The Mental Health Services Act

A Journey of Transformation and Lives Impacted

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MESSAGE FROM THE DIRECTOR

When California voters overwhelmingly approved the Mental Health Services Act (MHSA) in 2004, it was a monumental achievement for the thousands of advocates and supporters who recognized the need for a significant transformation of the behavioral health system. This was a defining moment for California residents living with mental health and substance use challenges, their families, and the broader community. MHSA has transformed public behavioral health systems and services throughout the state, positively impacting clients' lives by focusing on wellness and recovery, client and family driven services, culturally and trauma-informed care, and increased collaboration with community-based partners. Nearly 20 years after the passage of the MHSA, we acknowledge the unprecedented opportunity to fund, develop, and sustain programs and initiatives in San Mateo County Behavioral Health and Recovery Services (BHRS) that support wellness and recovery in our community.

I'm proud to share that the MHSA played a pivotal role in my journey in local public service. When MHSA funding began in San Mateo County in 2006, I was working in a local community-based organization. I learned about the MHSA Community Program Planning process, and for the first time I felt that the BHRS system cared about my experience as a provider and as a Filipino community member. After participating in two community input meetings, I felt encouraged to expand my work to make San Mateo County a place where all of our diverse residents have equitable access to high-quality, culturally informed behavioral health services. I soon had the opportunity to join BHRS and launch the BHRS Office of Diversity and Equity, where I led the County's work to promote health equity in the behavioral health system and oversaw the administration of the MHSA. I am moved when I think about where I started in 2006, and my role now as Director of BHRS.

This report highlights only a fraction of the MHSA-funded efforts that have impacted clients, community members, and the entire behavioral health system (outcomes of all of MHSA-funded programs may be found in our MHSA Annual Reports on the MHSA website, www.smchealth.org/MHSA). We are grateful to—and could not do this work without—our dedicated staff, partner organizations, advocates, and community members whose commitment and compassion are the engine of our behavioral health system. As we take this moment to celebrate the impact of MHSA over the years, and as we prepare for changes to the MHSA as a result of the recent approval of Proposition 1 in California, we reinforce our commitment to learning, growing, and continually improving how we support our diverse county to be well and thrive.

Dr. Jei Africa
Director of Behavioral Health and Recovery Services

Mental Health Services Act

AT WORK IN SAN MATEO COUNTY

FUNDED PROGRAMS

10
innovative programs

24
prevention and early intervention programs as of FY 2022-23

32
direct treatment programs as of FY 2022-23

ANNUAL TRAINING PARTICIPANTS*

1,460+
providers attended workforce development trainings*

FUNDED HOUSING SUPPORT

13
housing developments

130
housing units

ANNUAL CLIENTS SERVED*

6,555
prevention and intervention clients

4,275
direct treatment clients

28,000+
community members served through prevention-related activites

9
Funded

ORGANIZATIONAL CAPACITY DEVELOPMENT INITIATIVES

*annual average over the past five years

EXECUTIVE SUMMARY

The Mental Health Services Act (MHSA) was approved by California voters in November 2004 and provides dedicated funding for the expansion of behavioral health services across the spectrum of direct treatment, early intervention, prevention, workforce, and technology, and infrastructures strategies. For San Mateo County Health, Behavioral Health and Recovery Services (BHRS), the mission of MHSA has been to improve the quality of life for individuals and families living with mental health and substance use challenges by prioritizing cultural humility, equity, recovery-oriented and trauma-informed principles in the transformation of our behavioral health system of care.

SINCE MHSA INCEPTION, BHRS HAS INVESTED

$476M+
in the behavioral health system

$340M
in treatment

$90M
in prevention and early intervention

MHSA Outcomes

San Mateo County BHRS expansions and impact is observed across all seven state-defined MHSA goals.

1 **REDUCE THE DURATION OF UNTREATED MENTAL ILLNESS**	• Created prevention and early psychosis programs. • Carried out community education and training to recognize signs and symptoms of behavioral health challenges and connect individuals to community resources.
2 **PREVENT MENTAL ILLNESS FROM BECOMING SEVERE AND DISABLING**	• Developed Full Service Partnerships (FSP) with intensive support and treatment to adults and youth with the highest level of behavioral health needs. • Led new housing developments and creation of supportive housing units for individuals living with a serious mental illness and substance use disorders. • Created non-law enforcement crisis response systems for adults and youth.
3 **IMPROVE TIMELY ACCESS FOR UNDERSERVED INDIVIDUALS**	• Expanded culturally tailored programs in response to community-defined needs and priorities.
4 **REDUCE STIGMA AND DISCRIMINATION**	• Implemented community outreach, education and culturally relevant trainings for peers, clients, community, staff, and contractors.
5 **REDUCE NEGATIVE OUTCOMES THAT MAY RESULT FROM UNTREATED MENTAL ILLNESS**	• Delivered FSP services with significant improvements in participant outcomes including detention or incarceration, arrests, mental and physical health emergencies, school suspensions (youth), and use of psychiatric emergency services. • Offered crisis services to youth with all clients being diverted from psychiatric emergency services.
6 **INCREASE NUMBER OF INDIVIDUALS RECEIVING PUBLIC MENTAL HEALTH SERVICES**	• Created referral pathways from prevention and early intervention programs and community partners to BHRS. • Increased community awareness about community services and how to access services.
7 **REDUCE DISPARITIES IN ACCESS TO CARE**	• Expanded culturally specific, place-based programming, outreach, and education.

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GLOSSARY OF TERMS

ACT Assertive Community Treatment

AOT Assisted Outpatient Treatment

BHC Behavioral Health Commission

BHRS Behavioral Health and Recovery Services

BHSA Behavioral Health Services Act

BIPOC Black, Indigenous, and People of Color

CBO Community Based Organization

CDEP Community-Defined Evidence Practices

CDSS California Department of Social Services

CFTN Capital Facilities and Technological Needs

CPP Community Program Planning

CSIP Cultural Stipend Internship Program

CSS Community Services and Supports

DHCS Department of Health Care Services

EBP Evidence-Based Practice

FSP Full Service Partnership

FY Fiscal Year

GSD General System Development

HEI Health Equity Initiative

INN Innovation

LEA Lived Experience Academy

LEEW Lived Experience Education Workgroup

LGBTQ+ Lesbian, Gay, Bisexual, Transgender, Queer, Questioning

MCOD Multicultural Organization Development

MHA Mental Health Association of San Mateo County

MHSA Mental Health Services Act

O&E Outreach and Engagement

OCFA Office of Consumer and Family Affairs

ODE Office of Diversity and Equity

PEI Prevention and Early Intervention

PES Psychiatric Emergency Services

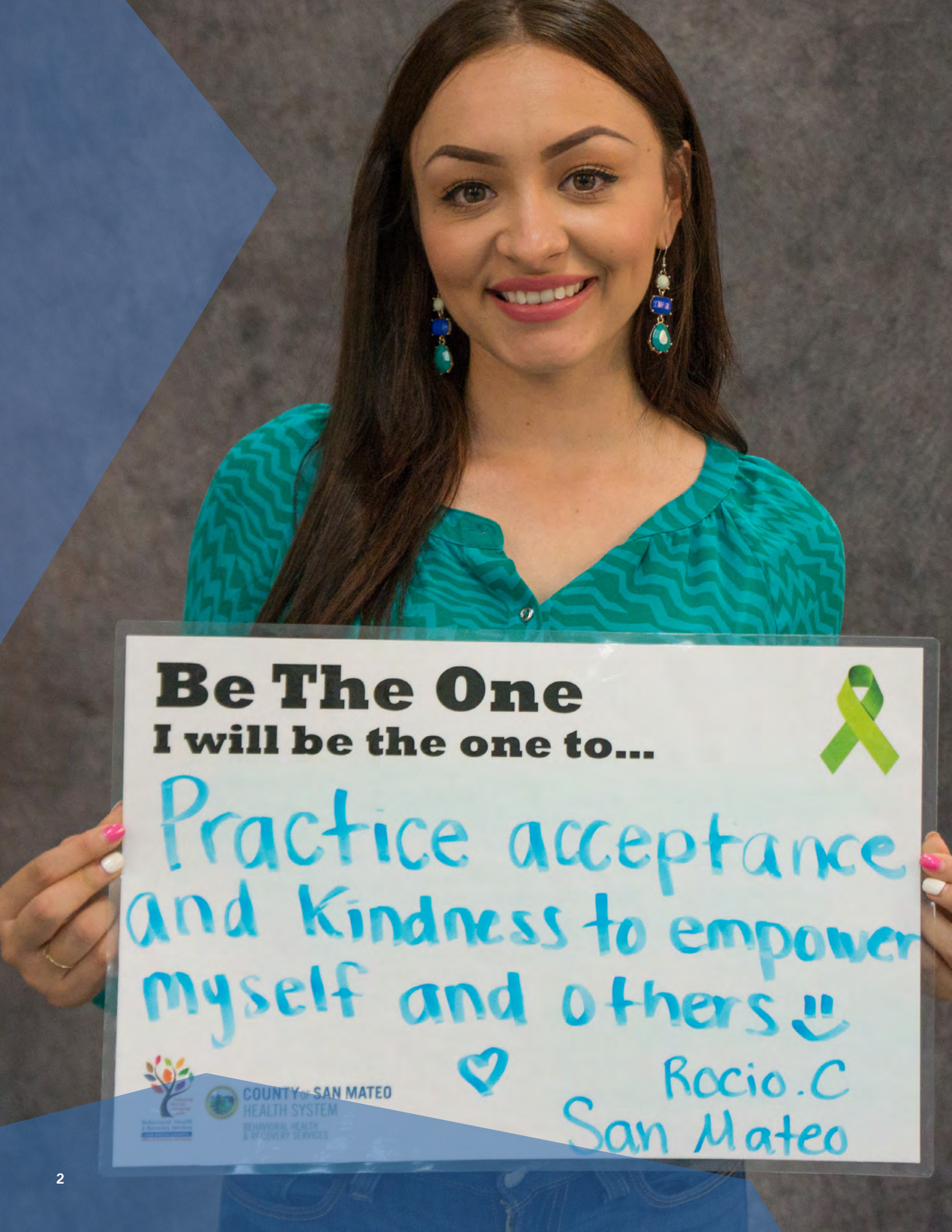
SED Serious Emotional Disturbance

SMI Serious Mental Illness

SOGIE Sexual Orientation, Gender Identity and Expression

TAY Transitional Age Youth

WET Workforce Education and Training


Be The One
I will be the one to...
Practice acceptance and kindness to empower myself and others
Rocio.C
San Mateo
COUNTY of SAN MATEO
HEALTH SYSTEM
BEHAVIORAL HEALTH & RECOVERY SERVICES

INTRODUCTION

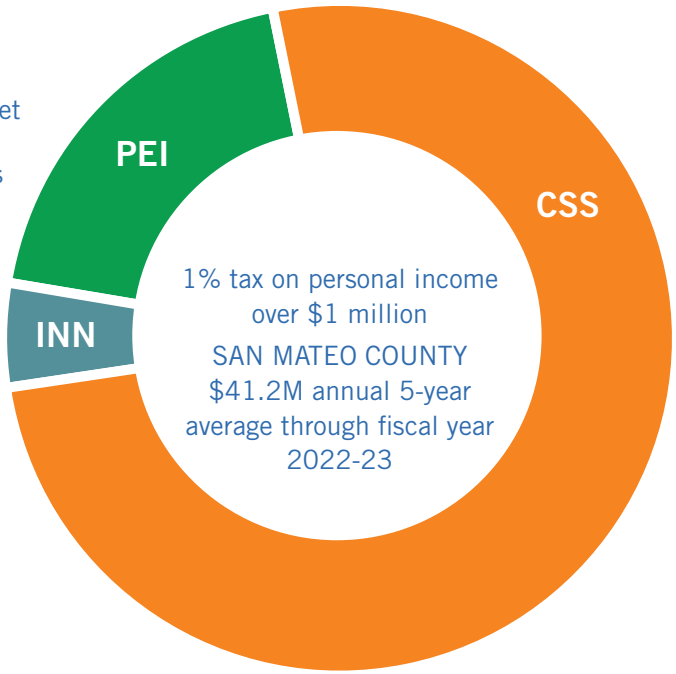
The Mental Health Services Act (MHSA), Proposition 63, was approved by California voters in November 2004 and provided dedicated funding for behavioral health services via a 1% tax on personal income over one million dollars. MHSA emphasized transformation of the behavioral health system, improving the quality of life for individuals living with mental health and substance use challenges and increasing access for communities impacted by structural inequities. Programmatic activities are grouped into "Components," each with their own set of guidelines and funding allocations. MHSA funding also mandated Community Program Planning (CPP) activities, including stakeholder engagement in planning, program implementation, and evaluation.

