SAN MATEO COUNTY HEALTH

BEHAVIORAL HEALTH & RECOVERY SERVICES

# PREVENTION & EARLY INTERVENTION EVALUATION

FY 2016/2017 & 2017/2018

# EXECUTIVE SUMMARY

San Mateo County funded 20 program utilizing Prevention and Early Intervention fund during fiscal years (FY) 2016-2017 and 2017-2018. Most of SMC PEI programs are delivered by community-based providers and they serve children, adults, older adults as well as marginalized and diverse populations. Approximately 32,630 community members received services; and they ranged from trainings, psycho-education workshops, teacher consultations, summer employment, direct treatment to fun family events.

# INTRODUCTION

## OVERVIEW

Prevention and Early Intervention (PEI) is one of the five components of MHSA. This component has its own reporting requirements, the most updated reporting requirements were implemented June 2018 by the California Mental Health Services Oversight and Accountability Commission (MHSOAC). PEI targets individuals of all ages prior to the onset of mental illness, except for early onset of psychotic disorders. PEI emphasizes reducing the seven negative outcomes of untreated mental illness; suicide; incarceration; school failure or pushout; unemployment; prolonged suffering; homelessness; and removal of children from their homes.

## PEI REGULATIONS

In June 2018, the PEI regulations were amended, and specific requirements were added that include indicators, data trackers, the explanation of a 3-year evaluation plan, annual evaluation report and the PEI component of a 3-year plan.

### PROGRAM CATEGORIES

**Prevention-** Set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. Prevention program services may include relapse prevention for individuals in recovery from a serious mental illness.

**Early Intervention-** Treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental

illness early in its emergence, including negative outcomes that may result from untreated mental illness. Early Intervention program services may include services to parents, caregivers, and other family members of the person with early onset of a mental illness as applicable. Services shall not exceed 18 months, unless the individual receiving service is identified as experiencing first onset of a serious mental illness or emotional disturbance with psychotic features, in which case early intervention services shall not exceed four years.

**Outreach for increasing recognition of early signs of mental illness-** The process of engaging, encouraging, educating, and/or training and learning from potential responders (family, school personnel, peer providers, etc.) about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness. Outreach for increasing recognition of early signs of mental illness may include reaching out to individuals with signs and symptoms of a mental illness, so they can recognize and respond to their own symptoms.

**Stigma and Discrimination reduction program-** The County's direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and /or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion and equity for individuals with mental illness, and members of their families.

**Access to linkage and treatment program-** A set of related activities to connect children, adults and seniors with severe mental illness, as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs (e.g. screening, assessment, referral, telephone help lines, and mobile response).

**Suicide prevention program-** Organized activities that the County undertakes to prevent suicide because of mental illness.

## PEI STRATEGIES

All programs need to be designed and implemented to further at least one of these strategies:

**Create access and linkage to treatment-** See above definition

**Timely access to mental health services for individuals and families from underserved population-** To increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness received appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services. Services shall be provided in a convenient, accessible, acceptable, culturally appropriate setting.

**Non stigmatizing and Non-Discriminatory Practices-** Promoting, designing, and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services accessible, welcoming, and positive.

## DATA SOURCES AND ANALYSIS

A mixed-methods research framework was used to conduct this evaluation plan and included both qualitative and quantitative data that was provided by our contractors and staff. While a standardization of data is our goal, currently there are some variations across programs that reflect staffing capacity, technology access and the differences between target populations. However, all our PEI programs have been implemented and designed to work towards reaching PEI goals consistent with MHSA legislation.

The data sources that were used for the completion of this report were the following:

1) ### MHSA ANNUAL REPORT TEMPLATES
   In 2017 a new MHSA annual report template was created to standardize information collected. Each contractor is responsible for completing this template on an annual basis. Currently the template collects metrics such as unduplicated number of clients served, demographics, outcomes as well as narrative regarding program activities, interventions, program successes and challenges. This template continues to be refined as we adhere to new PEI guidelines as well as customize to program needs.

2) ### KEY STAKEHOLDER INTERVIEWS
   Some of the data analysis and collection of PEI programs is done externally through a contract with the American Institutes for Research (AIR). To supplement this quantitative data analysis and give context to data collection key stakeholder interviews were conducted with these programs.

3) ### PROGRAM TRACKING LOGS AND SIGN-IN SHEETS
   Internal PEI programs use tracking logs and sign in sheets to document the number of clients, outreach, and referrals made. Some tracking sheets are also online through survey monkey and are analyzed by AIR.

4) ### PROGRAM TOOLS/SURVEYS
   Many of the PEI programs use pre-post test program surveys to collect outcome data as well as client satisfaction with the program. These surveys include Likert scales, open ended questions, and capture a variety of outcomes such as changes in attitude, knowledge, behaviors. Measures also capture the increase in protective factors to mental illness as well as social-emotional wellbeing and use of new skills. The use of pre

and post tests are being reviewed to make sure they align with the outcome metrics we hope to collect across programs.

5) PREVIOUS EVALUATION REPORTS

For fiscal years 2013-2014 as well as 2014-2015 an independent evaluation consultant was hired to evaluate MHSA funded programs. This consultant was able to evaluate whether programs were implemented efficiently, how effective the strategies were, the state of client satisfaction, responsiveness to target population, how programs advanced the MHSA vision as well as recommendations for improvement. This initial evaluation report served as a starting point for this evaluation plan.

## OPPORTUNITIES FOR IMPROVEMENT

San Mateo County has had extremely limited organizational capacity due to the staffing of the MHSA team. Currently, the MHSA team includes the MHSA coordinator, and one Community Health Planner that assist with various MHSA administrative and programmatic duties. A dedicated PEI Coordinator would make it easier to monitor PEI data collection, oversight, as well as the structure and maintenance of new MHSA requirements and regulations. Contract monitoring for our some of our programs is done through clinical supervisors who are expected to meet with contractors regularly, however due to increased workloads, this is not always possible and places a strain on our workforce's ability to engage in meaningful oversight.

Additionally, another challenge we face is that there is no PEI database or centralized portal for data collection. This poses a challenge for data collection because different contractors and internal programs have varying levels of understanding when it comes to data reporting, measurements and the requirements for PEI funded programs. We can capture data with Electronic Health Records for other MHSA programs; however, these systems are not integrated into PEI programs. Furthermore, since there is no centralized system it is difficult to make comparisons from year to year effectively. This affects coordination and our ability to implement data driven quality improvement strategies that are needed across our system of care. Recently, through a local stakeholder planning process, $200,000 one-time available funds was allocated for this purpose and we look forward to implementing this priority next fiscal year (FY) 2020-21.

## STRENGTHS

San Mateo County has implemented 19 different PEI programs, that provide services to a variety of target populations, are located across our county and work to prevent the negative outcomes associated with mental illness as well as severe mental illness. Our most current PEI budget for FY 2020-21 is $7 million with 51% allocation to Children and Transitional Age Youth (TAY) ages 0-25.

Additionally, as mentioned previously, SMC engaged in an evaluation process for FY 2013-2014 and FY 2014-2015. Programs have been added since then however, the recommendations from the evaluator enabled SMC to implement several changes that are the building blocks for systems change and is congruent with thoughtful PEI evaluation. Some of these changes include adding detailed evaluation requirements to the Request for Proposal (RFP) process. This section includes requirements for evaluation tools, data collection frequency and analysis. The contracting process has also changed, when our last evaluation occurred, many of the PEI contracts did not have deliverable requirements, now contracts include expectations of deliverables which include minimum numbers for outreach, groups, events, workshops, and presentations etc. The most recent contracts for new programs to be implemented in the future have included the requirement for client/family satisfaction with the program, specific validated scales to be used pre and post to collect data on outcomes and updated demographic forms for participants.

Another strength that was found when reviewing PEI programs is our compliance with the new regulations that state, that each PEI programs need to fall within each of the six strategies mentioned above. The PEI programs that have been implemented thus far also further the strategies required by the new regulations which are:

- Create access to linkage and treatment
- Timely access to mental health services for individuals and families from underserved populations
- Non-stigmatizing and non-discriminatory

Furthermore, within SMC the MHSA team is housed under the Office of Diversity and Equity (ODE), which results in all MHSA PEI programs being designed, implemented, and evaluated with an equity lens. The Office of Diversity and Equity serves Behavioral Health and Recovery services, but also influences and touches many parts of San Mateo County Health. Having MHSA housed under ODE enables the administrative team to stay close to community partners, stakeholders, as well as clients and family members. These sustained relationships have developed into meaningful partnerships that optimize our ability to stay connected to community so that the voice of marginalized communities is always at the center of all the work that is carried out; from the three-year planning process, the design and implementation of programs, needs assessments, as well as advance systems change policies.

## MOVING FORWARD

Based on the findings of this report, some system improvement needs, oversight limitations and data collection needs have been identified. First, we acknowledge that currently we do not have the staffing or structure to carry out an evaluation internally. To be able to comply with the new PEI requirements below are some action steps that need to be implemented to make the evaluation of PEI programs sustainable, meaningful and community centered. There are

several programs in this report that use the number of clients served as their only outcome. The data reporting for these programs is out of compliance with new regulations that ask for specific metrics such as # of referrals, time from initial contact to engaging in services etc. Below are the action steps that SMC will take to ensure that data collection of the PEI programs is in compliance and used meaningfully to evaluate success, as well as improvement.

- CONTRACT AN EXTERNAL EVALUATOR: Due to limited staffing capacity, an evaluator from an outside agency will be contracted to guide the PEI evaluation process, outcomes, and implementation of tools. They will work with PEI administration staff to meet with contract monitors, contract agencies, establish and implement outcome metrics for each of the programs. The standardized outcome template will be changed to reflect specific data requirements. The outcome metrics will be developed with contractors, clients/family members as well as staff to ensure outcomes that they are representative of the work being done, that they fulfill the PEI requirements and are meaningful to the community. This will enable us to develop an evaluation plan that is culturally competent and includes the perspective of diverse people with lived experience.

- HOLD REGULAR MEETINGS WITH CONTRACT MONITORS: These meetings will be held with each of the contract monitors to update and provide them with the new PEI regulations. It will enable us to gain understand as to their involvement with the contractor, familiarity with the data requirements and establish oversight procedures for data collection.

- HOLD REGULAR MEETINGS WITH PEI PROGRAMS AND CONTRACT AGENCIES: These meetings will be held with each of the contractors regarding implementation, data collection and analysis. One of the recommendations from our previous evaluator was that contract agencies needed training on data collection. These preliminary meetings will serve to gauge the capacity of the agency, obtain feedback on outcome measures and tools proposed, creation of a PEI data base, and review of the new PEI guidelines as well as updated expectations and potential contract amendments.

- DEVELOP A PEI DATABASE: Currently, data collection is not standardized. Many programs submit annual reports with quantitative data that changes from year to year based on their capacity/turn over and many outcomes are based on what the agencies deem to be meaningful at the time. With the standardization of outcome metrics and reporting, as well as a centralized data base, it will enable us to make data driven systems improvements, compare year to year outcomes and comply with PEI regulations.

- CREATE PROTOCOLS: Formal written protocols are needed for PEI programs, these protocols would include communication of PEI requirements, clear expectations of what needs to be completed by each program, who is responsible for each task assigned, as well as timelines for all activities. These protocols would specify the expectations

around data collection, the role of the contract monitors and reporting expectations, such as quarterly reports, and annual reports for programming.

## PREVENTION AND EARLY INTERVENTION AGES 0-25

The following programs serve children and transitional age youth 0-25 exclusively. Some programs serve both populations. The MHSA guidelines require 19% of spending to fund PEI and of that 51% of the PEI budget is required to fund programs for children and youth. In San Mateo County there are five programs that serve this age group. Other programs in our PEI category also serve this age group, however it is not exclusively. These programs serve several special populations and are found in geographically underserved areas of the county. These programs include consultations with teachers, parents, workshops, outreach as well as employment.

**PEI Ages 0-25**

- Early Childhood Community Team (ECCT)
- Project SUCCESS
- Seeking Safety
- Teaching Pro Social
- Crisis Hotline, Youth Outreach and Intervention Team

**910** total clients served

## EARLY CHILDHOOD COMMUNITY TEAM

ECCT employs both prevention (60%) and early intervention (40%) strategies. ECCT incorporates several major components that build on current models in the community, to support healthy social emotional development of young children.

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

The ECCT focuses services on the Coastside community - a low-income, rural, geographically isolated community. To better serve this disperse community, ECCT has built strong

relationships with key community partners and successfully refers families to the local school district, other StarVista services, Coastside Mental Health clinic and Pre-to-Three Program, among others.

## METHODS

ECCT is a program with three service modalities some of which are evidence based and others are promising practices.

### PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

Non-Stigmatizing and Non-Discriminatory Practices

### PROGRAM HIGHLIGHTS

213 clients served

39 teachers served

51 families received mental health services

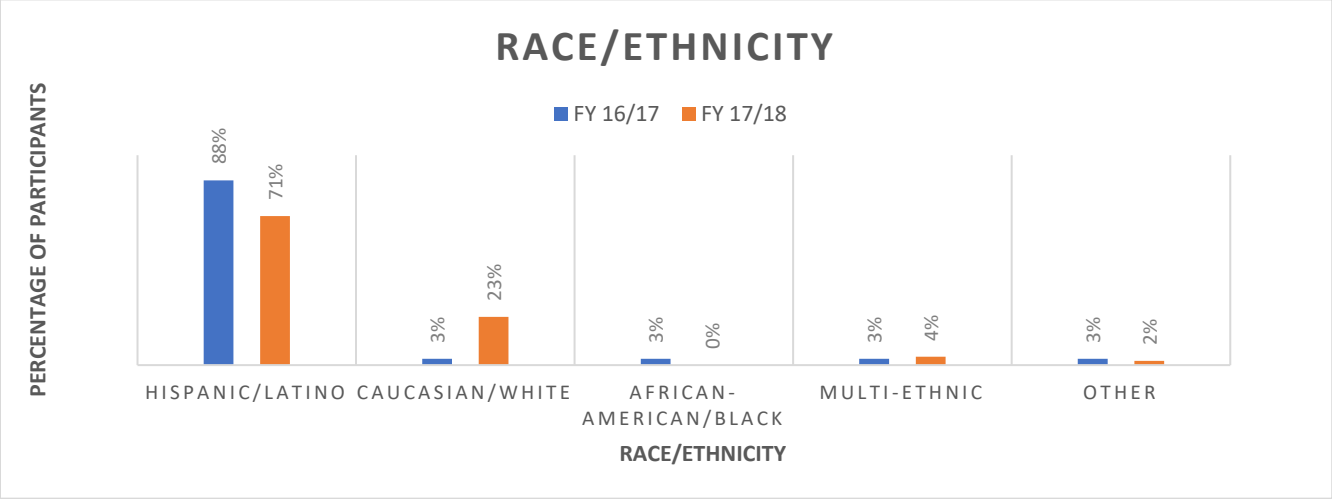
50 children and their families received weekly child-parent psychotherapy services

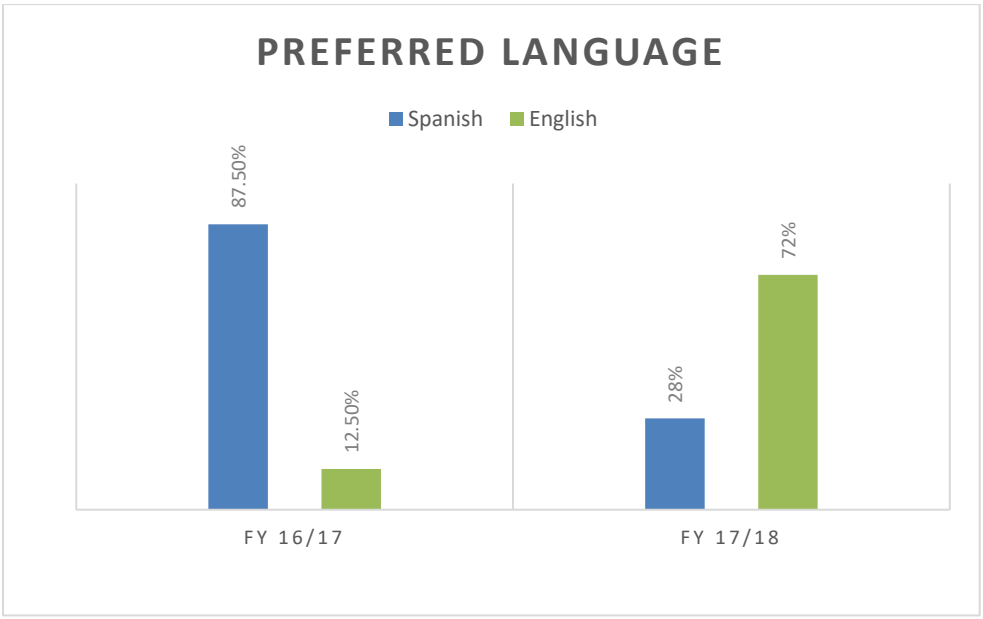
18 families received intensive case consultation

### DEMOGRAPHIC DATA

EECT served 213 clients in fiscal years 16/17 and 17/18. The demographic data in this section represents unduplicated data provided by those who were active in the program. The data shows that those who were most served were Latinos, as well as Spanish speakers. This is

congruent with the programs target population, as well as county wide demographic data that shows that Latinos from this region experience mental health challenges at a higher rate than other ethnic groups.




## OUTCOMES

ECCT tracks outcomes via the Child Behavioral Checklist that is filled out by the client's teachers, teacher satisfaction surveys, parent satisfaction surveys as well as informal conversation and observation. It has been a challenge obtaining high survey participation from parents.

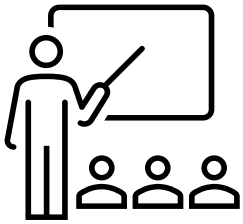
## TEACHER SATISFACTION SURVEY RESULTS

**FY 16/17**

| % of Respondents that Reported: | |
|---|---|
| Consultation was very effective in helping them think about children's development and behavior | 93% |
| Consultation was very effective or effective in contributing to their willingness to continue caring for a challenging child | 100% |
| Consultation was very effective or effective in contributing to their ability to handle a challenging child | 86% |
| Consultation was very effective or effective in helping them understand a family's situation and its effects on the child's current behavior | 86% |
| Consultation was very effective or effective in helping them apply what they learned about a specific child to other children | 100% |

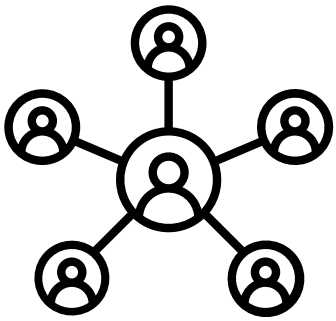
**FY 17/18**

| % of Respondents that Reported: | |
|---|---|
| Consultation was very effective or effective in contributing to their willingness to continue caring for a specific child with challenging behaviors | 92% |
| Consultation was very effective or effective in helping them in their relationship with this child's family | 91% |
| Consultation was very effective or effective in helping to relieve some of the pressure in responding to the family's needs. | 92% |
| Consultation was very useful or very useful in thinking with them about supporting all children in their classroom. | 92% |
| Consultation was very useful or useful in helping them think about children's engagement in classroom activities. | 92% |



All teachers reported a greater ability to understand and respond to the social-emotional needs of children in their centers

## FAMILY CENTERED OUTCOMES



18 families have increased their capacity to understand their child's behaviors and respond effectively to their social-emotional needs

22 families reported an improvement in multiple areas related to the child's development and/or behavior

100% of families that engaged in parenting education reported an improvement in their child's behavior

## QUALITATIVE DATA

"A mother became much more engaged [after services] speaking to teachers more often, spending more time at school, expressing a wider range of affect and greater involvement with her child"

## PROJECT SUCCESS

Project SUCCESS, or Schools Using Coordinated Community Efforts to Strengthen Students, is a research-based program that uses interventions that are effective in reducing risk factors and enhancing protective measures.

Project SUCCESS is designed for use with youth ages 9-18 and includes parents as collaborative partners in prevention through parent education programs. Clinical staff trained in culturally competent practices ran all the groups. The school district's small size provides an opportunity for every student in the district, ages 9-18, to participate in one or more Project SUCCESS activities. All groups were offered in English and in Spanish.

### METHODS

Project SUCCESS is a SAMHSA model program that prevents and reduces substance use and abuse and associated behavioral problems among high risk; multi-problem youth ages 9-18. It is an evidence-based program.

### PROGRAM STRATEGIES

Create Access to Linkage and Treatment

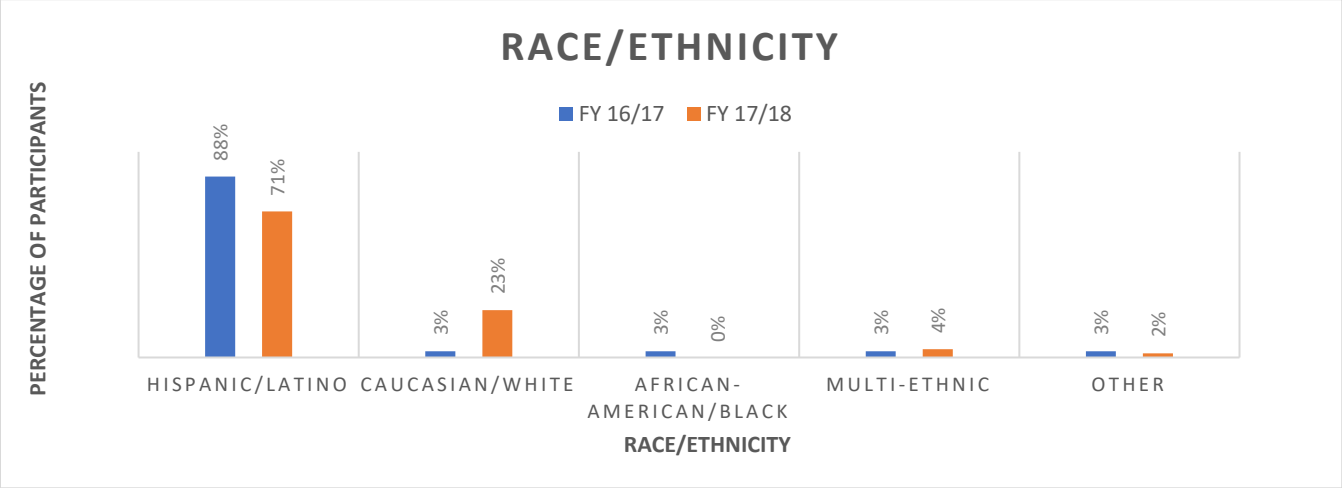
### PROGRAM HIGHLIGHTS

222 clients served

84 families served

## DEMOGRAPHIC DATA

Project SUCCESS served 222 clients in fiscal years 16/17 and 17/18. The demographic data in this section represents unduplicated data provided by those who were active in the program. The data shows that those who were most served were Latinos. This is congruent with the programs target population, as well as county wide demographic data that shows that Latinos from this region experience mental health challenges at a higher rate than other ethnic groups.



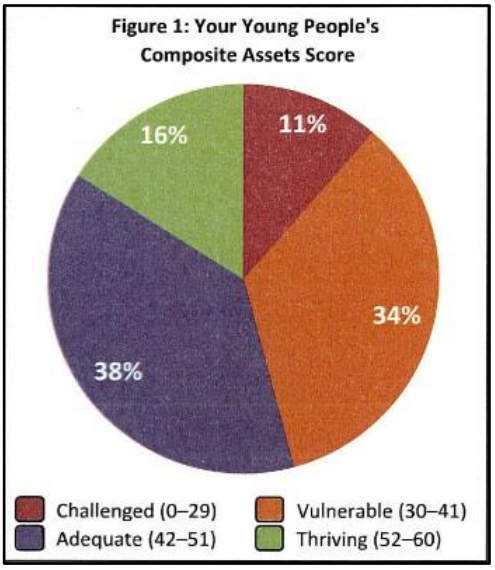

## OUTCOMES

Project SUCCESS tracks outcomes via the Developmental Asset Profile that is filled out by the students and analyzed by the Search Institute. The Developmental Asset profile incorporated 40 developmental assets framework that addresses the needs of young people in the community. This survey focuses on understanding the strengths and supports (or Developmental Assets) that young people experience in their lives. These assets are tied to young people making positive life choices. Research has shown that youth with higher level of assets are more likely to; do better in school, be prepared for post-high school graduation and careers, contribute more to their communities and society and avoid high risk behaviors, such as violence, substance abuse and sexual activity.

## COMPOSITE ASSETS SCORE

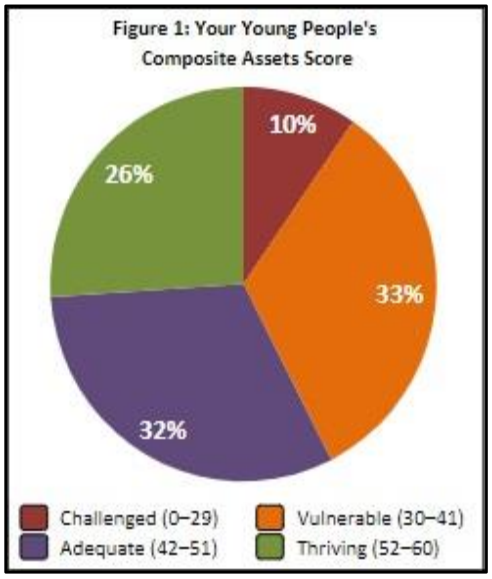
This score shows the percentage of youth who fall into four levels based on their survey results, each score is out of 60: challenged (0-29); vulnerable (30-41); adequate (42-51); and thriving (52-60).

