented over time**?	• Successes and/or challenges to implementation • Adaptations to implementation in response to participant needs • Demographics of participants served • Total number of participants served • Total, count, and type of services provided • Collaboration • Staff support • Program elements that contributed to participant engagement	• Participant intake forms • Participant surveys • Participant focus groups and/or interviews • Staff focus groups and/or interviews • Evaluation meeting notes • Training survey

		• Program elements that contributed to participant perceived outcomes • Participant experience in accessing long-term recovery services • Average wait time for participants to get into a long-term recovery treatment center • Total and count of participants who drop out before entering a long-term recovery treatment center • Type and count of trainings held • Total and count of people trained • Types and demographics of people trained	
To determine the extent to which the Recovery Connection program enhances access to recovery and mental health services for individuals who were not previously engaged in such services, with a focus on participation, barriers to access, service delivery to underserved	**OUTCOME EVALUATION**		
	To what extent does the Recovery Connection program **increase access** to recovery services and mental health services and supports for individuals	• Count and proportion of participants who were not previously connected to substance use treatment or services • Count and proportion of participants who report they would be unlikely to have	• Participant intake forms • Participant surveys • Participant focus groups and/or interviews • Staff focus groups and/or interviews

populations, and the identification of co-occurring disorders.	who were not previously engaged in services?	accessed services outside of the drop-in center • Count and proportion of participants from underserved populations compared to County-reported penetration rates by race/ethnicity • Level of participants' engagement in services • Type, count, and proportion of referrals to mental health and recovery services	
To examine the extent to which the Recovery Connection program improves long-term recovery outcomes for participants, with a focus on recovery time, relapse rates, mental wellness, economic mobility, and overall quality of life.	To what extent do individuals who participate in WRAP and other drop-in recovery center services through the Recovery Connection program experience in their **long-term recovery**, including recovery time, number of relapses, mental wellness indicators and economic mobility?	• Length of time in recovery compared to previous lengths of recovery time, with goal of 60% increasing their length of recovery • Proportion of participant use of Alcohol and Other Drugs (AOD), with goal of 60% reducing AOD use • Changes (reported as proportions) in housing status, employment status, income, family and peer relationships, with goals of 65% reducing their involvement with the criminal	• Participant intake forms • Participant surveys • Participant focus groups and/or interviews • Staff focus groups and/or interviews

		justice system and 65% increasing their housing stability • Proportion of participants who experience improved quality of life, with goal of 65% improving their quality of life • Level of social support received by participants • Type of social connections • Count and proportion of participants who develop a sense of belonging • Type, count, and proportion of referrals made to other services (e.g., basic needs) • Level of satisfaction with program services	
To evaluate the extent to which the Recovery Connection program enhances capacity in San Mateo County for using WRAP with individuals facing substance use and mental health challenges, focusing on the number of trainings, trained individuals, their knowledge and skills, readiness to use WRAP, and satisfaction with training.	To what extent does training peer workers, clinicians, and paraprofessionals in WRAP through the Recovery Connection program **increase capacity** in San Mateo County to use WRAP with individuals with substance use and	• Proportion of trainees reporting increased knowledge and skills in WRAP • Proportion of trainees reporting likelihood of using WRAP with clients • Trainees' level of satisfaction with training • Type and count of barriers to attending training	• Training survey • Staff/trainer interviews • Community partner/trainee interviews

	mental health challenges?	• Type and count of facilitators to attending training • Type of trainer resources and support	