In March 2024, California voters narrowly passed Proposition 1, which will amend the MHSA to the newly named Behavioral Health Services Act (BHSA) and significantly shift funding allocations for counties.[1] On the brink of the MHSA's restructure, this report highlights the enduring impact of the MHSA on our local values and service delivery systems through particularly meaningful client and program outcomes that go beyond symptom reduction to system-level changes and client engagement in decisions that inform services and impact their quality of life. The report concludes by looking ahead as (BHRS) continues to transform our system and services to address the needs of the community.

MHSA Components

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



76%
COMMUNITY SERVICES AND SUPPORTS (CSS)
Direct treatment and recovery services for serious mental illness or serious emotional disturbance

Capital Facilities and Technology Needs (CFTN)
Buildings and technology used for the delivery of MHSA services to individuals and their families

Workforce Education and Training (WET)
Education, training, and workforce development to increase capacity and diversity of the mental health workforce

MHSA Core Values

MHSA legislation called for a set of standards that counties use as guiding principles for planning, implementation, and evaluation of programs and services.[2] These standards have served as Core Values in San Mateo County from the inception of MHSA and will be highlighted throughout the document with the respective icon from right.

COMMUNITY COLLABORATION

Clients, family members, community members, agencies, organizations, and businesses work together to share information and resources to fulfill a shared vision and goals.

CULTURAL COMPETENCE

Services reflect the values, customs, beliefs, and languages of the populations served and reduce disparities in service access.

FOCUS ON WELLNESS, RECOVERY, AND RESILIENCY

Services promote wellness in body, mind, and spirit, and incorporate concepts key to recovery: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

INTEGRATED SERVICE EXPERIENCE

Services promote coordinated agency efforts to create a seamless experience for clients, consumers, and families.

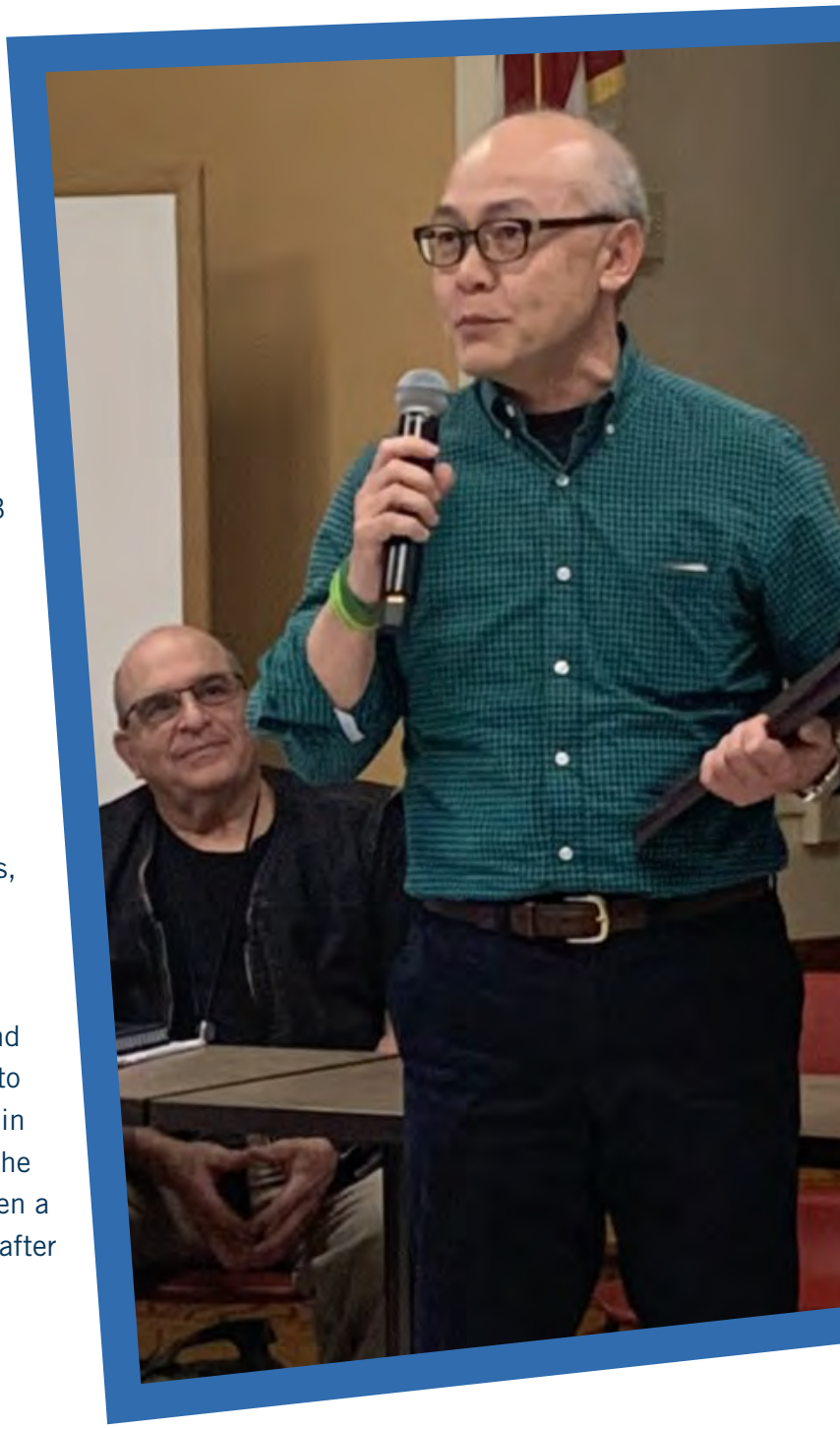
CLIENT AND FAMILY DRIVEN SERVICES

Clients and family members have a primary decision-making role in identifying needs, preferences, and strengths, and a shared decision-making role in determining services, including peer-to-peer services.

Statewide Impacts

In the first 10 years of MHSA implementation in California, large-scale evaluations across the state consistently found that the MHSA led to significant changes in values, service delivery systems, and client outcomes. The impacts of the MHSA on a statewide level are clear and aligned with how the MHSA has impacted San Mateo County for 20 years.

- Values: The MHSA prompted counties to shift from a clinical treatment model to a client-centered, recovery model. MHSA has supported widespread introduction of peer support services. The required stakeholder planning process has centered the voices of clients and family members in the decision-making process.[3]
- Service Delivery Systems: MHSA has been a catalyst for bringing recovery-oriented programs and services such as Full Service Partnerships (FSP), peer-run services, family partners, and culturally driven services to the forefront.[4] A 2013 cost analysis of FSP programs in each California county found significant cost savings.[5]
- Client Outcomes: Numerous studies at the state and county levels have demonstrated that the FSP program is highly effective in reducing the use of psychiatric emergency services.[6] FSP clients have experienced significant reductions in homelessness, incarcerations, and hospitalizations, and (for children) out-of-home placements.[7] Early intervention programs for psychosis and other serious mental illness have shown reductions in psychotic symptoms, increases in employment, and reduced psychiatric emergencies and admissions to psychiatric hospitals among adolescents.[8] Clients in prevention programs have either remained below the threshold for clinically significant symptoms or seen a reduction in negative behavioral health outcomes after receiving services.[9]



HISTORY OF MHSA IN SAN MATEO COUNTY

MHSA Timeline

2004

Landmark MHSA legislation passed by California voters.

2005

First funding allocation to counties to expand direct treatment services.

2005

Intensive community planning process for MHSA conducted with over 100 community input sessions gathering input from over 1,000 individuals including youth.

2007

PEI and Housing Program funding released; 121 supported housing units funded over the next 10 years.

2008

Peer supports expansions begin – peer support workers and family partners positions hired throughout the system, launch of the Lived Experience Academy and other peer support services facilitated by the OCFA.

2009

BHRS ODE and (HEIs) formally established with MHSA PEI funding, propelling efforts and partnerships across San Mateo County to improve diverse and equitable services.

2011

MHSA Administration and MHSA (WET) oversight under BHRS (ODE).

2014

First MHSA (INN) project, Total Wellness, approved.

2015

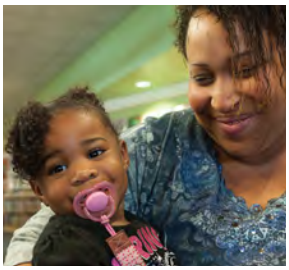
The BHC successfully advocated for the amendment of the Welfare & Institution Code to allow for a client or consumer who obtains employment, in a position in which they do not have any interest, influence, or authority over any financial or contractual matters, to serve and be appointed to a local commission.

2016

AB 1421 "Laura's Law" approved by San Mateo County Board of Supervisors.

2017

PEI Taskforce prioritizes trauma-informed capacity development for providers serving children ages 0-5 and non-law enforcement response to youth crisis.



2018

No Place Like Home legislation allocates MHSA funds to the development of permanent supportive housing.

2020

MHSA Housing Initiative Taskforce allocates $12.5M to fill gaps in housing continuum of care. $10M to the Department of Housing for supportive housing units increasing supportive housing units.

AB 2265 authorizes MHSA funds for substance use treatment.

2021

Proposition 1 passed by California voters to transform behavioral health systems including MHSA.

2022

FSP Workgroup and Multi-County FSP Innovation led to contract improvements across 9 areas of FSP services.

2024

The San Mateo County BHC amends its bylaws to add the MHSA Steering Committee as a standing committee.

* OCFA - Office of Consumer and Family Affairs; HEIs – Health Equity Initiatives; PEI – Prevention and Early Intervention; INN – Innovation; WET – Workforce Education and Training; BHC – Behavioral Health Commission

Before and After MHSA

MHSA has propelled system-level changes to behavioral health services in California counties. In San Mateo County, MHSA's emphasis on consumer and family driven services and the required Community Program Planning (CPP) process have transformed what engagement and leadership looks like by bringing the county's diverse communities and people with lived experience to the table as participants in decision-making spaces including the Behavioral Health Commission (BHC), Health Equity Initiatives (HEIs), the MHSA Steering Committee, and MHSA Workgroups. At the same time, MHSA has brought an influx of funding that is more flexible than other traditional behavioral health funding sources, making it possible to expand innovative, community-driven solutions. Below is a summary of significant behavioral health system transformations that MHSA has engendered in San Mateo County—and how these transformations have taken hold—emphasizing the MHSA core principles in action.

Peer-Driven Services

Before MHSA: The behavioral health system provided minimal support for peers to meaningfully participate in the behavioral health system.

After MHSA: There is regular training and support for peers to enter the workforce and become involved through paid employment as a peer or family partner, achieve peer certification, become an ambassador of health for their community, and get involved in BHRS committees and local advocacy opportunities.

Wellness & Recovery-Oriented Services

Before MHSA: Behavioral health treatment was largely limited to the medical model of treatment.