**FY 16/17**




54% of the youth scored in the adequate and thriving level, and about 11% of the youth scored as challenged. This composite score sheds light on the foundation of assets that youth have. A further look at the data suggests that the groups that have the lowest composite scores are Latinos (40.3) as well as 8th graders and 11th graders which mark years of transition.

**FY 17/18**




58% of the youth scored in the adequate and thriving level, and about 1-% of the youth scored as challenged. A further look at the data suggests that the groups with the lowest composite scores are Latinos (36.7) as well as 8th graders and 10th graders.

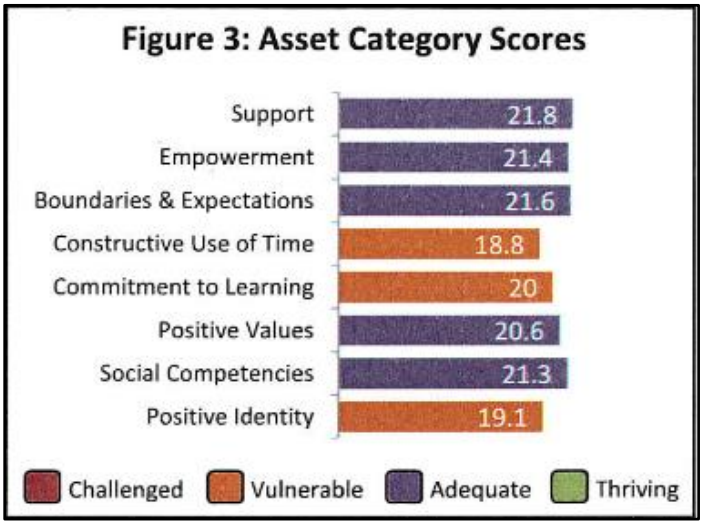
## ASSET CATEGORY SCORES

The framework of the Developmental Assets is organized into eight categories which are shown below. These categories represent key supports (external assets) and strengths (internal assets) that young people need to have and develop in order to thrive. The external assets are relationships and opportunities provided by family, school, and community. The internal assets are internal values, commitments, skills, and self-perception that young people develop within

themselves that lead to self-regulation, internal motivation, and personal character. A youth who can make positive life choices, need to have both external and internal assets.

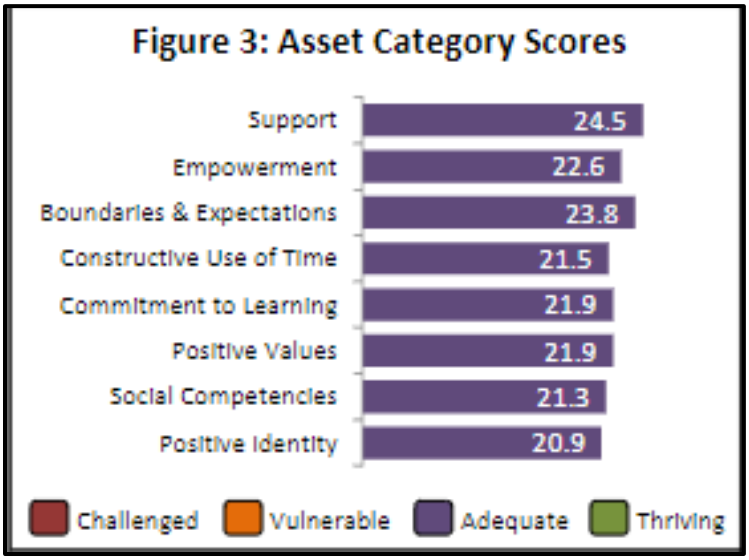
| THE EIGHT CATEGORIES OF DEVELOPMENTAL ASSETS | |
|---|---|
| **External Assets** | **Internal Assets** |
| **SUPPORT**<br>Young people need to be surrounded by people who love, care for, appreciate, and accept them. | **COMMITMENT TO LEARNING**<br>Young people need a sense of the lasting importance of learning and a belief in their own abilities. |
| **EMPOWERMENT**<br>Young people need to feel valued and valuable. This happens when youth feel safe and respected. | **POSITIVE VALUES**<br>Young people need to develop strong guiding values or principles to help them make healthy life choices. |
| **BOUDARIES AND EXPECTATIONS**<br>Young people need clear rules, consistent consequences for breaking rules, and encouragement to do their best. | **SOCIAL COMPETENCIES**<br>Young people need the skills to interact effectively with others, to make difficult decisions, and to cope with new situations. |
| **CONSTRUCTIVE USE OF TIME**<br>Young people need opportunities—outside of school—to learn and develop new skills and interests with other youth and adults. | **POSITIVE IDENTITY**<br>Young people need to believe in their own self-worth and to feel that they have control over the things that happen to them. |

**FY 16/17**




The survey results show that the relative areas of strength are Support, Boundaries and Expectations. The areas that are not as strong are Positive Identity, Commitment to Learning, and Constructive Use of time. When analyzing the data more closely, Latino youth struggle with Positive Identity the most.

**FY 17/18**




The survey showed that the relative areas of strength are Support and Boundaries and Expectations. The categories that are not as strong are Social Competencies and Positive Identity. When analyzing the data more closely, Latinos continue to struggle with Positive Identity more so than any other asset category.

Project SUCCESS has increased the composite asset scores as well as the asset category scores for the past two years. These results show that the foundations for youth assets is continuing to strengthen as youth go through the program. Puente was also able to extend their programs to all 5th to 12th graders in the school districts of Pescadero and La Honda, which gives the agency the potential to touch all the students in these school districts.

## QUALITATIVE DATA

Our families struggle with domestic violence, sexual abuse, family drug and alcohol abuse, and for many of our migrant families who are monolingual Spanish, their children learn English and are then expected to take on enormous amounts of responsibility. Our programs give families access to tools like mental health, referrals, and parent education in their own communities.

## SEEKING SAFETY

Seeking Safety is a curriculum that focuses on environmental and treatment solutions for substance use and Post-Traumatic Stress Disorder and relies on strong case management direction and referrals to community resources. Seeking Safety groups address the needs of this age group by utilizing a developmental framework that provides general supports for young adults, such as safety, relationship building, youth participation, community resources, and skill building. By incorporating these practices into the group framework, youth learned to build upon internal and external assets which are essential for a healthy transition to young adulthood. The age group for this program is Transitional Age Youth 18 to 25.

### METHODS

Seeking Safety is an evidence-based program that is a present-focused model to help people attain safety from trauma and/or substance abuse. It is a safe model as it addresses both trauma and substance use, but without requiring clients to delve into trauma narrative.

### PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

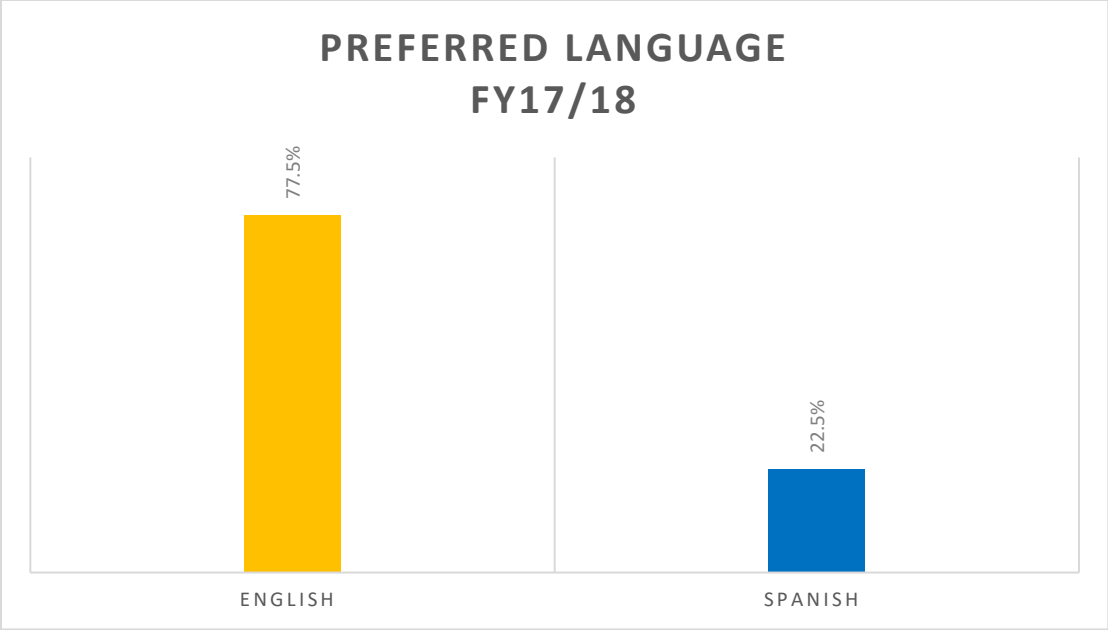
### PROGRAM HIGHLIGHTS

113 clients served

265 groups were held serving TAY

### DEMOGRAPHIC DATA

Seeking Safety served 113 youth in fiscal years 16/17 and 17/18. They did not collect any race/ethnicity demographic data for the dates that this report covers. Additionally, the Seeking Safety program was ended in June 2018. From preliminary data shared with us, most of the participants identified as cis gendered male.

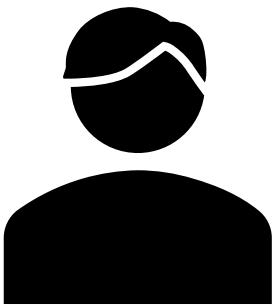



The language preference data shows that most of the participants were English speaking, however over 20% were Spanish speakers. When looking closely at the data, most of the Spanish speakers accessed this program in Redwood City versus Halfmoon Bay. In FY 16/17 the data read that in Redwood City 70% of participants were bilingual and in Halfmoon Bay 100% were bilingual.

## OUTCOMES

This program was able to provide us with only qualitative data for their evaluation in the form of a client story.

### QUALITATIVE DATA



Mark is a 24-year-old, single, Latino male. He had multiple arrests including, felonies. He went to El Centro to receive treatment for his substance abuse to methamphetamines, heroin, cannabis, and alcohol.

He attained abstinence form all drugs through treatment and guidance of the program. He signed up for college courses, re-established relationships with his family and found housing as well as employment.

After 10 months he completed his outpatient program, and both his Fall and Spring college courses with passing grades. Has strengthened his relationship with his family and has built a foundation for recovery.

"The encouragement, support and guidance that he received at El Centro have empowered him and enabled him to build a stronger foundation for himself"

## TEACHING PRO SOCIAL

The purpose of TPS is to help elementary school children learn pro-social skills to improve their social and behavioral functioning in school. TPS serves children in San Mateo County where Family Resource Centers (FRC) are located, and these centers include mental health programming. FRC's are available at schools that have high needs among the student population and a lack of other resources available to the broader community. Underserved students face greater academic and social struggles and benefit from a pro social skills group that is culturally sensitive.

### METHODS

TPS is a ten-week program that uses "skill streaming" an evidence-based, social skills training program designed to improve students' behaviors, replacing less productive ones.

### PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

Non-Stigmatizing and Non-Discriminatory Practices

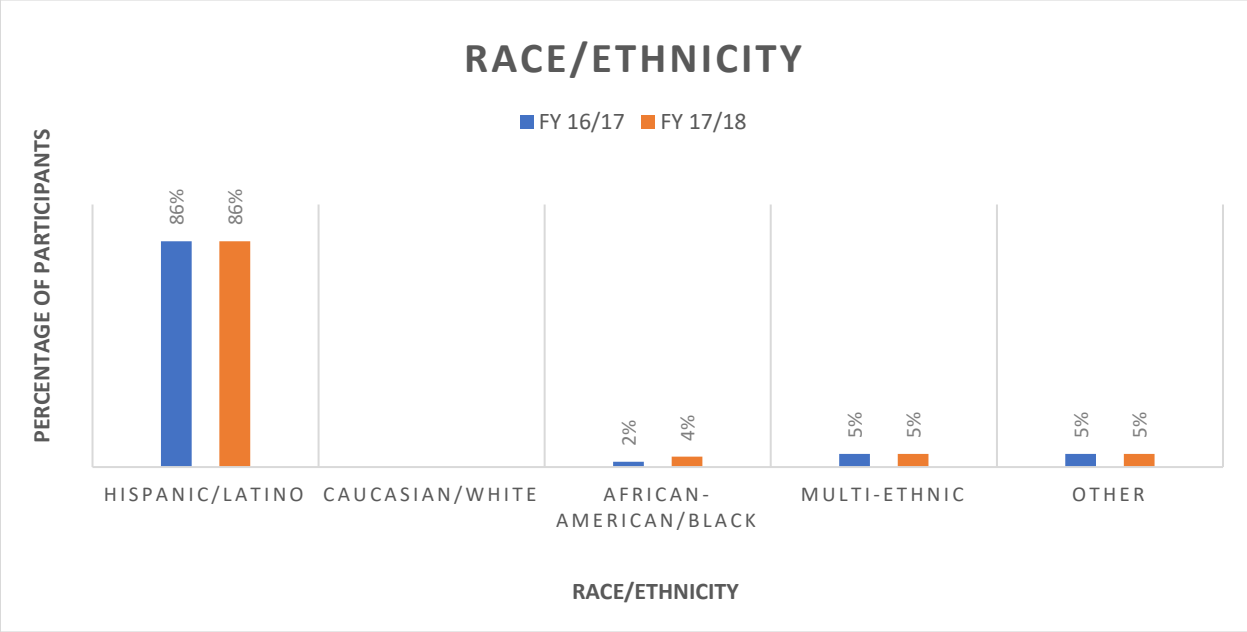
## PROGRAM HIGHLIGHTS

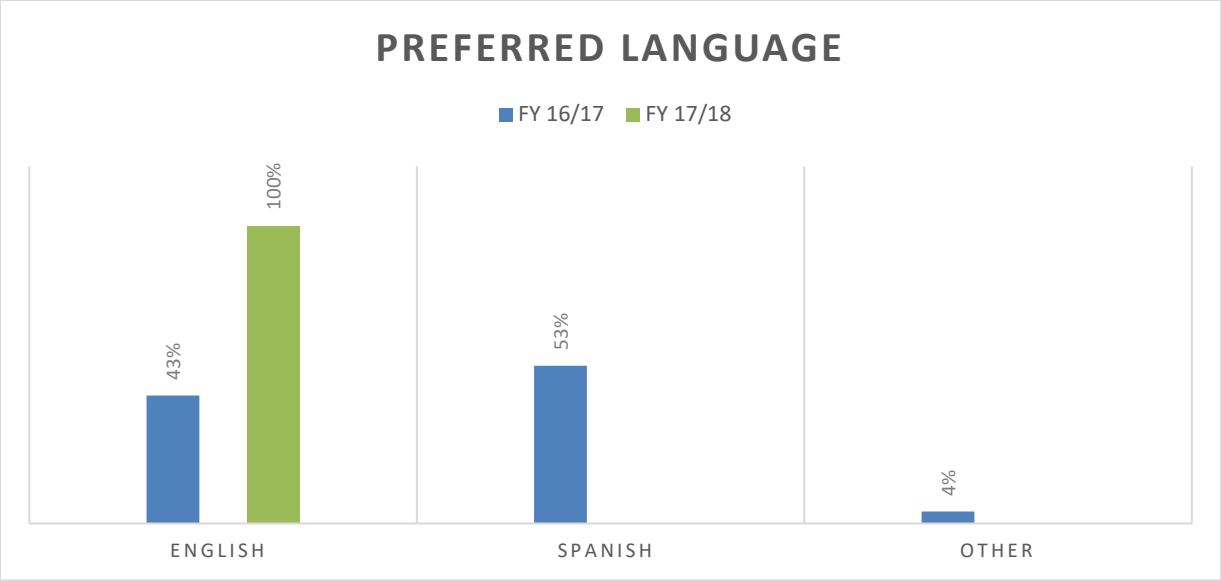
132 clients served

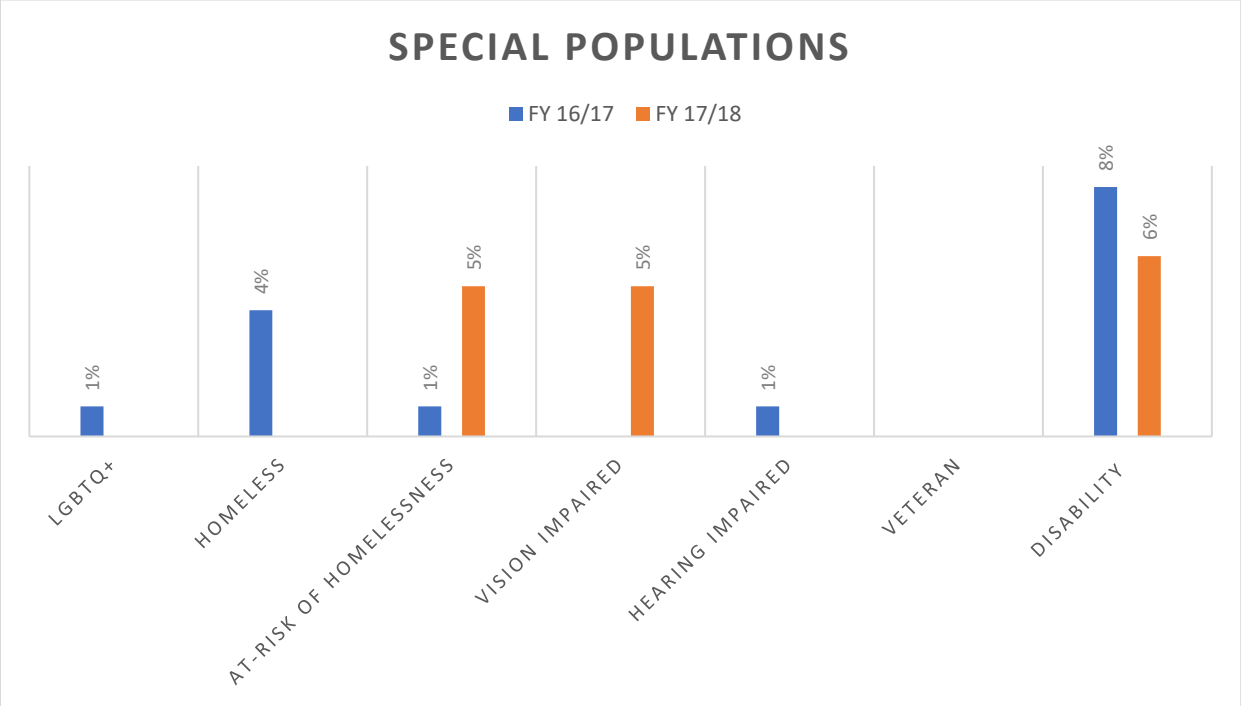
28 groups implemented at family resource centers

## DEMOGRAPHIC DATA

TPS served 152 clients in fiscal years 16/17 and 17/18. The demographic data in this section represents unduplicated data provided by those who were active in the program. The data shows that those who were most served were Latinos. Additionally, in fiscal year 16/17 there was more of a demand for Spanish sessions. TPS is implemented by bilingual staff. The most prevalent special populations were homeless, risk of homelessness, and those with a disability.





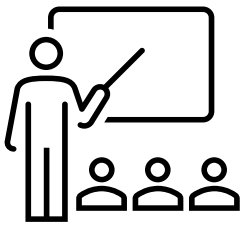




## OUTCOMES

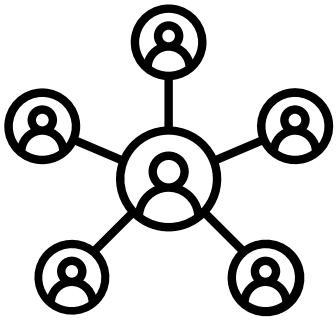
Students are referred to TPS by their teachers, who fil out the streamlining teacher behavior checklist. This tool is a 60-item survey that asks teachers to rank 60 positive behaviors, then based off this survey the curriculum for the groups are implemented in a series of six to ten sessions each semester. The teachers choose their top 10 social skills from the survey and they pretest their students in each skill included in the curriculum and then fill out a post-test after. Satisfaction surveys are also used, for the parents and teachers.

## GROUPS

| Family Resource Center Site | Number of groups | | Number of Participants | |
|---|---|---|---|---|
| | FY 2016/2017 | FY 2017/2018 | FY 2016/2017 | FY 2017/2018 |
| **Taft** | 1 | 1 | 4 | 4 |
| **Hoover** | 3 | 1 | 14 | 3 |
| **Fair Oaks** | 1 | 1 | 4 | 6 |
| **Belle Haven** | 3 | 4 | 0 | 23 |
| **Brentwood** | 2 | | 9 | |
| **Bayshore** | 2 | 2 | 13 | 12 |
| **Sunset Ridge** | 2 | | 13 | |
| **LEAD** | 3 | | 19 | |
| **Puente** | | 2 | | 8 |
| **Total** | 17 | 11 | 76 | 56 |



Lead facilitators observed significant behavior changes among students in areas of: understanding and coping with their feelings, dealing with anger, apologizing, empathy and self-control. Improvements in scores between pre and post test indicate progress for the majority of participants

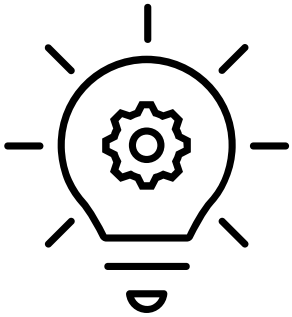


Consistent communication among facilitators, teachers, school staff, and parents

Positive behavior changes such as friendship making skills, and aggression

TPS homework was completed with more frequency due to higher parent involvement

### FEEDBACK



- Teachers requested that groups be provided more frequently such as twice per week and held at varied times so a student would not miss too much for one class
- Weekly emails informing teachers what skill was taught that week so they could support the skill in class

### POSSIBLE OUTCOME METRICS

- Improve performance in school
- Increase awareness of mental health wellness and recovery
- Reduce stigma

## YOUTH CRISIS RESPONSE & PREVENTION

The Crisis Intervention & Suicide Prevention Center (CISPC) has four components with the sole purpose of providing crisis and suicide support to all ages of the SMC community. The four components include: a 24/7 Crisis Hotline, a youth website and teen chat service, outreach and training and mental health services. This team employs both early intervention (70%) and prevention (30%).

### METHODS

Youth Crisis Response and Prevention is an evidence-based practice withs components embedded that are promising practices.

### PROGRAM STRATEGIES

Create Access to Linkage and Treatment

## PROGRAM HIGHLIGHTS

277 new cases for case management consultation

388 sessions provided for case management/follow up consultation

21,721 calls received and answered

139 interventions with new youth

## DEMOGRAPHIC DATA

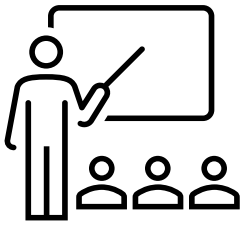
Youth Crisis Response and Prevention did not report any demographic data for FY 16/17 or 17/18.

## OUTCOMES

The CISPC program impacts the health outcomes of clients served in several ways including; the reduction of stigma, talking non-judgmentally about mental illnesses, mitigating undiagnosed mental illnesses, prevention and early recognition for youth, and suicide prevention. Below is the quantitative data recorded for delivery of each service.

| CASE MANAGEMENT/FOLLOW-UP PHONE CONSULTATION (youth and adults) | FY 16/17 | FY 17/18 |
|---|---|---|
| # of new cases | 132 | 145 |
| Total # of sessions provided | 202 | 186 |
| **YOUTH OUTREACH INTERVENTIONS (evaluations at school sites)** | | |
| # of initial interventions (new youth served) | 91 | 48 |
| # of follow up sessions with youth | 165 | 131 |
| # of follow up contacts w/ collateral contacts | 154 | 226 |
| **CLINICAL TRAINING/SUPERVISION (youth and adults)** | | |
| hours provided (including prep. time) | | 77 |
| number of trainings attended | | 11 |
| **CRISIS HOTLINE & CHAT ROOM** | | |
| Number of calls | 10574 | 11147 |
| Total Number of Chatters (group &/or private) | | 2 |
| Teen Chat Room # of Private Chats this month | | 115 |

| OUTREACH PRESENTATIONS | | |
|---|---|---|
| # of presentations | 72 | 90 |
| # of people served | 5609 | 8533 |
| School-Community Training in Suicide Prevention (# of presentations, the number served is captured on separate worksheet) | 70 | 81 |



Reduction of stigma associated with mental illness through psychoeducational presentations, working with clients in crisis, and conversations with hotline callers

## QUALITATIVE DATA

A mother called the mental health clinician concerned about her adolescent son who was suicidal. The clinician assessed the child and began short term therapy when it was clear there was no immediate risk. His main source of stress was school, he needed an IEP. The clinician helped him and his mother through that process. His suicidal thoughts decreased to zero.

College student called the hotline in distress and shared how she was struggling and the self-harm she was inflicting on herself because of stress. Volunteer was able to offer support, and tools. The caller was able to feel better and expressed her gratitude with the service.

## POSSIBLE OUTCOME METRICS

- Increase access to timely care
- Increase access to early mental health services
- Reduce stigma

## EARLY INTERVENTION

The following programs are Early Intervention programs. These programs provide treatment and other services and interventions including relapse preventions, to address and promote recovery and related functional outcomes for a mental illness early in its emergence. Programs in this category include emergency response teams, referrals, as well as programs.

**Early Intervention**

- Early Psychosis Program- Re(MIND)/BEAM
- Primary Care Interface
- SMC Mental Health Assessment and Referral Team

**9347** Clients served

## EARLY PSYCHOSIS PROGRAM-RE(MIND)

Re (MIND) identifies and intervenes with individuals experiencing a recent onset episode of psychosis. By intervening early with evidence based, culturally responsive, and comprehensive assessment and treatment, the impact of psychosis can be transformed and treated to remission. The program provides treatment and support for the client and family through an intensive outpatient model of care.

### METHODS

Early Psychosis- Re (MIND)/BEAM integrated five evidence-based practices into a single treatment approach.

### PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

Non-Stigmatizing and Non-Discriminatory Practices

## PROGRAM HIGHLIGHTS

214 clients served

3,271 sessions of Cognitive Behavioral Therapy for Early Psychosis (CBTp)

538 sessions of Family Support Services

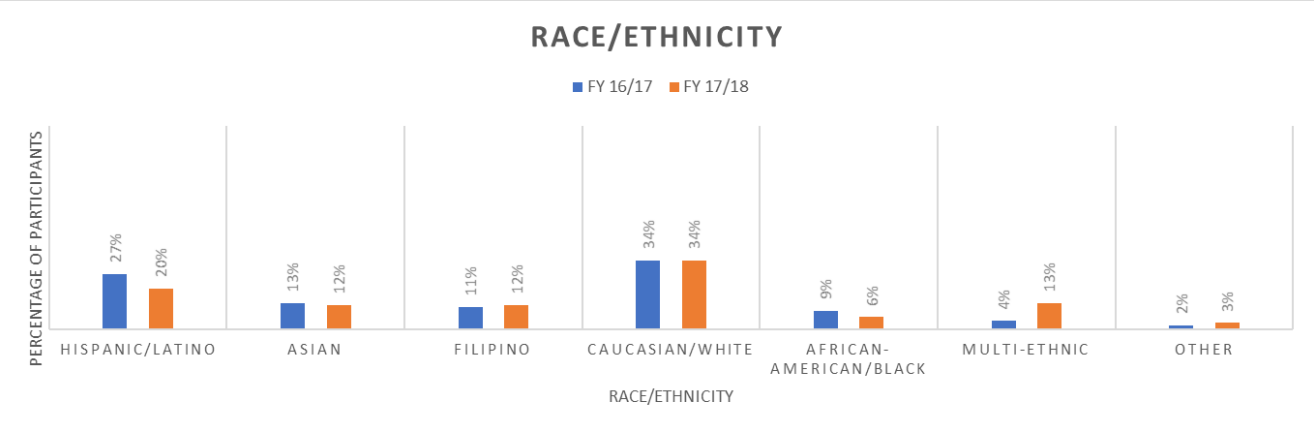
645 sessions of Peer Support Services

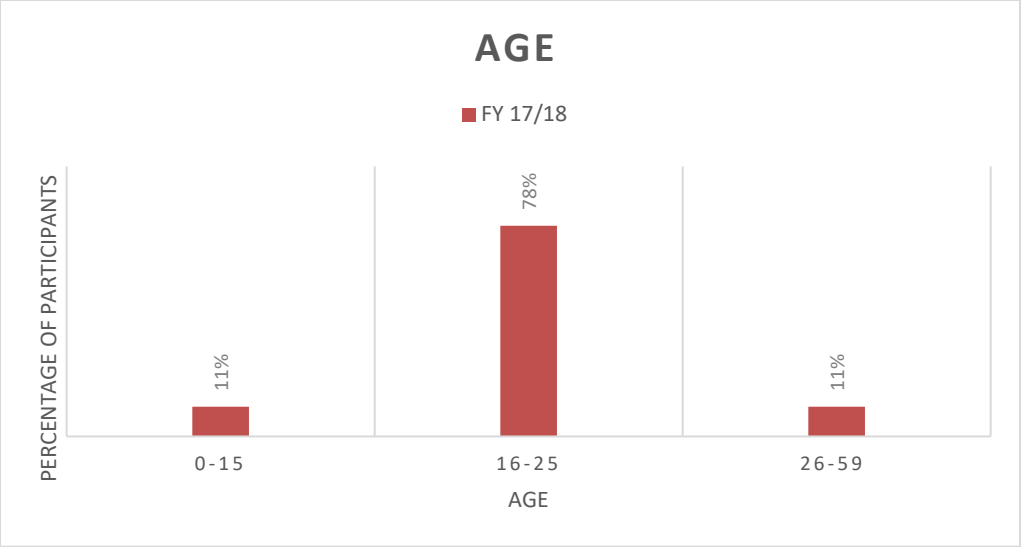
1,568 sessions of Education/Employment & Case Management

830 medication management consultations

## DEMOGRAPHIC DATA

Re (Mind)/BEAM served 214 clients in FY 16/17 and 17/18. The racial group that is most represented in services are the Caucasian/white population. Most clients were 16-25 years old.



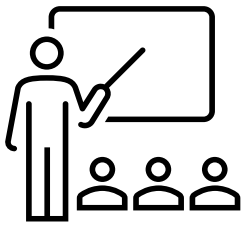



## OUTCOMES

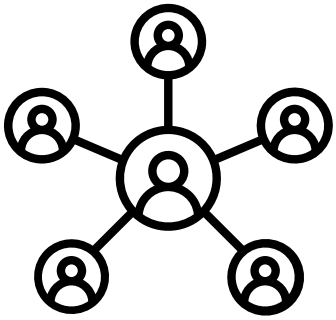
The BEAM program is evaluated via a series of surveys that include, California Department of health Care Services Consumer Perception Survey to evaluate participants satisfaction and quality of life. Hospitalization data are collected through the county database (AVATAR) and entered into Felton's EHR database. Medication adherence and symptom reduction data is collected using the Adult Needs and Strengths Assessment (ANSA). Supportive Employment and Education Services (SEES) are tracked via an internal tracker to provide education and employment data for participants. SEES staff and Director work to update the spreadsheets and database monthly. As seen below the PREP program was changed to BEAM halfway through 17/18. However, both programs saw positive outcomes in hospitalization reduction, medication adherence increase, vocational and educational engagement, and service satisfaction.

Overall, the outcomes show that clients who participate in this program experience reduced acute hospitalizations, increase their medication adherence, and can engage in part time or full-time school or work. Additionally, the great majority are satisfied with services and report an increase in quality of life due to this program.

| Evaluation Metrics | 16/17 | Prep 17/18 | BEAM 17/18 |
|---|---|---|---|
| **Hospitalizations** | | | |
| Participants with prior hospitalizations (12 months from enrollement) that experienced a reduction in acute hospitalizations within the first 12 months of | 59% | 53% | 93% |
| Participants experienced a reducation in days hospitalized | 59% | 56% | 60% |
| Participants with no history of hospitalizations (12 months from enrollment) that continued to not have hospitalizations within the first 12 months of engagement | | 19% | 40% |
| **Employment and Educational Engagement** | | | |
| Participants engaged in part-time or full-time work during their first year of treatment | 44% | 86% | 87% |
| **Medication Adherence** | | | |
| Participants that either imporved or maintained high medication adherence with an ANSA score of 1 or 0 | 71% | 69% | |
| **Symptom Reduction** | | | |
| Participants that demonstrated an improvement or maintained low symptom serverity in psychosis | | | 47% |
| Participants that demonstrated an improvement or maintained low symptom serverity in depression | | | 80% |
| **Service Satisfaction** | | | |
| Agreed or strongly agreed that they found services to be satisfactory | | 96% | 100% |
| Agreed or strongly agreed that as a direct result of services they received they feel more effective at handling daily life | | 78% | 100% |



Implementation of a Quarterly Community Advisory Board that has met three times and included participation of family members and staff. Board gives stakeholders the opportunity to inform the service delivery system and better meet the needs of the community especially cultural needs



Development of new peer and family activity groups to foster connection and recovery. Additional weekly social networking/ activity group and biweekly teen and adult peer support group.

## PRIMARY CARE INTERFACE

Primary Care Interface focuses on identifying persons in need of behavioral health services in the primary care setting. BHRS clinicians are embedded in primary care clinics to facilitate referrals, perform assessments, and refer to appropriate behavioral health services if deemed necessary. The model utilizes essential elements of the IMPACT model to identify and treat individuals in primary care who do not have Serious Mental Illness (SMI) and are unlikely to seek services from the formal mental health system. This program also provides services to those with ACE coverage who otherwise would not be able to access these services. Services include harm reduction, psychoeducation, and motivational interviewing by case manager.

### METHODS

Primary care interface is an evidence-based practice that uses elements of the IMPACT model.

### PROGRAM STRATEGIES

Create Access to Linkage and Treatment

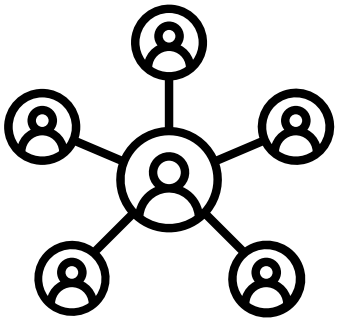
### PROGRAM HIGHLIGHTS

3,642 clients served

### DEMOGRAPHIC DATA

The Primary Interface program did not report demographic data for FY 16/17 and 17/18.

## OUTCOMES



In 16/17 620 clients were referred for co-occurring case management. They were referred directly from their PCP and assessed by an interface IMAT case manager

As a result of this service clients were able to reduce or abstain from the use of substances, reconnect with family, secure housing, or employment, and reduce symptoms of anxiety

In 16/17, 21 SMI clients were transferred to BHRS regional clinics

## POSSIBLE OUTCOME METRICS

- Improve access to linkages for services
- Reduce the number of hospitalizations
- Increase individual engagement in services/improve continuity of care

# SMC MENTAL HEALTH ASSESSMENT AND REFERRAL TEAM (SMART)

The SMART team are specially trained paramedics that are a part of the American Medical Response west. They are trained to respond to law enforcement Code 2EMS which are requests for individuals having a behavioral health emergency. The SMART paramedic performs the mental health assessment, places a 5150 hold if needed and transports the client to Psychiatric Emergency Services, or if they do not meet criteria another community resource such as a crisis residential facility, doctor's office, detox, shelter, home etc. This ensures increased connectivity and treatment for community members. Additionally, many individuals are more likely to be forthcoming with a psychologically trained medic about what they are experiencing as compared to law enforcement. This resource can only be accessed through the County's 911 system.

## METHODS

SMART is a promising practice that provides the SMC community with an alternative to law enforcement and having to go to the hospital for an assessment.

### PROGRAM STRATEGIES

Create Access to Linkage and Treatment

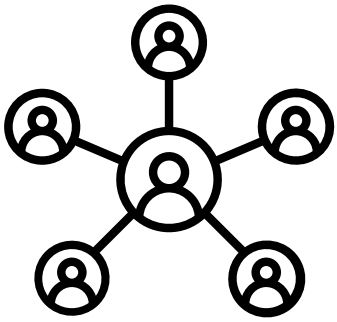
### PROGRAM HIGHLIGHTS

5,491 community members served

### DEMOGRAPHIC DATA

The SMART program did not report demographic data for FY 16/17 and 17/18. The demographic data that is collected is inputted into a database that is not readily accessible.

### OUTCOMES



AMR has successfully diverted 37.5% of calls, were a 5150 was not placed, the goal was to divert at least 10% of calls.

SMART has successfully responded to many people under 18, who are in crisis and the team is able to address the youth's concerns, provide supportive services and directly involve the parents

SMART is continuing to work and train law enforcement to wait before they place a 5150 hold.

### POSSIBLE OUTCOME METRICS

- Reduce the number of hospitalizations
- Improve access to linkages to services
- Increase individual engagement in services/improve continuity of care

### SYSTEM TRANSFORMATION

The SMART team continues to work alongside law enforcement and engages in training them when it comes to mental health emergencies. This move away from law enforcement always being involved in 5150 allows individuals who may have had traumatic experiences with law enforcement to feel more comfortable asking for help, staying safe and being placed appropriately. Additionally, instead of going to PES they are referred to a resource that fits their needs.

## ACCESS AND LINKAGE TO TREATMENT

The following programs provide access and linkage to treatment, they connect individuals with severe mental illness to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.

**Access and Linkage to Treatment**

- Ravenswood Family Health Center (40% CSS; 60% PEI)
- Senior Peer Counseling (50% CSS; 50% PEI)
- HEI Outreach Worker Program
- North County Outreach Collaborative
- East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) and East Palo Alto Behavioral Health Advisory Group (EPABHAG)

**16,123** clients served

## RAVENSWOOD FAMILY HEALTH CENTER

Ravenswood Family Health Center is a community based Federally Qualified Health Center (FQHC) that serves East Palo Alto residents. Ravenswood provides outreach and engagement services and identifies individuals presenting for healthcare services that have significant behavioral health needs. Many of the diverse populations that underserved, or underserved will more likely visit the doctor for a physical health concern. If Ravenswood identifies someone that could benefit from services, they provide a referral for SMI and SED clients to be seen in the county clinic.

### METHODS

This practice is evidenced based and a promising practice, it is not uncommon to see that physical and mental health services are integrated or offered in coordination with each other.

### PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

Non-Stigmatizing and Non-Discriminatory Practices

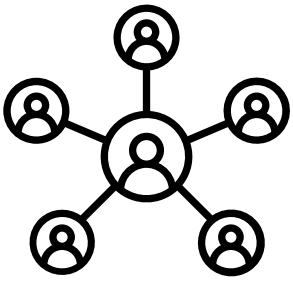
### PROGRAM HIGHLIGHTS

944 clients served

### DEMOGRAPHIC DATA

Ravenswood Family Health Center did not report demographic data for FY 16/17 and 17/18.