After MHSA: There are a variety of community-based client supports aligned with a recovery and resilience model of care including peer support, drop-in centers, supported employment, support groups, and access to alternative care interventions such as equine therapy, yoga, and art-based healing.

Community Collaboration

Before MHSA: There was limited community involvement in BHRS planning and program/service improvements.

After MHSA: The CPP process has informed not only MHSA, but our entire BHRS system by engaging providers, staff, clients, family members, peers and marginalized ethnic and cultural communities including Black, Indigenous, and People of Color (BIPOC) and LGBTQ+ communities.

Evidence-Based Practices

Before MHSA: Treatment programs did not have enough capacity to meet the need for intensive, evidence-based, and high-quality services.

After MHSA: The Full Service Partnership (FSP) "whatever it takes" evidence-based model was implemented and over time BHRS expanded FSP slots, added FSP Youth Drop-in Centers, added peer supports for the Transition Age Youth FSP, and increased slots for FSP Housing.

Housing Continuum

Before MHSA: There were gaps in the housing continuum and limited funding for housing strategies to support people living with mental health challenges to maintain stable housing.

After MHSA: The 2008-2016 MHSA Housing Program, the 2016 No Place Like Home initiative, and 2021 Housing Initiative Taskforce local prioritization of housing allowed BHRS to fund various strategies including the development of supported housing units, FSP integrated housing services, homeless outreach strategies, housing navigation and maintenance supports, transitional housing, augmented board and care, and others.

Cultural Responsiveness

Before MHSA: There was a lack of culturally informed approaches, exacerbating inequities in access to mental health and substance use services.

After MHSA: The BHRS Office of Diversity and Equity was established to lead efforts prioritizing cultural humility, inclusion, and equitable quality care. BHRS ODE supports staff training, language access demographic data collection and co-development of culturally tailored programs in response to community-defined needs and priorities.

Crisis Continuum

Before MHSA: There were no integrated systems for youth crisis intervention, gaps in the crisis continuum of care, and limited funding to support expansions.

After MHSA: MHSA funded staffing to support crisis coordination and management across BHRS. MHSA has enabled the expansion of crisis hotline supports, suicide prevention efforts, partnerships and protocols with schools, and the creation of a non-law enforcement mobile crisis response system for youth and adults.

Integrated Care

Before MHSA: Integration of substance use and mental health was lacking across the system and within programs.

After MHSA: Prior to the Drug Medi-Cal Organized Delivery System (DMC-ODS) implementation, MHSA funded staffing to support co-occurring integration efforts and contracted substance use providers to implement co-occurring strategies, including integrating mental health clinicians, training, and other supports into their services. Programs funded by MHSA were refined to incorporate substance use supports and collect data that demonstrates integration.

MHSA Investment and Reach

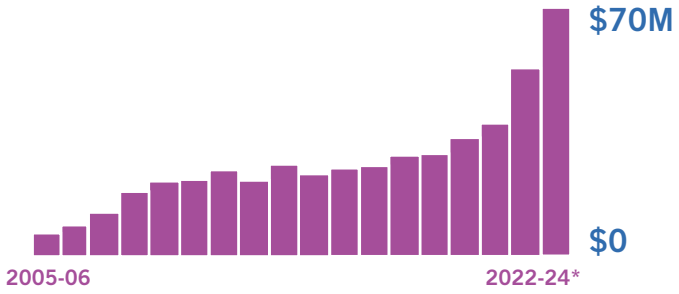
While MHSA funding makes up a fraction of the overall BHRS budget (16-20%), MHSA has enabled San Mateo County to invest over $476 million since MHSA inception—that's nearly half a billion dollars in behavioral health programs and system improvements.

MHSA funding has been integral to the expansion of treatment, early intervention, and prevention programs and services in San Mateo County, with annual funding amounts—including allocations to priority programs including housing, substance use, outpatient mental health treatment, and peer programs—growing over time (Figures 1-2).

Annually, looking specifically at direct mental health and substance use treatment, MHSA has led to an average of over $25 million per year, in the past five years. This funding has been critical for improving access and penetration rates,[10] especially for youth, substance use services, and racial/ethnic groups where we see lower engagement in behavioral health services for Latinx and Native Hawaiian and Pacific Islander communities. In FY 2022-23, over one-third (36%) of clients across BHRS were served in MHSA-funded programs.

MHSA-funded programs served an average of 4,275 clients in direct treatment programs and 6,555 clients in prevention and early intervention programs each year, looking at the past five years.[11] In addition, on average MHSA-funding programs have reached more than 28,300 community members annually through prevention-focused trainings/workshops, outreach and engagement, and social media.

FIGURE 1
Total annual MHSA expenditures have increased over time



*Estimated expenditures

FIGURE 2
Allocations for priority MHSA programs have increased over the past four years

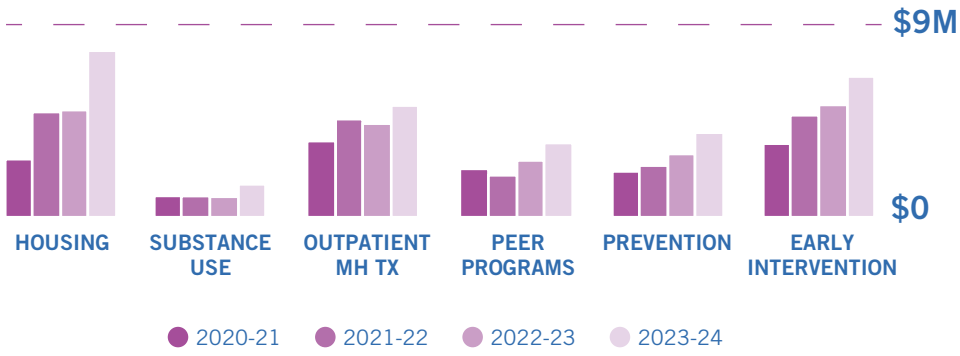
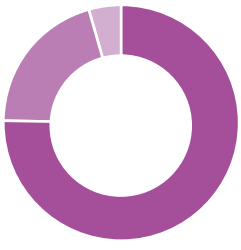


FIGURE 3
Since MHSA inception millions of dollars have been invested in the full spectrum of services



- 71% TREATMENT
- 19% PREVENTION
- 4% INNOVATION

COMPONENT	TOTAL EXPENDITURES
CSS Total	$340,145,631
CSS FSP	$156,575,478
CSS GDS/O&E*	$117,188,378
PEI	$90,135,989
INN	$16,660,617
WET	$7,661,772
CFTN	$21,670,273
Total	**$476,274,282**

*General Systems Development/Outreach and Engagement

Number of Programs Funded by MHSA

32
direct treatment programs as of FY 2022-23

24
prevention and early intervention programs as of FY 2022-23

10
Innovative programs

13
supported housing developments providing 130 housing units as of FY 2022-23

9
organizational capacity development initiatives

Annually, on average over the past five years, MHSA-funded programs served:*

4,275
client in direct treatment programs

1,029
children/youth and transition age youth (TAY)

1,679
adults and older adults

1,929
multiple age groups

6,555
client in direct prevention and early intervention programs

1,035
children/youth and TAY

761
adults and older adults

6,364
multiple age groups

28,000+
community members through prevention-focused trainings/ workshops, outreach and engagement, and social media

1,460+
participants in workforce development trainings for staff and contracted providers

(*numbers may be duplicated across programs)

MHSA Impact on Health Equity

The map on the following page illustrates MHSA investments in prevention and early intervention services in relation to the county's Health Equity Index. These investments represent a commitment to upstream strategies that promote health equity in communities of color most impacted by structural inequities and health disparities.

While many programs serve individuals countywide, BHRS has made focused investments in geographic communities including the Coastside, which, with a high proportion of low-income, Latinx families and migrant farmworkers, has the highest income inequality in the county; North County, which has lower median household income than much of the county, higher proportions of families and children below the poverty line, and a large Asian and Pacific Islander population; and East Palo Alto, which has the lowest median household income and highest percent of children living below the poverty line in the county, higher Latinx and Black populations, and the highest proportion of residents who reported having poor mental health for 14 or more days in the past month.[12]

ANNUAL PEI INVESTMENTS*

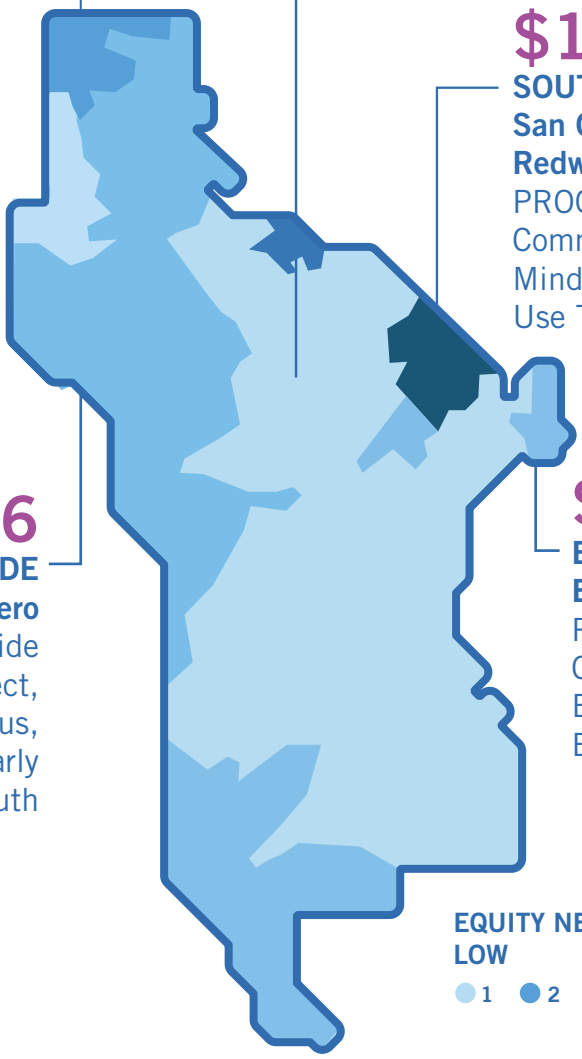
$1,118,515
NORTH
Daly City, Pacifica, Colma, Brisbane, South San Francisco, San Bruno
PROGRAMS: Early Childhood Community Team, Mindfulness-Based Substance Use Treatment, North County Outreach Collaborative, Kapwa Kultural Center and Cafe, PIONEERS for Native Hawaiian and Pacific Islander Youth

$500,000
CENTRAL
San Mateo
PROGRAMS:allcove Youth Drop-In Center

$165,874
SOUTH
San Carlos, Redwood City/North Fair Oaks
PROGRAMS: Early Childhood Community Team, Mindfulness-Based Substance Use Treatment

$1,201,026
COASTSIDE
Half Moon Bay, Pescadero
PROGRAMS: Coastside Collaborative, Cariño Project, Farmworker Equity Express Bus, Trauma-Informed Early Interventions for Youth

$400,565
EAST PALO ALTO/BELLE HAVEN
East Menlo Park, East Palo Alto
PROGRAMS: Early Childhood Community Team, East Palo Alto Partnership for Behavioral Health Outreach



$8,837,825
COUNTYWIDE
Programs: Crisis Response, Mental Health First Aid, Mental Health Awareness, Health Ambassador Program, Health Equity Initiatives, Substance Use Prevention, Suicide Prevention, Storytelling, Primary Care Interface, Early Psychosis, Pride Center, Older Adult Peer Counseling

$12,223,805
TOTAL ANNUAL INVESTMENTS

*data from FY 2023-24

IN FY 2022-23

76%
fund allocation

32
MHSA-funded direct treatment programs

4,987
unique clients served

COMMUNITY SERVICES AND SUPPORTS (CSS)

Community Services and Supports (CSS) is the largest MHSA component and funds strategies that BHRS uses to serve and reach the most vulnerable individuals in the community living with serious mental illness substance use disorders (SUD) (SMI), or serious emotional disturbance (SED).[13] Services funded are identified with stakeholder input through a Community Program Planning (CPP) process. CSS strategies include system integration and improvement and direct services to clients in the form of evidence-based practices (EBPs) including one-on-one clinical services, groups, family support, and other specialized outpatient treatment programs.[14] In FY22-23, BHRS had 32 MHSA-funded direct treatment programs that served nearly 5,000 unique clients.[15]

The following are types of CSS services that can be funded with MHSA revenues and a few highlights of programs that have been implemented in San Mateo County since MHSA inception. A link to the description of all current MHSA-funded programs can be found in the endnotes.

Full Service Partnerships (FSP)

At least 51% of the CSS allocation is required to fund FSPs. In San Mateo County, Edgewood and Fred Finch FSP programs have been operational since 2006 and serve children, youth, and transition age youth (C/Y/TAY) using the Wraparound model,[16] Telecare FSP has also been operational since 2006 and Caminar FSP was added in 2009 to offer comprehensive services, based on the Assertive Community Treatment (ACT) model,[17] to adults, older adults, and their families.

The FSP program model uses a "whatever it takes" approach to engage adults living with SMI or children living with SED in a partnership to achieve their individual wellness and recovery goals through 24/7 intensive case management, psychiatric care, evidence-based clinical practices, and linkages to primary care, health care coverage, social services, housing, financial benefits, employment, education, recreation, and other community-based services.

General System Development (GSD)

GSD allows for funding to improve the behavioral health service delivery system as a whole. In San Mateo County, GSD supports integration across needs and with service sectors that impact clients' lives including substance use, intellectual disabilities, older adults and chronic illnesses, criminal justice and child welfare involvement. In San Mateo County, GSD funds the integration of evidence-based practices, peer and family partners throughout the behavioral health system of care, and community peer-run and peer-focused wellness centers such as Voices of Recovery San Mateo County, The Barbara A. Mouton Multicultural Wellness Center in East Palo Alto, and the California Clubhouse.

The majority of programs funded are outpatient treatment programs meeting individuals where they are and with specialized supports such as the Pre-to-Three Initiative, School-Based Mental Health, Older Adult System of Integrated Services (OASIS), Pathways Program for justice-involved clients, and the Puente Clinic for clients living with an intellectual disability dual diagnosis.

Outreach & Engagement (O&E)

O&E services are intended to reach, identify, and engage unserved individuals living with serious mental illness, in behavioral health treatment. San Mateo County strategies include pre-crisis supports for BHRS clients through the Family Assertive Services Team (FAST) operated by Mateo Lodge, which provides in-home outreach assessment, consultation, and support services to adults (age 18+); and primary care-based linkages.

PROGRAM HIGHLIGHT

Adult and Older Adult Full Service Partnership (FSP)

One of the biggest changes in the service delivery system due to MHSA was the implementation of the FSP program. FSPs are based on the Assertive Community Treatment (ACT) model, which features assertive outreach approaches, holistic services, multidisciplinary teams, integrated services, low client-to-staff ratios, and continuous care. The ACT model was piloted by counties through a state demonstration grant and incorporated as an evidence-based practice in the MHSA legislation.[18]

As part of the FSP program, San Mateo County's Assisted Outpatient Treatment (AOT) FSP serves adults living with a serious mental illness or substance use disorder who have not had a successful and lasting connection to treatment and recovery services and have declined voluntary participation in treatment. AOT was mandated in San Mateo County in 2016, after the County of San Mateo Board of Supervisors voted to implement California's Assembly Bill 1421 (the Assisted Outpatient Treatment Demonstration Project Act of 2002–commonly known as Laura's Law). As the AOT mandate did not come with funding attached, MHSA offered a solution to implement AOT by funding an internal BHRS AOT team that receives referrals, assesses eligibility and needs, completes court orders (if warranted), and links AOT clients to ongoing behavioral health services through the MHSA-funded FSP program.

Since FSP inception, over 665 adults and older adult FSP clients have been served by contracted providers Caminar and Telecare, including 143 served by Caminar in the AOT FSP from 2016 to 2022. From FSP program inception, adult Caminar FSP clients (including AOT and other FSP clients) have shown significant improvements in most self-reported outcomes, including detention or incarceration, arrests, and mental and physical health emergencies, and the program has seen significant decreases in the average number of hospitalizations, days spent in the hospital, and use of psychiatric emergency services among adult clients.[19]

James' Story*

TELECARE FULL SERVICE PARTNERSHIP

Before coming into Telecare, I felt like I didn't have an identity. In those moments, I didn't care about my life, I didn't care about the choices I was making and how they were hurting my family. I was in a dark place.... [Telecare] pushed me to see that I was better than whatever was going on in my life and conflict internally. They worked with me on goals and more and more doors opened.... Telecare, and more importantly my family's support in my journey, has also helped me muster that last seed of hope I was holding onto, this hope that I wasn't able to see before in my life but now I am able to see that I am more loving, caring, and I carry a 'can do it' attitude. The biggest part of my journey has been figuring out who I am and would like to be, and I know now I am more than my diagnosis.

* pseudonym used to protect client's identity

SYSTEM TRANSFORMATION HIGHLIGHT

Integrating People with Lived Experience in the Behavioral Health System

BHRS has promoted consumer and family driven services through training to support meaningful involvement in behavioral health education and advocacy, hiring peers and family members, and creating leadership opportunities for peers and family members. Not just to the MHSA planning but to BHRS in general or to improve our system. To formalize the role of individuals with lived experience in the behavioral health system, the BHRS Office of Consumer and Family Affairs (OCFA) supports peers to apply for state certification as a peer support specialist and BHRS approved a new classification and compensation structure for the Peer Support Specialist I/II. Peers and family members know firsthand the challenges of living with, recovering from, and/or supporting family members with a behavioral health diagnosis, and work collaboratively with BHRS clients and family members based on that shared experience.

For peers and family members interested in becoming more involved in the behavioral health system, (OCFA)—which is led and staffed by individuals with lived experience as peers and family members—offers the Lived Experience Academy (LEA), a workshop series that gathers clients and family members in a supportive place focused on the value of their experience and the power of their role as advocates in the behavioral health system. Graduates of the LEA are eligible to go on to be a part of the Speakers' Bureau to present their stories with behavioral health staff and community members at trainings and community events, and the Lived Experience Education Workgroup (LEEW), a workgroup that promotes workforce opportunities for clients and family members, shares information on statewide conferences and initiatives, and supports people serving in BHRS peer programs.

In response to feedback from LEA participants, OCFA created the Advocacy Academy and peer training

to strengthen participants' skills in local and state advocacy and launched a Lived Experience Leadership Academy to provide mentorship and ongoing support in leadership development for peers. The LEA and Advocacy Academy have offered a space for consumers and family members to find camaraderie and support, launch into leadership roles in BHRS, and influence MHSA funding decisions.

BHRS expanded the number of peer and family partners to 13 peer support workers/peer support specialists and 6 family partners/family peer support specialists in 2023. Peers and family members also serve as co-chairs and members of (HEIs), the MHSA Steering Committee, and MHSA Workgroups that seek community input and prioritize programs as part of the CPP process. Peers and family members who are not paid staff receive stipends for their participation in BHRS activities.

In the prevention arena, the MHSA-funded Health Ambassador Program (HAP) and Health Ambassador Program for Youth (HAP-Y) train community members with lived experience as a member of vulnerable high-risk communities in San Mateo County to increase awareness, reduce stigma, and assist in identifying behavioral health needs in their communities. Health Ambassadors have gone on to pursue behavioral health careers and hired positions within BHRS and other community-based organizations.

"We got to a place where [decision-makers] are more open to advocacy from peers…I have heard County leaders say, 'I welcome being pushed, we need to be pushed….' [It has] opened the minds of leadership to get this type of feedback."

Doris Estremera, MHSA Manager

"Without LEA, many of us would not be where we are today. We wouldn't feel like we have the support of the public or BHRS or the Health System of San Mateo County at all."

LEA participant

Renee's Story

I started my recovery on December 26, 2000. It was the day after Christmas, when I was arrested by the East Palo Alto Police Department because I had a warrant out for my arrest that I was not aware of. While in custody, I was asked what was going on in my life that I ended up in jail. I did not know that I was suffering from depression and anxiety from 1996 to 2000 and I was untreated. I had multiple suicide attempts during this time. Finally, I was able to talk to someone and I was offered help through the San Mateo County Drug Court, and that is when my journey of recovery began. Through Drug Court, I was connected to mental health and substance use services at Women's Recovery Association (WRA) and BHRS. During the process of my recovery, I became pregnant with my daughter, and I was connected to a program called Prenatal to Three. (Pre-to-Three) Initiative. Without that program and the wonderful staff that gave me the strength and support, my daughter and I would not have been a successful story. BHRS, County Drug Court, WRA, and Pre to 3 all came together and helped me, a young woman who was suffering from PTSD (post-traumatic stress disorder), depression, and anxiety.

Once I began to feel better, I got involved in the Supported Education Program through Caminar [a program funded by MHSA] to learn about depression, anxiety, and schizophrenia. The instructor told me about a job at Caminar where I could support clients through their recovery. She guided me through the courses and certifications, and I started working as a Job Coach at Caminar. While working at Caminar, I got involved in the early MHSA focus groups and other activities with the County. I was also a client of BHRS at the time, and I soon heard about a peer position. The Director of the Office of Consumer and Family Affairs (OCFA) at the time mentored me to help me prepare for interviews and navigate the County hiring process. I ended up scoring 100% on the county civil service process for the Peer Support Specialist position and I was hired at the East Palo Alto clinic in 2006. I have been there ever since.

What I love most about my work is to be able to reconnect with the community. I was on drugs out there, I know that community, I know the struggles that they go through. I support clients with whatever it takes to keep them in their recovery journey, with what they really need, such as helping them apply to SSI (supplemental security income) so that they don't fall through the cracks. I fell through the cracks—I went four years without any treatment. My passion is to make sure that no one has to suffer longer than they need to. That's where my passion comes from—because I've been there before.


SAN MATEO COUNTY HE
BEHAVIORA
RECOVER
DISASTER SERVICE WORKER

PROGRAM HIGHLIGHT

Child, Youth and Transition Age Youth Full Service Partnership (FSP)

BHRS's youth-focused FSP Wraparound programs provide comprehensive services to the county's highest risk children/youth, TAY, and their families. Often considered to be the last treatment option prior to a residential placement, the youth-focused FSP works to stabilize children, youth, and TAY in their home environment and prevent, or transition back from, a higher level of care (e.g., psychiatric hospital, residential facility, juvenile hall, etc.). FSP Wraparound services, delivered by Edgewood Center for Children and Families and Fred Finch for out-of-county foster care youth, provide a multidisciplinary, trauma-informed, multicultural, and family-centered network of services including 24/7 crisis support, case management, individual and family therapy, psychiatric assessments and medication support, peer support for youth and parents, therapeutic after-school programming, housing support, and independent living skills development. Through MHSA funding, BHRS has been able to align the youth-focused FSP with the evidence-based Wraparound model, expanding the County's capacity to apply requirements from the Department of Health Care Services (DHCS) and California Department of Social Services (CDSS) to provide Wraparound services for child welfare-involved youth.

From FSP program inception in 2006, the youth-focused FSP has served nearly 1,200 children/youth and TAY. Children in the FSP program have experienced significant improvements in most self-reported outcomes, including arrests, mental and physical health emergencies, and school suspensions for children/youth and TAY. The program has seen significant decreases in the average number of hospitalizations for children/youth and the use of psychiatric emergency services among children and TAY.