## OUTCOMES



944 clients served in FY 16/17 and 17/18

## POSSIBLE OUTCOME METRICS

- Increase access to care
- Increase awareness of mental health, wellness and recovery
- Improve participant engagement in services

# SENIOR PEER COUNSELING

The Senior Peer Counseling Program, recruits, and trains volunteers to serve homebound seniors with support, information, consultation, peer counseling, and practical assistance with routine tasks such as accompanying seniors to appointments, assisting with transportation, and supporting social activities.

### METHODS

This practice is evidenced based and a promising practice, it is not uncommon to see that physical and mental health services are integrated or offered in coordination with each other.

## PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

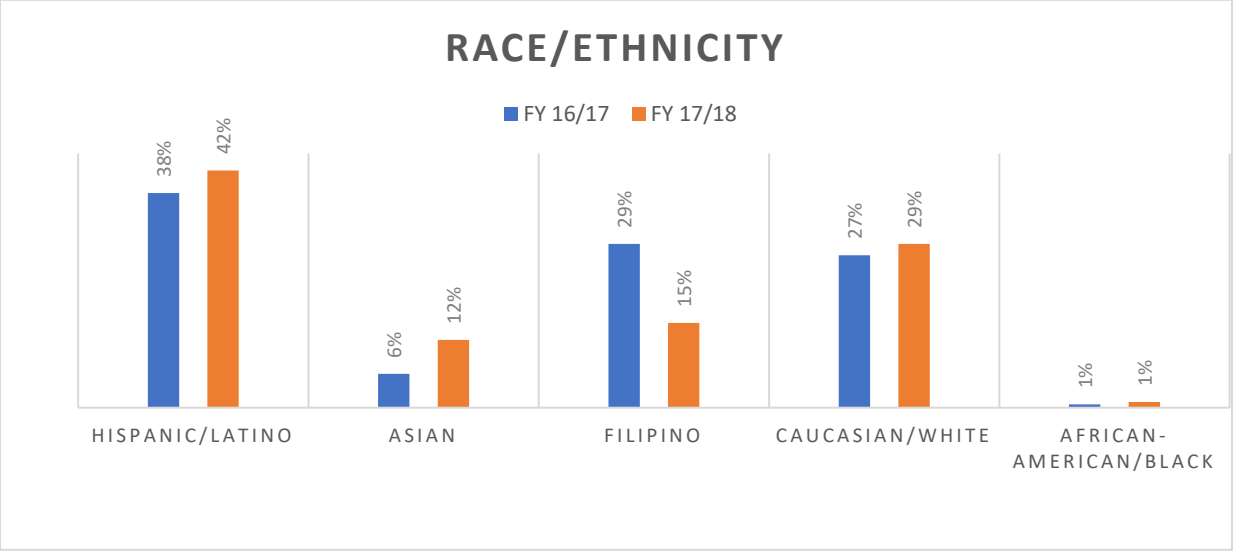
Non-Stigmatizing and Non-Discriminatory Practices

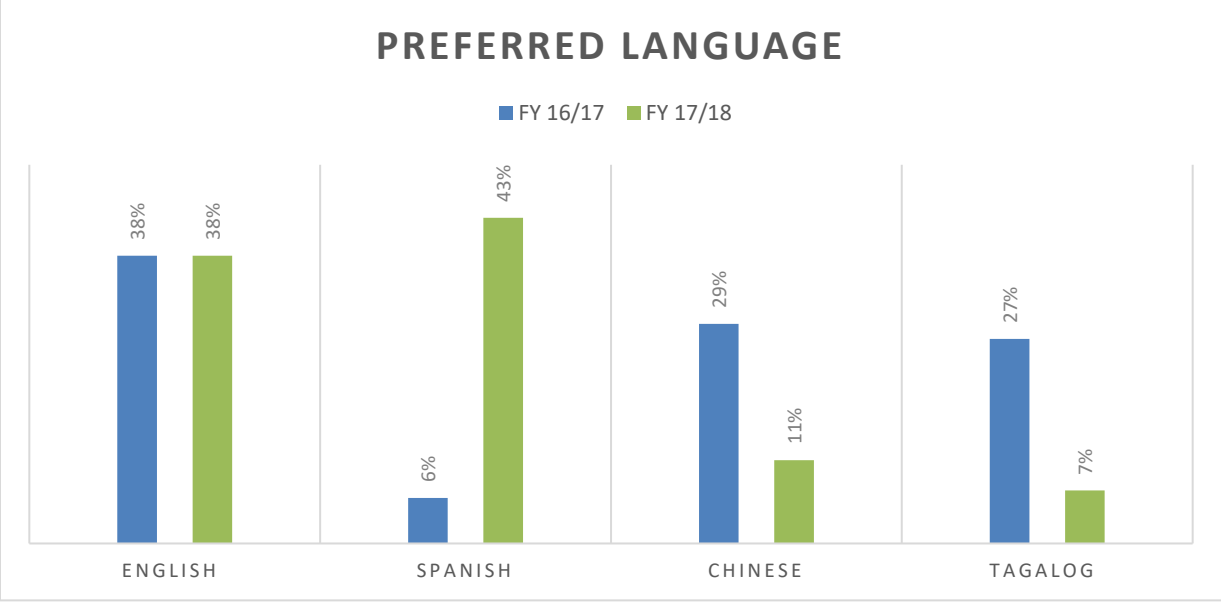
## PROGRAM HIGHLIGHTS

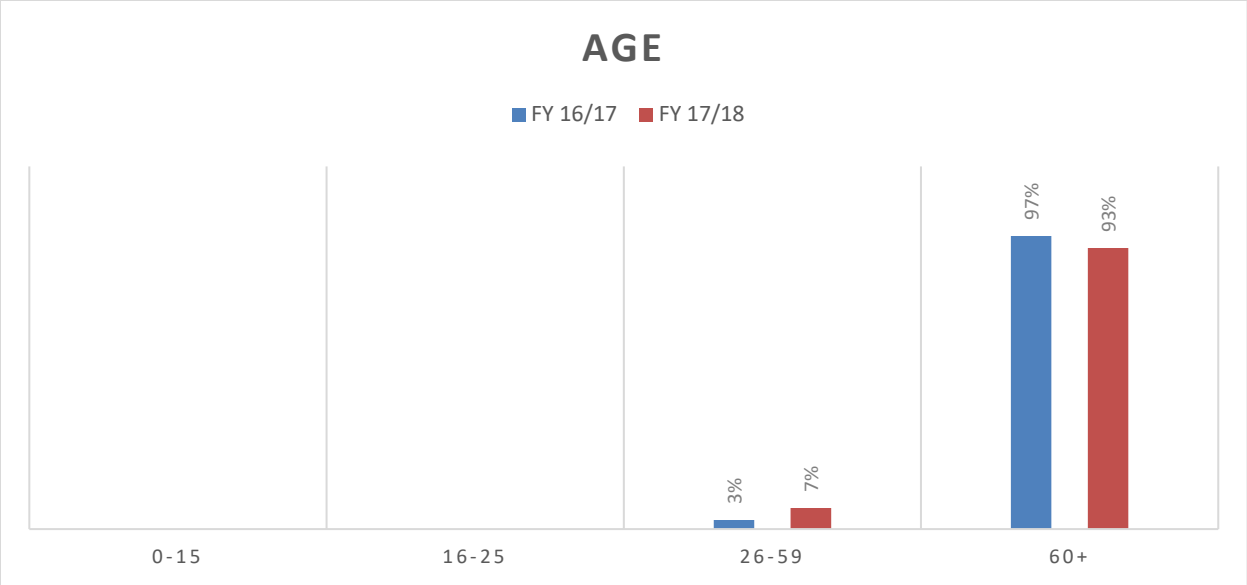
1032 clients served

## DEMOGRAPHIC DATA

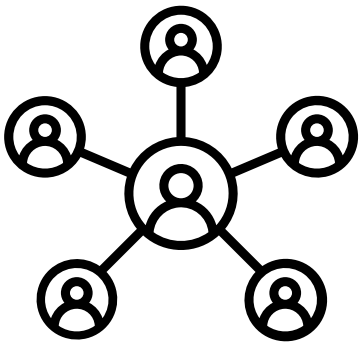
The Senior Peer Counseling program served a diverse population for FY 16/17 and 17/18 with the largest groups served being Latinos, Filipinos and Caucasians. The preferred languages included English, Spanish, Chinese, and Tagalog. The largest age group served were those who were 60 years and older.






## OUTCOMES



12 weekly support groups located in senior centers, senior housing, the PRIDE center etc.

Recruited 125 new peer counselors

Trained 72 new peer counselors, 104 counselors currently active

## POSSIBLE OUTCOME METRICS

- Improve access to linkages for services
- Reduce stigma
- Improve understanding of mental illness

## OUTREACH COLLABORATIVES

Community outreach collaboratives include the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) and the North County Outreach Collaborative (NCOC) This collaborative provides advocacy, systems change, resident engagement, expansion of local resources, education and outreach to decrease stigma related mental illness and substance abuse and increase awareness of and access and linkages to culturally and linguistically appropriate behavioral health, entitlement programs, and promote and facilitate resident input into the development of MHSA funded services

### PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

Non-Stigmatizing and Non-Discriminatory Practices

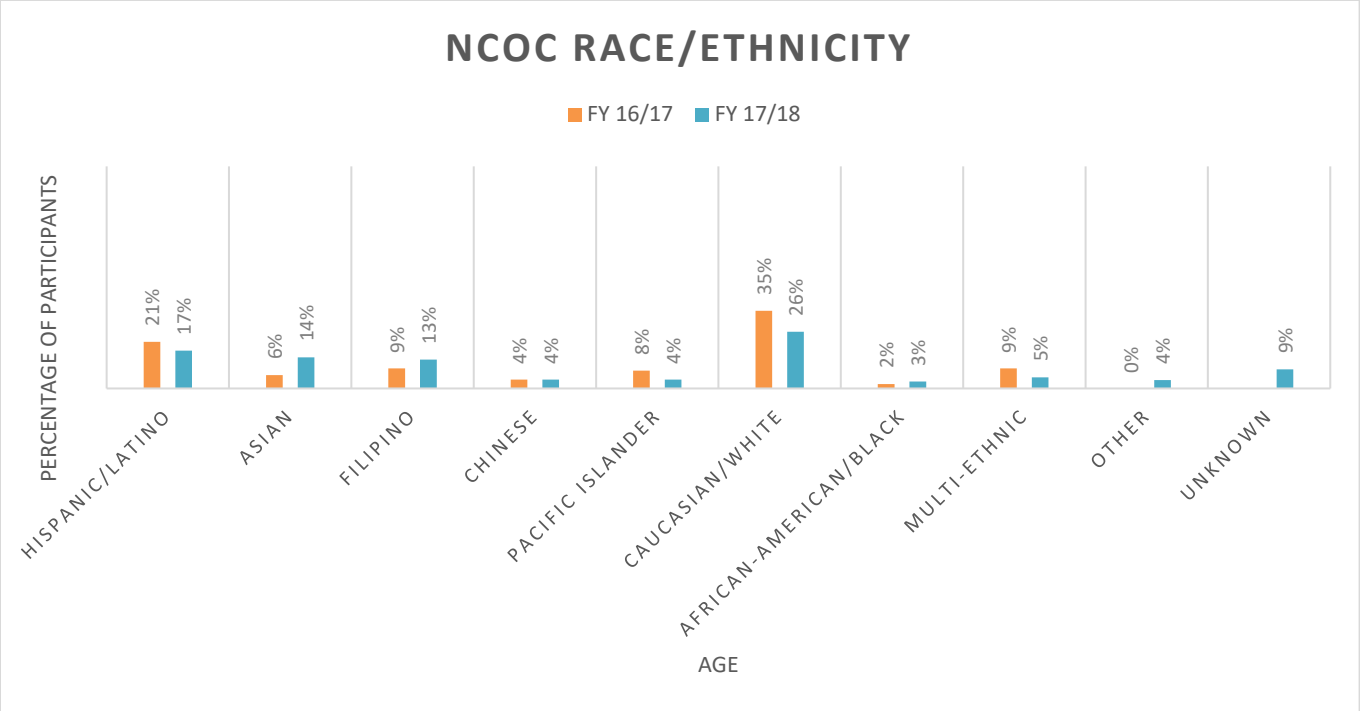
### PROGRAM HIGHLIGHTS

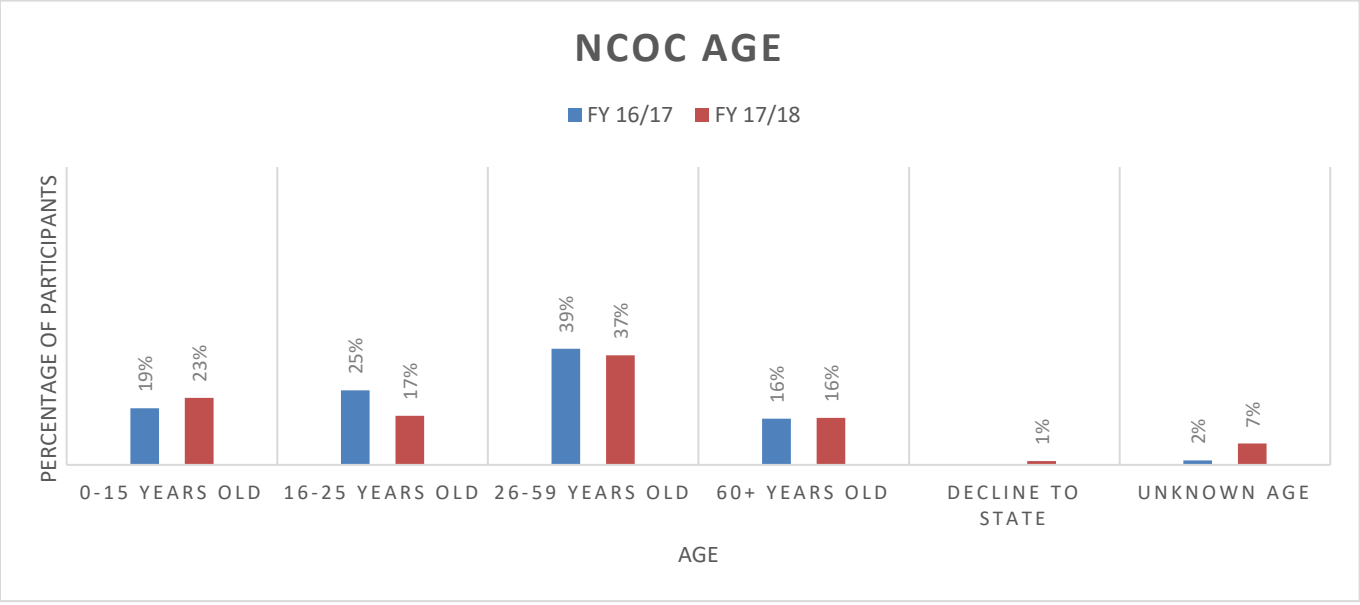
16,123 clients served

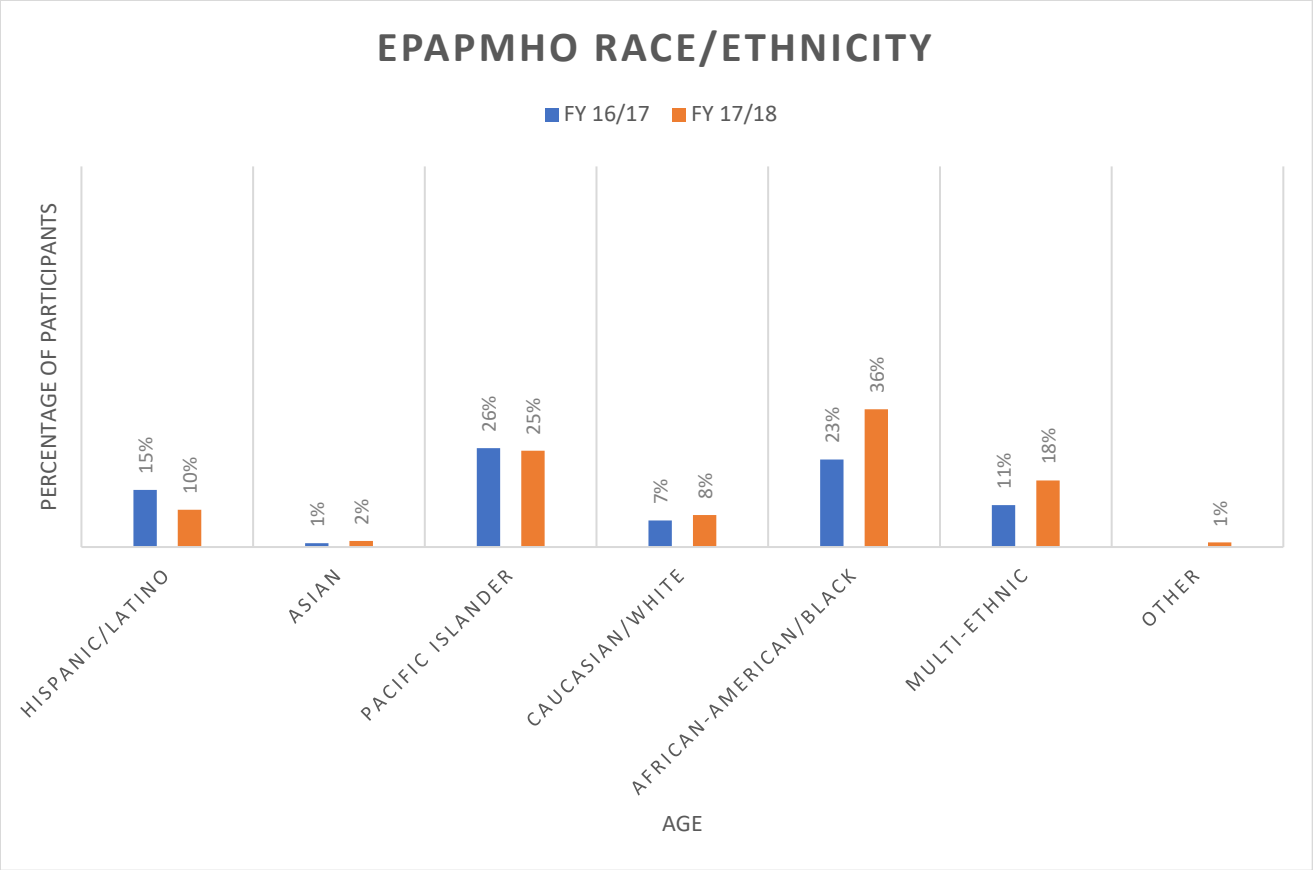
190 referrals to mental health services

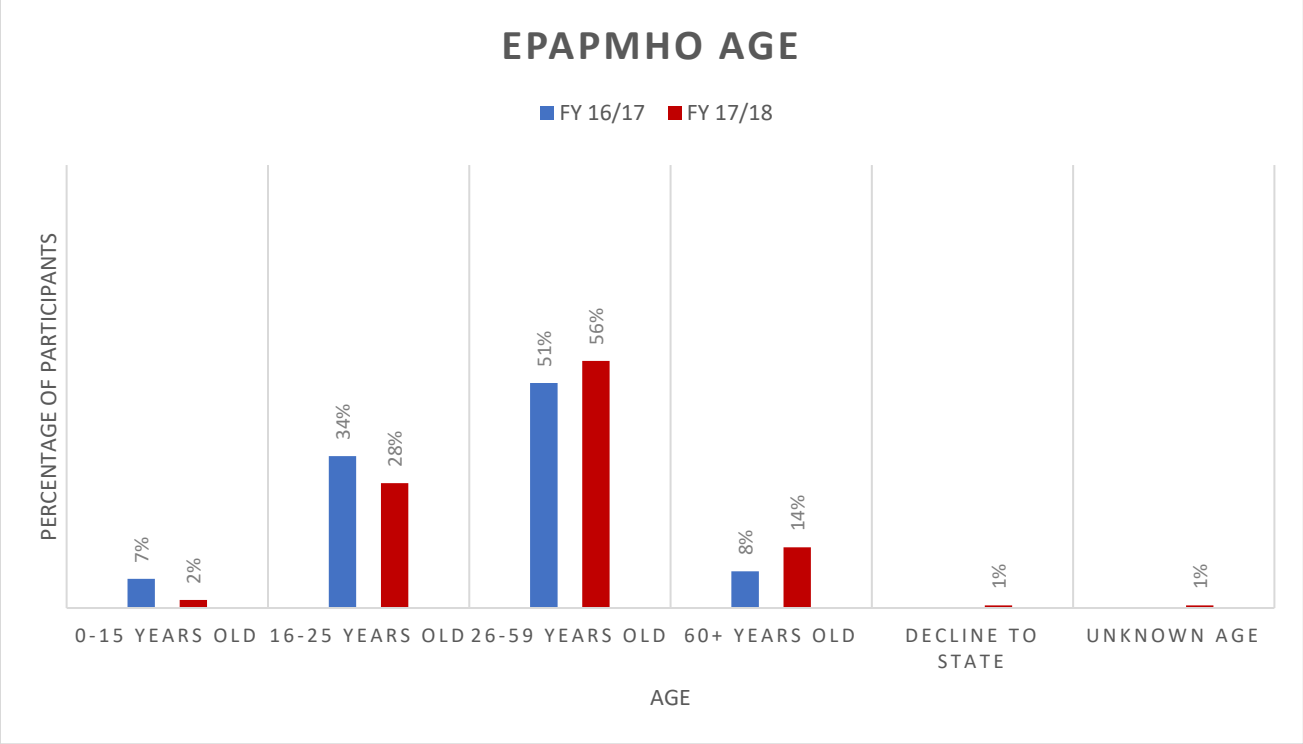
381 substance abuse referrals

## DEMOGRAPHIC DATA

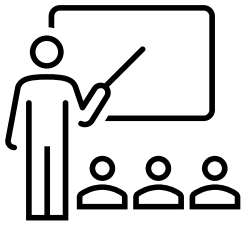


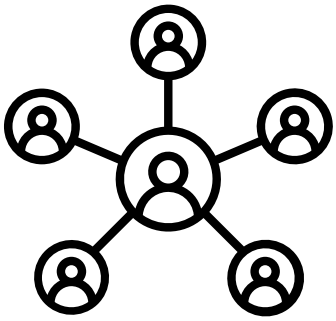

EPAPMHO RACE/ETHNICITY
FY 16/17
FY 17/18
PERCENTAGE OF PARTICIPANTS
15%
10%
1%
2%
26%
25%
7%
8%
23%
36%
11%
18%
1%
HISPANIC/LATINO
ASIAN
PACIFIC ISLANDER
CAUCASIAN/WHITE
AFRICAN-AMERICAN/BLACK
MULTI-ETHNIC
OTHER
AGE


EPAPMHO AGE
FY 16/17
FY 17/18
PERCENTAGE OF PARTICIPANTS
7%
2%
34%
28%
51%
56%
8%
14%
1%
1%
0-15 YEARS OLD
16-25 YEARS OLD
26-59 YEARS OLD
60+ YEARS OLD
DECLINE TO STATE
UNKNOWN AGE
AGE

## OUTCOMES



The outcomes of the outreach collaboratives are being impacted by less outreach being conducted due to gentrification, fear provoked by immigration policies and fear of deportation, and impact of drug MediCal on outreach cases.



Largest number of referrals given for social services by the NCOC were for housing, legal assistance, and food. For EPAPMHO they were medical care and housing.

Special population served by NCOC were at-risk of homelessness, veterans and homeless. Special populations served by EPAPMHO were homeless, and those at-risk of homelessness.

## QUALITATIVE DATA

A 17-year-old cis gendered male student from Brazil was referred to DCYHC for major depression, anxiety, and substance use. He started seeing a counselor. He disclosed his immigration status and a clinician worked closely with the school to create a safe place to speak about both immigration and his mental health.

## SYSTEM TRANSFORMATION

The outreach collaboratives are the front line to the community, they many times are from the community in which they work, they have rapport with community and they culturally identify with the population that they serve. Through the outreach collaboratives, and their data collection it becomes apparent the most pressing needs of the community. The most pressing social service referrals are around housing and that speaks to the cost of living in SMC, and concurrently the gentrification that continues in low income and unserved communities. This

information is vital to MHSA because it allows us to think of prevention in an upstream approach and see the social determinants of health such as housing, food access/insecurity and political climate as factors that affect the mental health of the community. It guides our efforts as we expand our programs, and ideas for new programming.

## PREVENTION

### OFFICE OF DIVERSITY AND EQUITY (ODE)

ODE is committed to advancing health equity in behavioral health outcomes of marginalized communities. The office was established in 2009 via dedicated MHSA funding allocated to address cultural competence and access to mental health services to underserved communities. This office demonstrates a commitment to understanding and addressing how health disparities, health inequities, and stigma impact an individual's ability to access and receive behavioral health and recovery services. ODE works to promote cultural humility and inclusion with the County's behavioral health service system and in partnership with communities. The following programs are housed under ODE:

**Prevention**

- **Health Equity Initiatives**
- **The Parent Project**
- **Health Ambassador Program**

**Recognition of Early Signs of MI**

- **Adult Mental Health First Aid**

**Stigma Discrimination and Suicide Prevention**

- **Digital Storytelling and Photovoice**
- **Stigma Free San Mateo County**
- **San Mateo County Suicide Prevention Committee (SPC)**

**6250** community members served

## METHODS

The **evidence-based programs** found under ODE are the following:

- The Parent Project
- Adult Mental Health First Aid
- Digital Storytelling and Photovoice

These three programs are curriculum-based programs with extensive research validating the effectiveness, and minimum modifications.