> **"[The FSP] helped [my child] stabilize and grow up emotionally so that he wouldn't get exasperated over everything…And I think they also helped him quite a bit with his confidence to socialize with his peers […]"**
>
> **Family member**

> **"One of the team members [at Edgewood] was a Family Partner—she was the most important person on the team…my Family Partner taught me how important it was to develop a network of support for your family member and yourself with this journey."**
>
> **Family member**

FSP OUTCOMES, 2006-2023

1,197 CHILDREN & YOUTH + **665** ADULTS & OLDER ADULTS = **1,862** TOTAL SERVED SINCE INCEPTION

Overall, FSP clients have experienced significant improvements in many self-reported outcomes and significant decreases in hospitalizations and use of psychiatric emergency services. This table displays the percent change in each outcome after participating in an FSP compared to before FSP participation. For example, out of 116 adult clients, 48 experienced homelessness before enrollment in FSP. This number changed to 35 in the first year following FSP, which is a 27% improvement.

Self-Reported Outcomes+	CHILDREN 0-15 (N=232)	TRANSITION AGE YOUTH 16-25 (N=287)	ADULTS* 26-59 (N=116)	OLDER ADULTS 60+ (N=24)
Homelessness	▼ 11%	▼ 3%	▼ 27%	▼ 40%
Detention or Incarceration	0%	▼ 20%	▼ 37%	▼ 25%
Arrests	▼ 67%	▼ 69%	▼ 80%	▼ 75%
School Suspensions	▼ 55%	▼ 77%	—	—

Heath Care Utilization	CHILDREN 0-15 (N=213)	TRANSITION AGE YOUTH 16-25 (N=225)	ADULTS* 26-59 (N=388)	OLDER ADULTS 60+ (N=80)
Hospitalization	▼ 70%	▼ 41%	▼ 54%	▼ 45%
Psychiatric Emergency Services (PES) Use	▼ 55%	▼ 41%	▼ 28%	▼ 36%

+ Percent change is the change in the number of partners with the outcome of interest in the year after joining an FSP as compared with the year just prior to FSP.

● Indicates a statistically significant change

* Only includes data from Caminar, not Telecare FSP due to data reporting changes.

SYSTEM TRANSFORMATION HIGHLIGHT

Expanding Housing for Individuals Living with Serious Mental Health and Substance Use Challenges

As part of the MHSA Community Program Planning (CPP) process, stakeholders prioritized addressing the housing needs of individuals living with serious mental health and substance use challenges. In 2021, BHRS gathered an MHSA Housing Initiative Taskforce to explore what a comprehensive San Mateo County housing continuum would look like, to research and identify the gaps in the continuum, and develop funding recommendations for housing and supportive services to help individuals obtain and maintain stable housing. Accomplishments since the recommendation include:

- Collaboration with County of San Mateo, Department of Housing for the funding and development of additional Supportive Housing Units for clients, with 25 MHSA units completed in East Palo Alto, North Fair Oaks and South San Francisco, and 25 MHSA units completed in Redwood City and Daly City, contributing to the 130 units of supportive housing overall that have been funded through MHSA.
- Hiring two clinicians for Homeless Engagement Assessment and Linkage (HEAL) homeless outreach team.
- Creating a flexible fund to support BHRS clients with housing-related expenses (e.g., moving costs, deposits, first-month rent).
- Increasing housing funds for adults and older adults enrolled in FSP programs to support obtaining and maintaining stable housing.
- Providing incentives and supports (e.g., training, on-site support groups) for licensed Board and Care facilities to encourage them to sustain their services and improve the quality of services.
- Increasing funding for additional FSP enrollment for children/youth and TAY to support high-risk youth to remain stable in their home environment.

> **“MHSA has attracted developers to want to apply for [housing] funds, use those funds, and serve the population. It has allowed us to do better development.”**
>
> **Melissa Platte, Executive Director, Mental Health Association of San Mateo County**

MHSA funding for housing development has enabled organizations such as the Mental Health Association (MHA) of San Mateo County, which develops housing and provides supportive services for individuals living with serious mental illness and/or substance use disorders, to use extra funds that might otherwise go toward developer fees to help develop, furnish, and make housing units welcoming for clients. MHSA has encouraged developers to apply for housing development to serve this population, thereby promoting more housing development at higher quality.

RESIDENTIAL BOARD & CARE
Unlocked. Eligibility requirements. 24/7 Staffing. Skill building and long-term stability. Ideal for support with basic needs.

TRANSITIONAL
Independent units. Staffing on-site. Intensive support services on-site. Ideal for stable individuals needing support

RESIDENTIAL TREATMENT
Unlocked. 24/7 staffing. Stabilization and skills building. Ideal for individuals out of higher level of care.

SUPPORTIVE HOUSING
Independent integrated housing. Support service staffing on-site. Ideal for individuals who are able to manage their needs with some support.

REHABILITATION CENTERS
Locked. 24/7 Staffing. Most restrictive. Ideal for highly symptomatic individuals

INDEPENDENT LIVING
Independent housing. Some support. Ideal for individuals who need minimal to no support.

IN FY 2022-23

19%
fund allocation

24
prevention and early intervention programs

5,523
unique clients served

PREVENTION AND EARLY INTERVENTION

In a context where most state and federal behavioral health funding is allocated to treatment, MHSA has supported investments in upstream prevention and early intervention strategies to design and implement community-defined, culturally informed 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, and increase protective factors (e.g., access to information and resources, stable employment or income, adequate food and housing, education, health care, connectedness an belonging).[20] Protective factors help reduce the significant personal, family, and social costs of mental health and substance use challenges.[21]

Prevention and Early Intervention (PEI) programs 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 has focused its PEI since inception dollars on evidence-based and community-defined interventions in family, school, and community-based settings. In FY22-23, BHRS had 24 prevention and early intervention programs, which served over 5,500 unique clients.[22]

The following are types of PEI services that can be funded with MHSA revenues and few several highlights of programs that have been in implemented in San Mateo County since MHSA inception.[23]

Ages 0-25

At least 51% of the PEI allocation is required to fund services and strategies for children and youth ages 0-25. In San Mateo County programs and strategies include trauma-informed systems capacity development for children and youth providers, community and school-based interventions such as the Early Childhood Community Team (ECCT), Brief Intervention, Mindfulness-Based Substance Abuse Treatment and other evidence-based curriculum focused interventions.

Early Intervention

Early Intervention programs provide treatment and other services, including relapse prevention, to address and promote recovery 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 with psychotic features, in which case early intervention services shall not exceed 4 years. In San Mateo County, early intervention programs focus on crisis response including a 24 hours a day, 7 days a week crisis hotline, and clinician-led, non-law enforcement mobile response for all ages, on primary care-based short-term interventions, and on early psychosis recognition and supports.

Prevention

Prevention includes strategies related to increasing access and linkages to treatment, reducing stigma, recognizing the signs of mental illness, increasing mental health awareness and preventing suicide. Prevention programs reduce risk factors for developing serious mental illness and build protective factors for individuals whose risk of developing a serious mental illness is greater than average. Programs funded with MHSA PEI revenue include substance use prevention, the BHRS (ODE), HEIs, the (HAP) and (HAP-Y), The Parent Project®, Storytelling Program, Outreach Collaboratives in the northern region of San Mateo County, Coastside and East Palo Alto, and cultural-based wellness centers such as the Pride Center and the Cariño Project.

PROGRAM HIGHLIGHT

Stigma Reduction and Suicide Prevention Program

BHRS Stigma Reduction and Suicide Prevention programs aim to influence policies and systems, promote community awareness about behavioral health, and build community capacity to identify the signs and symptoms of behavioral health crisis and how to respond.

Since 2009, ODE stigma reduction and suicide prevention efforts have included community presentations and trainings, educational campaigns, awareness events, observances of May Mental Health Month and September Suicide Prevention Month, and culturally informed strategies such as filmed vignettes and digital and photovoice storytelling with consumers, family members, county staff, and community partners. In addition, suicide prevention trainings such as Applied Suicide Intervention Skills Training (ASIST), Youth, Adult and Teen Mental Health First Aid, and Be Sensitive Be Brave have also supported in-depth knowledge and skill-building, including how to support someone who is considering suicide or is at risk of suicide.

Suicide prevention is part of a robust crisis continuum of care. MHSA has allowed us to fund staffing to support crisis coordination and expand crisis hotline supports and suicide prevention efforts, including a partnership with the San Mateo County Office of Education to develop a Schools Suicide Prevention Protocol with guidelines for school site interventions for suicidal and self-injurious behaviors by students. This effort highlighted the need for mobile youth crisis response supports. In response, BHRS implemented Youth S.O.S., a clinician-led and peer-supported, non-law enforcement response to youth in crisis; the model has expanded to adults.

> **“Suicide Prevention Month allowed peers and San Mateo County staff to work alongside each other to be of service and meet the needs of our San Mateo County communities at large.... Partnerships with San Mateo County libraries...gave us all an open door to communicating the facts about suicide and the truths on how the action of choosing to end one’s life can be preventable.”**
>
> **Client/Peer and Suicide Prevention Committee Member**

BHRS suicide prevention efforts are led by a Suicide Prevention Committee and guided by a San Mateo County Suicide Prevention Roadmap, which includes a larger vision for reducing suicide deaths and suicide attempts. The Suicide Prevention Committee is made up of community partners, suicide survivors, and community members, which prioritizes efforts to educate the community about suicide and impact policies and systemic change related to suicide prevention.

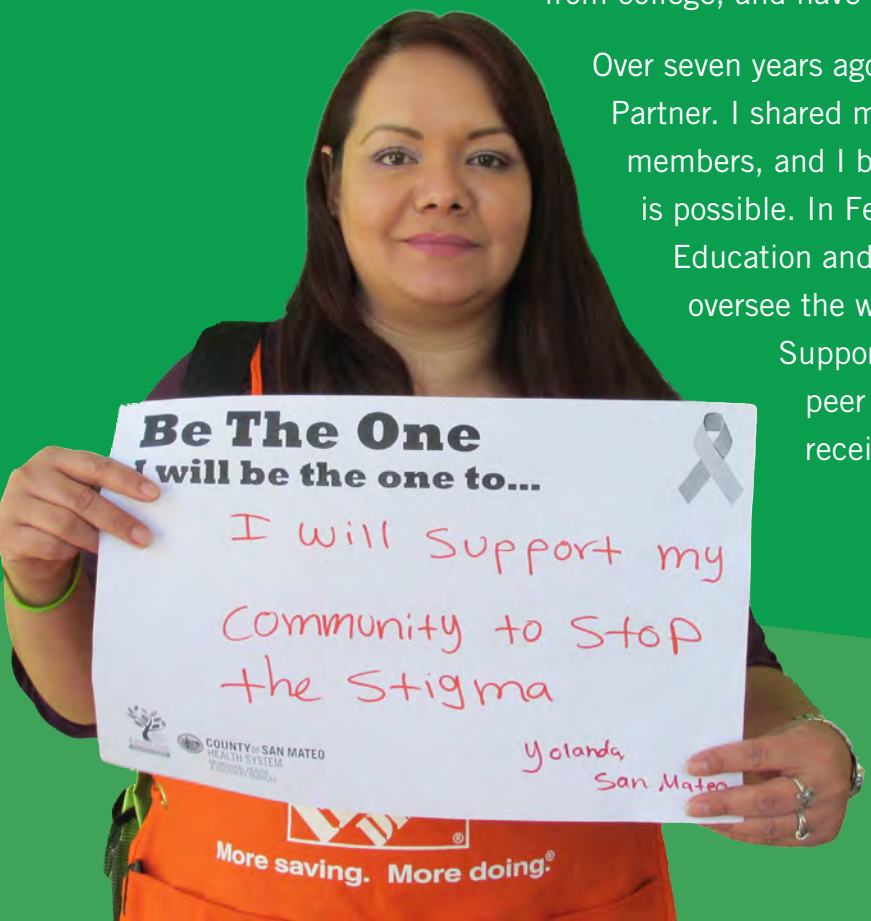
Significant achievements of our Stigma Reduction and Suicide Prevention programs include:

- In 2015, BHRS launched the #BeTheOneSMC anti-stigma campaign, which promoted awareness, access to services, and recovery by bringing conversations about mental health into community spaces and encouraging community members to talk about mental health with their families and communities. Individuals submitted personal photos, postcards, and online pledges on how they will address stigma in their families and communities. The campaign received thousands of pledges and was promoted via photo booths at community events, through social media posts on Facebook and Twitter, and the BHRS Blog.
- Each year during May Mental Health Month and September Suicide Prevention and Recovery Month, thousands of community members are reached annually through advocacy days, events (e.g., open mic, book club), and awareness campaigns. In 2022 the County of San Mateo and 19 out of 20 San Mateo County cities proclaimed September Suicide Prevention Month, and County buildings were lit purple and teal for the first time for Suicide Prevention Month.
- In 2020, the Suicide Prevention Committee worked closely with Caltrain to develop person-centered Caltrain Strike Incident Messaging, which included communications to passengers and the press when someone is struck on the Caltrain tracks. The messaging was presented to and endorsed by the Behavioral Health Commission (BHC).
- In 2023, the Be Sensitive, Be Brave training was adapted to serve the Tongan-speaking and Filipino/a/x Tagalog-speaking communities using culturally tailored approaches to outreach, including locating the trainings at trusted places of community gathering, and collaborating in co-ownership with trusted community leaders and elders. One participant commented, “I am so grateful to have this training opportunity on suicide for Tongans and Pacific Islanders. I feel free and comfortable discussing this sensitive issue amongst my people.”

Yolanda's Story

Over 10 years ago, my life had a significant change after I almost lost my children to suicide. At that time, I was attending a parenting class offered as part of the ODE program. Using my communication skills and the knowledge about suicide prevention I had just learned, I could help my children by seeking help for them to receive therapy and psychiatric treatment. Afterward, I was so scared of losing my children, and I felt alone in sharing our challenges with my family or friends because of the stigma about mental health issues in my Latinx community.

These challenges encouraged me to seek more opportunities to educate myself to better care for my children, maintain my wellness, be a positive role model for them, and advocate for reducing the stigma in my community. In 2014, I became a Health Ambassador for San Mateo County [a program funded by MHSA]. The Health Ambassador Program classes, workshops, and support groups opened a new world for me. As a parent, it wasn't easy to keep a roof over our heads and, at the same time, try to have more education to be a better person and a better mom. All my efforts were well worthwhile, as my children are in recovery from mental health issues, they have become successful adults, graduated from college, and have careers helping their community.



Over seven years ago, I started working for BHRS as a Family Partner. I shared my experience with other scared family members, and I believe I brought hope to them that recovery is possible. In February 2019, I was promoted to Family Education and Support Coordinator with OCFA, where I oversee the workforce development of 10 Family Peer Support Specialists and Family Partners providing peer Family Support for the families of youth receiving behavioral health services.

PROGRAM HIGHLIGHT

Early Psychosis Program

The (re)MIND® Early Psychosis Program serves youth and young adults ages 14 and 35, providing a wide array of services designed to detect signs and risks of developing serious mental illness at the earliest possible stages and wrap around the individual and their family members. Being quickly connected with effective treatment during early or first-episode psychosis can radically improve a person's behavioral wellness trajectory.[24] The Early Psychosis Program starts 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. Youth and young adults who are linked to the program receive evidence-based assessments and psychoeducation on diagnosis and treatment options. Clients work collaboratively to determine their treatment plan, which include Cognitive Behavioral Therapy for Psychosis (CBTp), medication management, individual peer and family support services, Psychoeducational Multifamily Groups (MFG), Supported Employment and Education using the Individual Placement and Support (IPS) model, strength-based care management, community-building activities, and (re)MIND® Aftercare services for program alumni.

The MHSA-funded Early Psychosis Program is the only program in the county that intervenes at early or first-episode psychosis, pointing to the impact of MHSA in preventing serious mental illness from limiting an individual's potential to achieve their hopes and dreams. The program is also unique in bridging both individual-level and community-level interventions—in this way, the program supports the detection of signs of early psychosis, and reduces stigma and discrimination by broadening the community's understanding of psychotic experiences existing in a continuum of common human experiences rather than limited to a pathological condition.

In the past five years, the Early Psychosis Program served an average of 72 participants and alumni per year. Of the 79 participants and alumni who participated in (re)MIND® and (re)MIND® Aftercare in FY 2022-23, 97% experienced improvements in meaningful activities (employment, academic placement/progression, volunteerism), 97% saw improvements in their psychosis assessment, and 70% had a reduction in hospitalizations.

93%

of (re)MIND® and (re)MIND® Aftercare participants and alumni surveyed in FY 2022-23 agreed that "Due to this program, I can take control of aspects of my life."

PEI Outcomes

MHSA-funded PEI programs have supported access to services and strengthened general mental health by promoting protective factors and reducing stigma around mental 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.[25] Reducing stigma around mental health can increase the potential of help seeking for mental health challenges.[26]

CONNECTION & SUPPORT

PEI programs increased feelings of support and connection to community, family, and/or providers.

93%
of Cariño Project participants surveyed (n=73) reported **feeling more connected to their community.**

80%
of Pride Center clients assessed (n=49) **experienced increased natural supports** (non-familial social support).

97%
of youth surveyed (n=29) 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.

ACCESS TO SERVICES

PEI programs increased client/participant ability to navigate and access mental health services for themselves or their loved ones.

PEI PROVIDERS MADE

772

referrals to outside mental health and substance use services

82%

of ODE Mental Health Month event participants (n=83) agreed or strongly agreed that they are now more willing to seek professional support for a mental health and/or substance use condition if they need it.

93%

of Senior Peer Counseling Group clients surveyed (n=41) reported that as a result of participating in the program, they are now connected to community resources.

STIGMA REDUCTION

PEI programs reduced stigma around mental health and help seeking.

88%

of Stigma Reduction Program participants surveyed (n=73) 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.

77%

of Health Ambassador Program-Youth participants surveyed (n=37) reported that they are comfortable discussing topics related to mental health as a result of their participation.

GENERAL MENTAL HEALTH

PEI programs improved mental health symptoms for therapy/counseling clients.

88%

of Pride Center clients assessed post-intervention for depression (n=49) experienced a reduction in symptoms.

89%

of Senior Peer Counseling group clients surveyed (n=41) reported feeling less stressed as a result of participating in the program.

68%

of the Primary Care Interface clients surveyed (n=92) agreed or strongly agreed that they are better able to manage their symptoms and participate in daily life.

SYSTEM TRANSFORMATION HIGHLIGHT

Advancing Diversity and Equity in BHRS Organizational Structure and Culture

In 2004, under the leadership of then San Mateo County Supervisor Rose Jacobs Gibson, community members and stakeholders came together to identify local disparities and develop a plan of action. This led to systemic efforts across the County Health system to address prioritized issues related to language access, substance use, and overall community wellness. By the time MHSA was enacted, momentum for addressing inequities and institutionalized barriers to accessing care was growing in healthcare settings and academic institutions across the country.

The MHSA Core Values and dedicated source of funding propelled BHRS's efforts to center community voices, address behavioral health inequities and access to care, and develop a organization and workforce that prioritizes equity and is inclusive of people from diverse identities. Cultural humility[27] and the social determinants of health[28] became key concepts that drove the work. In 2007, MHSA funding made it possible to fulfill the DHCS requirements to identify an Ethnic Services Manager to oversee cultural competence planning by funding a full-time manager to lead what later became the BHRS ODE. BHRS ODE leveraged the MHSA Community Program Planning requirements to elevate community voices, especially from historically marginalized communities, in planning decisions. In service of this goal, efforts were expanded to include funding for staff, clients, family, and community members to implement upstream prevention programming, engage in reducing stigma and increasing access to behavioral health services, and actively participate in the Behavioral Health Commission, MHSA Steering Committee, the Health Equity Initiatives, and other decision-making spaces.

In 2019, an annual survey reported that 73% of BHRS leadership and 77% of BHRS staff agreed that BHRS leadership values diversity at all levels of the organization, and 79% of staff and 80% of leadership agreed that their team provides a brave space in which speaking up on difficult cultural topics is encouraged.

Other BHRS ODE efforts have included a Multicultural Organization Development (MCOD) plan,[29] Trauma- and Resiliency-Informed Systems Initiative (TRISI),[30] system-wide trainings on cultural humility, racial equity and implicit biases, workforce retention, recruitment, internship and career pathways programs. As BHRS increased its emphasis on equity and engaged more intentionally with clients, families and community, leadership observed that more individuals with a social justice focus were attracted to work in BHRS.

Placing the county's MHSA administration under BHRS ODE has fueled systemic changes not only by prioritizing an equity lens in MHSA program and fiscal planning, but also in community engagement practices across BHRS, workforce transformation strategies funded through the MHSA Workforce Education and Training (WET) component, strategic partnerships, and policy and system change initiatives. Following San Mateo County's lead, several other counties have similarly aligned their MHSA CPP work with their equity work. Behavioral health equity work, made possible by MHSA funding, positioned BHRS as a leader when County-wide equity efforts launched. BHRS ODE was a key player in developing the broader County Health Racial Equity Action Plan and bringing the Government Alliance on Race and Equity (GARE), a national network of governments working to achieve racial equity, to the County of San Mateo.

> **"MHSA created the opportunity to think about disparities in a different way. We were the first County that really talked about not just 'cultural competence'…[but] about addressing disparities."**
>
> **Jei Africa, BHRS Director and former BHRS ODE Director**

SINCE INCEPTION

5%
fund allocation

10
innovation projects piloted

INNOVATION (INN)

Innovation (INN) programs give BHRS the opportunity to explore new or different approaches to better serve our community. The goals of INN are to increase access to and quality of mental health services, particularly to underserved groups, and promote interagency collaboration related to mental health services, supports, or outcomes. BHRS has been approved for a total of 10 Innovative programs over the course of the MHSA; four of the five projects that have completed the full INN cycle were sustained, with funding from MHSA and other local funding components.

In San Mateo County, MHSA INN provided a dedicated source of funding for communities to implement culturally informed programs and approaches to addressing inequities in behavioral health outcomes for marginalized ethnic, racial, and cultural communities.

These INN ideas were envisioned by peers for peers, by community advocates, staff allies and long-standing HEIs and other community collaboratives. The most recent CPP process for developing INN project ideas was led by a workgroup of community members and service providers including people with lived experience and their family members. The workgroup developed a process that was inclusive and accessible so a broad range of community members could submit project ideas.

Based on ideas from the workgroup, the following were developed:

- Frequently asked questions (FAQ) about INN and requirements for INN projects
- "MythBusters" to demystify the submission process
- A submission packet (translated into Spanish and Chinese) including scoring criteria and user-friendly online and fillable forms.
- An outreach plan to inform community members about the opportunity to submit ideas.
- An online informational session and an online training on how to conduct online research
- One-on-one technical assistance sessions where potential submitters could talk through their idea(s)

CURRENT AND PAST INN PROJECTS

Total Wellness

San Mateo County Pride Center

Health Ambassador Program-Youth (HAP-Y)

Neurosequential Model of Therapeutics (NMT) in the Adult System of Care

Help@Hand Technology Innovation

Kapwa Kultural Center (KKC) and Cafe for Filipino/a/x youth

PIONEERS project for Native Hawaiian and Pacific Islander youth

Farmworker Equity Express Bus

Music Therapy for Asians and Asian Americans

Recovery Connection Center

SYSTEM TRANSFORMATION HIGHLIGHT

Implementing Community-Driven Solutions to Meet Community-Defined Needs

Through the MHSA Community Program Planning (CPP) process, BHRS has engaged cultural and LGBTQ+ communities to voice the behavioral health needs of their communities and propose culturally informed programs and services. In turn, flexible innovation funding has enabled BHRS to pilot community-defined evidence practices (CDEP)—alternatives or complements to standard evidence-based practices that "offer culturally anchored interventions that reflect the values, practices, histories, and lived-experiences of the communities they serve." In San Mateo County, community-driven solutions funded by MHSA were inspired by the California Reducing Disparities Project (CRDP), one of the largest investments from any state in the country to look into diverse community perspectives on mental health disparities and recommendations for developing culturally responsive strategies.[31] BHRS has sought input on desired programs and services from community members and the Health Equity Initiatives (HEIs), which has resulted in many highly successful, culturally tailored programs and services.