Programs that are a **promising practice** are the following:

- Health Ambassador Program- This program follows the ideology and evidence-based practice of a Promotora program with added trainings, workshops, and leadership development
- Health Equity Initiatives- There are nine initiative under ODE, they each represent groups that are typically underserved in mental health services. These nine meeting groups allow for community, providers, and contractors to come together and decrease stigma, educate and empower community members, support wellness and recovery and build culturally responsive services
- Stigma Free San Mateo County- Online social media campaign to raise awareness of mental health and substance use
- Suicide Prevention Committee- A workgroup that coordinates efforts to prevent suicide in SMC.

## ODE STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

Non-Stigmatizing and Non-Discriminatory Practices

## PROGRAM HIGHLIGHTS

5,000 community members served by the Health Equity Initiatives

The Pacific Islander Initiative created a communication campaign on social media about suicide and the images were shared 300 times and 6,000 people saw them

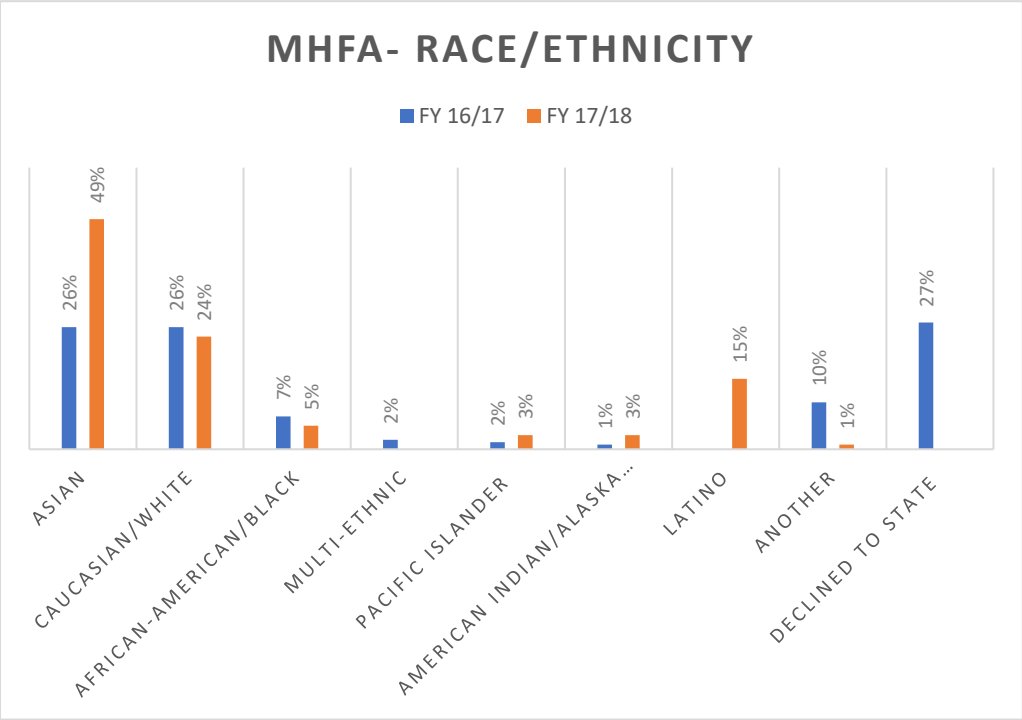
Parent Project reached 1,000 graduates

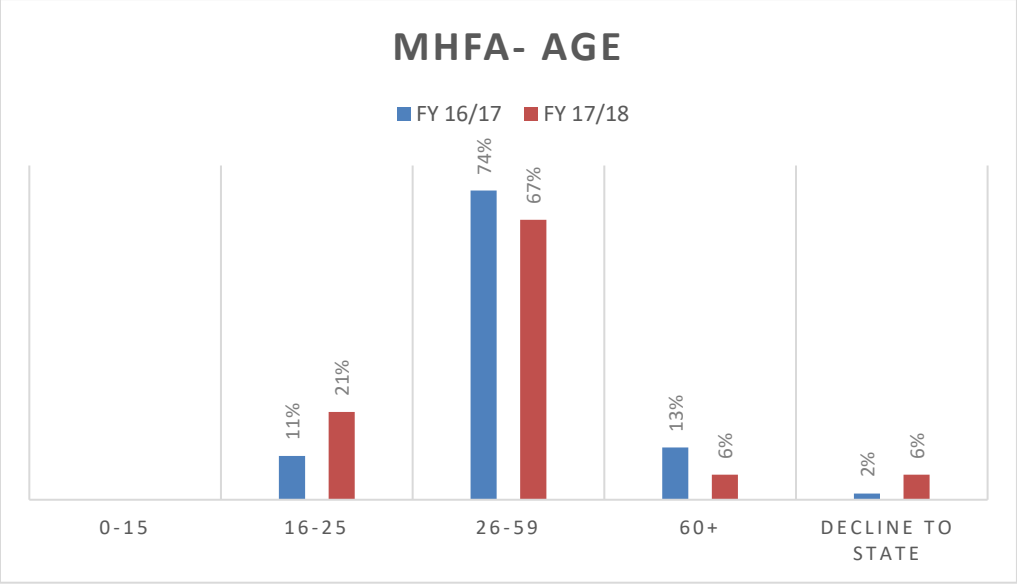
97% of Adult Mental Health participants feel confident to recognize and correct misconceptions about mental health, substance use and mental illness as they encounter them

## DEMOGRAPHIC DATA

Demographic data was not available for the Health Equity Initiatives, Health Ambassador Program, Digital Storytelling and Photovoice, Stigma Free San Mateo, and SMC Suicide Prevention Committee for FY 2016-17 and FY 2017-2018.

# MENTAL HEALTH FIRST AID






Additional demographic data was collected for the Mental Health First Aid program including, language, and disability status. However, these data points changed when the demographic form was updated, making them difficult to compare year to year.

## DIGITAL STORYTELLING & PHOTOVOICE

Demographic data was not collected for Digital Storytelling & Photovoice 16/17 was the startup year. Demographic started to be collected FY 18/19.

## EVALUATION FRAMEWORK

The Office of Diversity and Equity measures progress along 5 indicators. These definitions are influenced by (1) public health frameworks and (2) ODE's mission, values, and strategy.

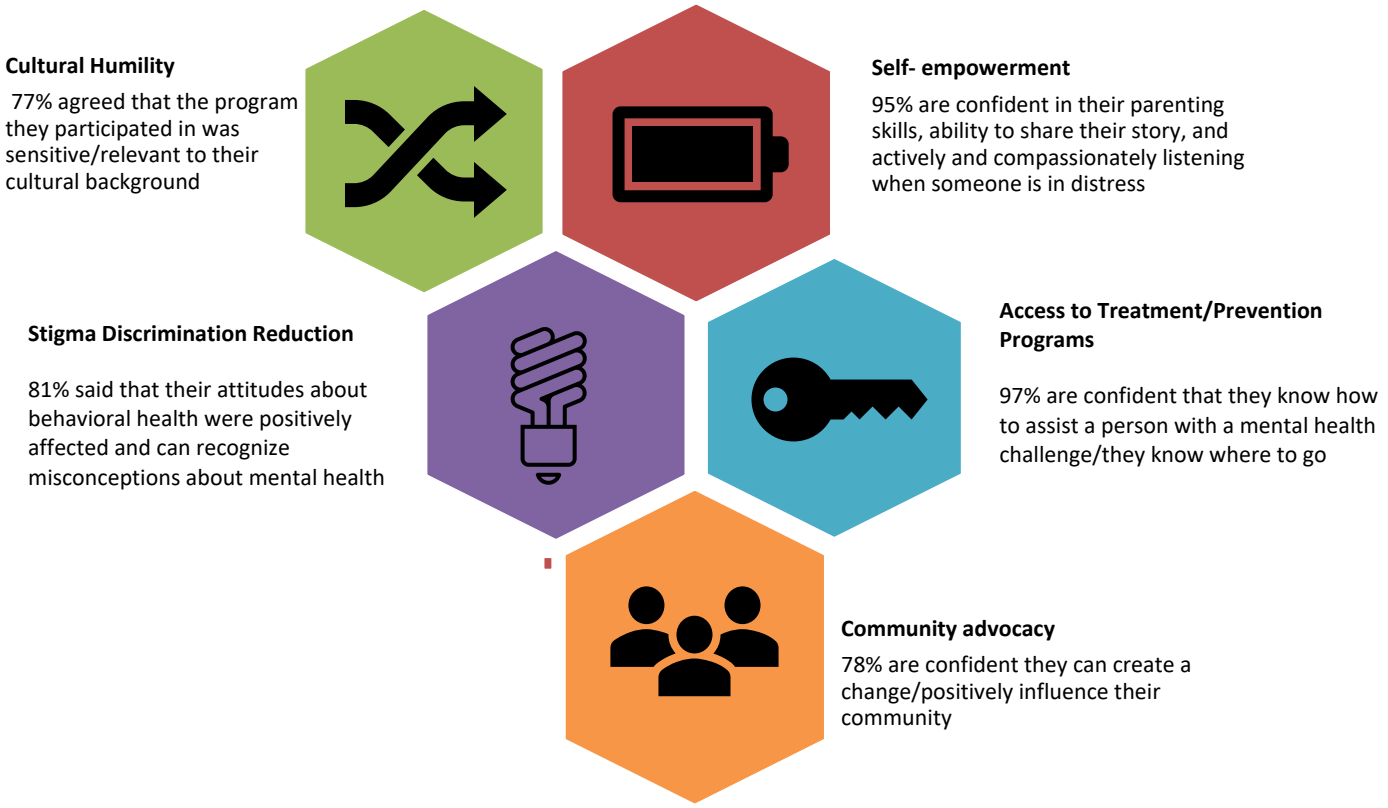
1. Self-Empowerment - enhanced sense of control and ownership of the decisions that affect your life
2. Community Advocacy- increased ability of a community (including peers and family members*) to influence decisions and practices of a behavioral health system that affect their community
3. Cultural Humility
    - heightened self-awareness of community members' culture impacting their behavioral health outcomes

- heightened responsiveness of behavioral health programs and services for diverse cultural communities serve

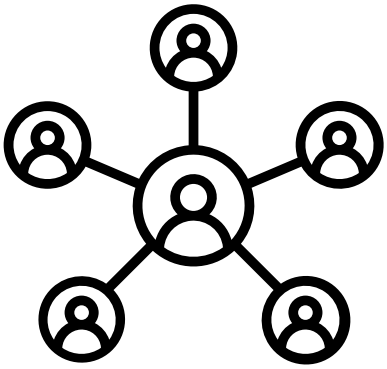
4. Access to Treatment/Prevention Programs (Reducing Barriers) - enhanced knowledge, skills, and ability to navigate and access behavioral health treatment and prevention programs despite potential financial, administrative, social, and cultural barriers.
5. Stigma Discrimination Reduction - reduced prejudice and discrimination against those with mental health and substance use conditions

## OUTCOMES

Implementation of the five evaluation indicators is currently being implemented with Adult Mental Health First Aid, The Parent Project, and Digital Storytelling and photovoice. Below are the results for the aggregated survey results across three of our evidence-based programs. All the programs will ultimately feed into these five indicators to measure impact of the Office of Diversity and Equity as a whole.



## PROGRAM SPECIFIC OUTCOMES



The HEI's hosted 156 events. These events included psycho-education workshops, trainings, community events, and ranged from attendance of 40 people to 1200.

More than 1,119 individuals have been trained in Adult Mental Health First Aid. Those trained have been teachers, leadership from Family Health services, Second Harvest Food Bank, Peninsula Library System, and students from San Mateo Adult School.

The Suicide Prevention Committee held 12 events in 2017 up from 1 event in 2016. Additionally, they held 7 gatekeeper trainings including ASIST, MHFA, QPR, Reconozca las señales (Spanish)

### QUALITATIVE DATA

**Parent Project**

"I was passing through one of those hardships in life when I learned about the Parent Project class. After enrolling and completing 12-week training, I knew that I needed to learn not only about parenting but also about behavioral health" – Client is now a HAP

**Storytelling Program**

"I like the way my story can help other succeed through the anxiety and depression we go through. Storytelling helps"

**Health Equity Initiatives**

"In collaboration with the Latino Collaborative and Spirituality Initiative, NIPI hosted a Drumming Circle. Participant stated feeling a calming effect and being open to drumming as tool for recovery.

**HAP Program**

"HAP has given me the tools to encourage other people to recognize the signs and symptoms of mental health and substance use"

## SYSTEM TRANSFORMATION

ODE is an integral part of BHRS in San Mateo County, it is the driver for many system transformation initiatives including the Government Alliance on Race and Equity which is an initiative that currently carried out within the Health System but is being expanded to all other county departments. Additionally, ODE is also tasked with leading the Multi-Cultural Organizational Development process which is internal to BHRS. MHSA being housed under ODE has allowed administrators to consider all funding through an equity lens, and this affects the way we conduct our needs assessments, hours of operation and events, co-location of services, as well as thoughtful inclusion of clients and families in decision making processes.