Health Equity Initiatives
African American Community Initiative, Chinese Health Initiative, Filipino Mental Health Initiative, Latino Collaborative, Pacific Islander Initiative, PRIDE Initiative, Spirituality Initiative, Native and Indigenous Peoples Initiative

"[MHSA] opened the doors to new, innovative approaches to addressing cultural and racial inequities in behavioral health outcomes that were completely community-driven."

Maria Lorente-Foresti, BHRS ODE Director

- The Pride Center (2014), San Mateo County's LGBTQ+ collaborative multi-service center, was championed by the PRIDE Initiative until MHSA Innovation (INN) funding made it a reality. After a five-year INN funding period, the Pride Center, now an essential fixture in the local LGBTQ+ community, was converted to a permanent program receiving a combination of CSS and PEI funding.
- The Kapwa Kultural Center and Café (2020) was proposed by the Filipino Mental Health Initiative to improve the lives of Filipina/x/os in northern San Mateo County, with the context that Daly City has one of the highest concentrations of Filipina/x/os in the country. Kapwa was approved for INN funding to provide culturally affirming programming for Filipina/x/o youth that combines leadership skills, workforce preparedness, entrepreneurial mentorship, and ethnic studies to support positive cultural identity formation and mental health education.
- The Cariño Project (2020), a wraparound community program grounded in cultural arts frameworks of intervention and engagement in Half Moon Bay, came about because of unmet behavioral health needs in San Mateo County's predominantly Latinx farmworker community. The scarcity of public data on indigent, farmworker families, an invisible community in the Coastside, made it difficult to demonstrate the unmet need to decision-makers. In response, BHRS conducted a grassroots needs assessment that engaged over 210 community members on the coast to inform the services now known as the Cariño Project, and the project was ultimately approved and funded by the PEI component of MHSA. The Farmworker Equity Express Bus extends cultural arts practices directly to farmworkers and their families with INN funding.

"I remember living in the County without the Pride Center existing—it felt like I was alone, very alone.... Just knowing the Pride Center is here in my community makes me feel more comfortable. The fact that it's supported by the County, the Board of Supervisors, I feel more welcome in this county, more comfortable to be who I am. It's empowering."

Pride Center participant

"We have been looking everywhere for counseling for my daughter who really needed it. ALAS opened the doors for us and she really likes it. It's so important because we are seeing a change in her behavior. I don't know what we would have done."

Cariño Project parent participant

PROGRAM HIGHLIGHT

Neurosequential Model of Therapeutics

The Neurosequential Model of Therapeutics (NMT) is a developmentally sensitive, neurobiology-informed approach to clinical problem solving for clients who have experienced severe trauma.[32] In NMT, certified clinicians assess clients' functional capacities in four domains—sensory integration, self-regulation, relational, and cognitive—and work collaboratively with clients to identify appropriate alternative therapeutic, educational, and enrichment activities aligned with clients' cultural practices, values, and interests, including trauma-informed yoga, equine therapy, swimming, martial arts, and intensive speech therapy. These interventions complement typical mental health care services such as talk-based therapy and psychiatric medications.

In San Mateo County, NMT was piloted within the Adult System of Care in 2016. MHSA Innovation (INN) funding allowed BHRS an opportunity to explore whether NMT—which was originally developed for children and offered to children and youth in the BHRS system—could be adapted in a way that led to better outcomes in recovery for adult BHRS clients. After the four-year MHSA INN project highlighted positive results, NMT was integrated into the Adult System of Care.

The number of clients participating in NMT services has increased each year for the last three years, with 90 TAY and adults receiving NMT services in 2022-23. Clients and providers alike have observed positive impacts of NMT on clients' experience of care and their recovery. Of the 46 clients with follow-up assessments during the INN program period (2016-2020), two-thirds (n=31) showed increases in their functional assessment scores, with TAY clients demonstrating greater improvements compared to adults. NMT clients have appreciated the individualized approach of NMT, the access to alternative interventions, and working with providers in a new way. Involvement in the NMT program has also empowered some clients to become more actively involved in managing their care plan.

Integrating NMT in BHRS has also promoted trauma-informed care and countered stigma and discrimination experienced by clients living with SMI in the broader public system. For example, NMT clinicians have fostered compassion for neurodiversity by helping other clinicians better understand and respond to past experiences that may have caused a client to present maladaptive behaviors. The use of NMT findings has also helped increase awareness of the strengths and resilience of BHRS clients among valued partners such as judges, probation officers, and other staff involved in child protective services cases, as well as staff from residential treatment facilities and other community-based organizations.

Theresa's Story*

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

*pseudonym to protect client's identity


Allo Bodega
BRING YOUR OWN BAG
WARNING
Security Cameras In Use
INCA KOLA
Infórmese sobre la vacuna contra el COVID-19
La vacuna es segura
La vacuna es gratuita para todos
Las personas que están en mayor riesgo la recibirán primero
La vacuna puede causar efectos secundarios temporarios
La vacuna es nuestra mejor oportunidad para superar la pandemia
SAN MATEO COUNTY HEALTH
Your Health is Essential

MHSA During the Pandemic

In 2020, the BHRS Office of Diversity and Equity (ODE) hosted a series of "Race & Coronavirus Town Halls" where feedback from staff, community-based organizations (CBO), client, community members and community and faith leaders pointed to the need for technology supports, and digital literacy for communities most impacted by the COVID-19 pandemic. Faith leaders, CBOs, and providers requested advanced technological support to learn how to run a Zoom meeting for their services, host a Facebook Live, and support the community with navigating telehealth appointments. Through the MHSA and the Coronavirus Aid, Relief, and Economic Security (CARES) Act, over $500,000 in funding was allocated for technology support for BHRS clients and parents/caregivers of youth clients during the pandemic. Through a federally subsidized low-cost data plan program offered by T-Mobile, BHRS offered a free refurbished phone with a one-year paid data plan at no cost to 700 clients and family members. The pandemic relief coincided with a state MHSA INN initiative called Help@Hand, which brought wellness apps for youth and older adults, along with digital literacy support and social connectedness for older adults called "Get App-y" workshops. The program has supported older adults to bridge the "digital divide," a particularly critical issue during the height of the pandemic.

PAINTED BRAIN

Painted Brain, a peer-run, peer-led agency, also began supporting behavioral health clients with digital and technology needs during the pandemic. Painted Brain supports the digital mental health literacy needs of BHRS clients and family members of clients that receive devices and data plans to support their engagement in telehealth and/or other online behavioral health services but may be struggling with the knowledge needed to use their devices safely and effectively. In Oct 2020, Painted Brain began facilitating Tech 101 and Train-the-Trainer trainings for peer staff to support clients with their devices and to lead Tech Café's for clients. In 2021, BHRS added advanced Zoom topics to Painted Brain's contract including a training to address equitable practices while facilitating Zoom meetings. Painted Brain now also provides virtual and over-the-phone technical guidance and assistance to BHRS clients on-demand.

"The [Help@Hand] Innovation at the beginning of the pandemic—if that hadn't happened, I don't know what we would have done during the pandemic. That's been big for getting people on the other side of the digital divide."

Jean Perry, MHSA Steering Committee Co-Chair

IN FY 2022-23

43
WET trainings—24 in cultural humility, language access, and sexual orientation, gender identity and expression

738
providers attended WET trainings

7
Cultural Stipened Internship Program participants

35
loan repayment recipients

WORKFORCE EDUCATION AND TRAINING (WET)

Since the passage of the MHSA in 2004, the WET component has provided a unique opportunity to expand and improve the public behavioral health workforce including evidence-based and promising approaches to training and capacity building for providers to respond to behavioral health issues, trainings for and by client/consumers and family members, career pathways to address ongoing vacancies in hard-to-fill positions, and stipends to trainees who contribute to the diversity and equity efforts of BHRS.

The WET component is particularly important in light of the high cost of living in San Mateo County, which—in combination with national behavioral health workforce trends during and following the COVID-19 pandemic—has led to staff shortages across BHRS and contracted service providers. MHSA funding has provided resources for BHRS to go beyond the basics of workforce development by increasing the number and types of capacity building trainings offered, increasing diversity and inclusion strategies, and offering retention programs aligned with statewide workforce development strategies.

In 2022, state-led efforts to address the shortage of behavioral health practitioners including the implementation of an Educational Loan Repayment program. A total of $525,000 was invested in San Mateo County for retention

of behavioral health employees in both BHRS and contracted providers with 35 qualified, eligible employees in "hard to fill/retain" positions being awarded $15,000 each toward repayment of educational loans in exchange for a 12-month service obligation. Starting in the Spring of 2024, BHRS will award up to $10,000 to eligible clinicians toward qualifiable educational loans, and another $10,000 to qualified employees working in a behavioral health setting who can commit to a 12-month service obligation.[33]

THE BHRS WET PROGRAM

- Training and capacity building for staff in cultural humility, trauma-informed care practices, and evidence-based and culturally affirming clinical modalities.
- Training and capacity building for clients/consumers and family members through the LEA, Advocacy Academy, and peer certification training offered by OCFA (described on page 24).
- Cultural Stipend Internship Program (CSIP) provides stipends to BHRS clinical interns to work on a system-level project to advance BHRS's diversity and equity goals.
- Staff Recruitment and Retention efforts including loan repayment and hiring/retention bonuses.

Staff training in cultural humility has been part of BHRS efforts to integrate a cultural humility framework across policies, quality improvement plans, onboarding protocols, and workforce training requirements. In 2011, the BHRS Office of Diversity and Equity (ODE) introduced Cultural Humility 101, a required training for BHRS workforce and contracted providers. Dr. Melanie Tervalon (co-author of the article, Cultural Humility vs. Cultural Competence: a critical distinction in defining physician training outcomes in multicultural education, published in 1998) facilitated the first cultural humility training in the country in San Mateo County and has collaborated with BHRS over the years to develop a train-the-trainer model and cohort of trainers and advanced cultural humility trainings. ODE has expanded the menu of trainings provided through WET to advance diversity and equity including Working Effectively with Interpreters, Sexual Orientation, Gender Identity and Expression (SOGIE), and Racial Equity, among others. ODE also developed the first language access videos in behavioral health settings in the country, to support the use of language interpreters and prepare providers for common challenges in working with interpreters. Interpretation services are a resource that, when used appropriately, can build trust, improve clients' service experience, and increase their willingness to continue with services and recommend our services to others. Current WET efforts are focused on evaluating the transformational impacts these trainings have had on our system of care, including how providers are applying learnings about culturally informed care and analyzing trends in clients' experiences over the years.

> **"[Trainings on cultural humility] open the door for difficult and important conversations amongst staff."**
>
> **Training participant**

PROGRAM HIGHLIGHT

Cultural Stipend Internship Program

MHSA enabled BHRS to design a Cultural Stipend Internship Program (CSIP) that augments BHRS's existing clinical internship program and offers stipends to recognize participants' contribution to diversity and inclusion in BHRS. Recipients of the stipend partner with a BHRS ODE Health Equity Initiative (HEI) to develop a project with the goal of improving the cultural responsiveness of BHRS services. Highest priority is given to applicants who are bilingual and/or bicultural and whose cultural background and experience is reflective of our culturally and linguistically diverse clients.

CSIP projects have consisted of needs assessments, workshops and presentations, and community education and awareness activities. Some examples include:

- A survey that assessed the impact of BHRS spirituality training and advocacy efforts including clinician comfort and client perspectives on including spirituality in treatment.
- A presentation to San Mateo County providers and the community on Native American mental health and strategies for working with the Native American community to improve health outcomes in this population.
- Creation and facilitation of a workshop on mental health and socio-emotional issues at a local high school's Filipino student group.
- A Photovoice[34] workshop for BHRS older adult clients to share their personal stories through photos as a means of healing, reducing stigma associated with mental health and substance use.
- Development of a sustainable online and social media plan for LGBTQ+ resources, events, groups, and services.
- An outreach event and presentation to Arab communities in San Mateo County on behavioral health and recovery resources, services, and issues.

Feedback from CSIP participants points to the impact of CSIP in preparing future clinicians to better understand issues related to diversity, marginalized communities, privilege, and power. The program's emphasis on cultural humility has helped foster skills, values, and perspectives to support participants' future work in the field. CSIP participants have remained involved in the BHRS system in several ways—for example, one former intern was hired as a Chinese community outreach worker and continued supporting the Chinese community at other local health settings one continued supporting the African American Community Initiative post internship; and others have been hired as providers in the BHRS system of care.

> “[CSIP] really helped me personally to be more motivated to help my own community. I would not have stepped into community mental health if I had not participated in the CSIP program.”
>
> CSIP participant

> “[CSIP] has allowed me to see where the areas of strength/deficit are when providing mental health services to [the Latinx] community, therefore giving me an idea of how I may be able to improve this system when I complete graduate school.”
>
> CSIP participant

CONCLUSION: LOOKING AHEAD

Over nearly 20 years, the MHSA has had a sweeping impact on access to culturally informed, recovery and wellness-oriented services in California. In San Mateo County, we have leveraged both the resources and the core values MHSA to increase capacity to serve our community.

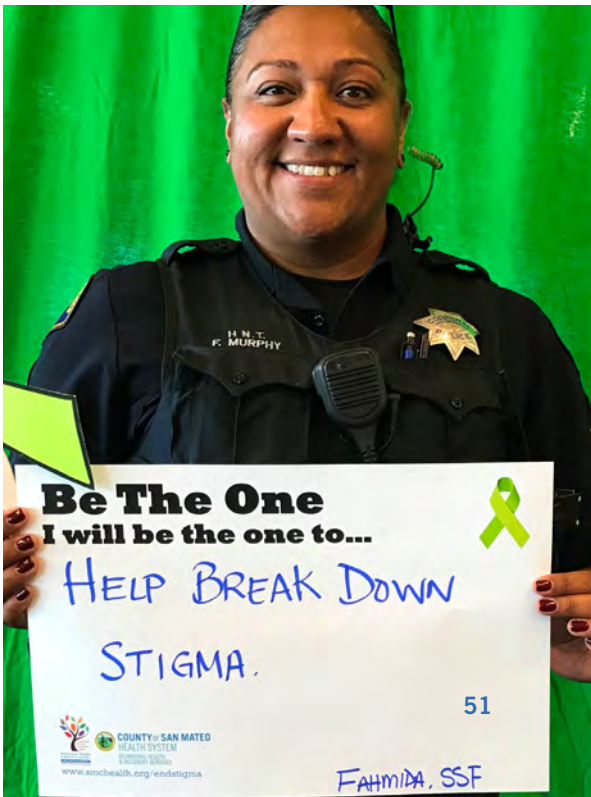
- We have fostered community collaboration by shifting decision-making about behavioral health services from behind the closed doors of government into the community, as demonstrated by our ever-growing community participation in decision-making spaces including commissions, advisory committees, steering committees and workgroups.
- We have uplifted cultural responsiveness by sourcing ideas for new programs from local communities, funding innovative and culturally informed programs, implementing practices to increase staff diversity, and training staff in cultural humility, language access, and sexual orientation, gender identity, and gender expression.
- We have integrated client and family driven services in our approach to mental health and substance use treatment, and through regular training and support for peers to enter the workforce and contribute to BHRS processes.

- We have centered wellness, recovery, and resiliency by expanding beyond the medical model of treatment to include peer support, drop-in centers, supported employment, support groups, non-law enforcement crisis services, and access to alternative care interventions.
- We have promoted an integrated service experience by implementing strategies to integrate mental health and substance use services, and solidifying partnerships with medical, housing, and community-based organizations.

As we celebrate these successes, we also recognize areas where we have fallen short and challenges we continue to face in our efforts to serve our community in a seamless and trauma-informed manner. Purely in terms of scale, the number of people who need behavioral health services continues to exceed our capacity. We know that our behavioral health system is situated in the context of structural racism, stigma associated with behavioral health needs, and other systemic inequities that reflect ongoing and historical injustices. While much headway has been made toward culturally and linguistically appropriate services, there is still work to do to make sure everyone has equitable access to programs in the languages they are most comfortable speaking. Income inequality and the high cost of living in San Mateo County means that it is a struggle for many community members to get their basic needs met, and many staff cannot afford to live in the county in which they work. Navigating the shortages of behavioral health staff is a challenge faced by behavioral health programs and regions across the state, and recruiting and retaining a diverse behavioral health workforce was prioritized as a top strategy in the most recent BHRS MHSA Three-Year Plan.

COVID-19 also posed obstacles from which our communities and the behavioral health system are still reeling. Despite innovations in telehealth, the halt in in-person services in homes, schools, and other community locations hindered engagement for many clients. Additionally, there is a continued need to improve how the behavioral health system engages clients living with SMI and co-occurring mental health and substance use challenges who are not receiving services. We also seek to further integrate people with lived experience across the behavioral health system by building career pathways and professional ladders for peers and family members.

In one view, nearly 20 years of MHSA is a significant period in which we have made vast improvements to the behavioral health system; in the bigger picture, we are in the early stages of systems change. As we move forward, particularly in light of the shifting policy landscape around behavioral health with the passing of Proposition 1 and consequent redistribution of MHSA funds in California, we will draw on the framework for systems change that the MHSA has inspired—one that centers client voice, equity, trauma-informed, recovery and resilience, and collaboration and coordination—as we focus on addressing the housing needs of individuals living with serious mental health challenges.



Transforming our behavioral health system to a trauma-informed and, equitable system that is able to meet the need in our community will require a continued investment of time, energy, and resources. We look forward to continuing to collaborate with our staff, local partners, clients, family members, and the community at large to advance behavioral wellness in San Mateo County.

ENDNOTES

1 For more on Proposition 1, see: https://www.dhcs.ca.gov/BHT/Pages/home.aspx

2 Cal. Code Regs. Tit. 9, § 3320 - General Standards

3 California's Mental Health Services Act: Is It Working? (2010). Berkeley Health, Fall/Winter 2010, 19–23; Cashin, C., PhD, Scheffler, R., PhD, Felton, M., MPH, Adams, N., MD, MPH, & Miller, L., PhD. (2015, January 13). Transformation of the California Mental Health System: Stakeholder-Driven Planning as a Transformational Activity. Psychiatric Services. https://ps.psychiatryonline.org/doi/10.1176/ps.2008.59.10.1107

4 California's Mental Health Services Act: Is It Working? (2010).

5 Steinberg Institute & County Behavioral Health Directors Association of California. (2016). MHSA - FSP Program Impact.

6 Brown, T. A., Chung, J., Choi, S., Scheffler, R. M., & Adams, N. (2012). The Impact of California's Full-Service Partnership Program on Mental Health-Related Emergency Department Visits. Psychiatric Services, 63(8), 802–807. https://doi.org/10.1176/appi.ps.201100384

7 Steinberg Institute & County Behavioral Health Directors Association of California. (2016); Ashwood, J. S. (2018, March 13). Evaluation of the Mental Health Services Act in Los Angeles County: Implementation and Outcomes for Key Programs. RAND. https://www.rand.org/pubs/research_reports/RR2327.html

8 Steinberg Institute & County Behavioral Health Directors Association of California. (2016).

9 Ashwood et al. (2018).

10 Penetration rates are a measure of the number of persons receiving mental health and substance use treatment out of the Medi-Cal eligible population and provide a means for counties to identify disparities in access. The San Mateo County penetration rate for adults (8.7%) is higher than other like-size counties (5.1%) and the state (5.9%), and lower for youth (4.5%) and for substance use services (2.0%) than other like-size counties (5.6% and 3.1% respectively) and the state (7.5% and 3.6% respectively).

11 The number of unique individuals served through direct prevention programs is likely undercounted because some prevention programs are only required to report a portion of their unique clients served.

12 The 2024 Health Equity Index, created by Conduent Healthy Communities Institute, is a measure of socioeconomic need that is correlated with poor health outcomes. The index is part of Conduent's SocioNeeds Index® Suite, which provides analytics around social determinants of health to advance equitable outcomes for a range of topics. https://www.smcalltogetherbetter.org/indexsuite/index/healthequity?localeType=3&parentLocale=278

13 SMI and SED are mental, behavioral, or emotional disorder diagnosis resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.

14 Evidence-based practices have consistently demonstrated significant improvements in client outcomes through formal research studies.

15 If clients participated in more than one program, they are counted in both programs.

16 Wraparound models emphasize the importance of care coordination across a support network, which many include family, friends, teachers, mental health professionals, and other community members: https://www.cdss.ca.gov/inforesources/cdss-programs/foster-care/wraparound.

17 Bond, G. R., & Drake, R. E. (2015). The critical ingredients of assertive community treatment. World psychiatry : official journal of the World Psychiatric Association (WPA), 14(2), 240–242. https://doi.org/10.1002/wps.20234

18 California's Mental Health Services Act: Is It Working? (2010).

19 Due to differences in data reporting by Telecare, only Caminar FSP outcomes are reported here.

20 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

21 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/

22 If clients participated in more than one program, they are counted in both programs.

23 BHRS Services and Resources, https://www.smchealth.org/general-information/behavioral-health-services-resourcesA

24 Early or first-episode psychosis (FEP) refers to when a person first starts to show signs of losing touch with reality. https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/Psychosis

25 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

26 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

27 Cultural humility is a practice and commitment to lifelong self-reflection and learning of own and others culture to diminish power imbalances, improve quality of services and build trusting relationships with clients. https://melanietervalon.com/wp-content/uploads/2013/08/CulturalHumility_Tervalon-and-Murray-Garcia-Article.pdf

28 Social determinants of health are the social, economic, and physical environments that impact health. https://www.who.int/publications/i/item/9789241506809

29 MCOD is an organizational change framework established to support BHRS' ability to work effectively and respectfully with people from diverse cultural, linguistic, and social backgrounds.

30 TRISI is organizational commitment to address trauma and promote resiliency in local programs, structures, and culture with a long-term goal of embedding trauma- and resiliency-informed policies and practices at every level of the system.

31 California Reducing Disparities Project (CRDP): https://cultureishealth.org/wp-content/uploads/2023/06/ADA_CRDP_SWE_Executive_Summary_PARCLMU_6.1.23.pdf

32 https://www.neurosequential.com/nmt

33 Since implementation of HCAI's Regional Behavioral Health Workforce Grants and based on feedback from California counties, CalMHSA has expanded its menu of services to include temporary clinical staffing, remote supervision, training and certification, including for peer support specialists. San Mateo County BHRS is opting to partner with CalMHSA to bring these much-needed workforce staffing supports to the behavioral health workforce.

34 Photovoice empowers community members to share their stories of recovery and wellness through photography and written narrative.