



County of San Mateo

Inter-Departmental Correspondence

Department: HEALTH

File #: 21-694

Board Meeting Date: 9/14/2021

Special Notice / Hearing: None
Vote Required: Majority

To: Honorable Board of Supervisors
From: Louise F. Rogers, Chief, San Mateo County Health
Scott Gilman, Director, Behavioral Health and Recovery Services
Subject: San Mateo County Mental Health Services Act Annual Update FY 2021-22

RECOMMENDATION:

Adopt a resolution authorizing the approval and submission of the San Mateo County Mental Health Services Act Annual Update FY 2021-22 to the State Mental Health Services Oversight and Accountability Commission and the Department of Health Care Services.

BACKGROUND:

In 2004, California voters passed Proposition 63, known as the Mental Health Services Act (MHSA), which made additional state funds available to expand and transform mental health services. Since 2006, MHSA resources and expenditures have been approved by the Board as part of the larger County Health budget. State legislation requires that the MHSA Annual Updates be approved by the County's Board of Supervisors. The Mental Health and Substance Abuse Recovery Commission (MHSARC) held a public hearing and voted to close a 30-day public comment on July 7, 2021 and is recommending approval of the MHSA Annual Update FY 2021-22 by your Board.

On August 4, 2020, your Board approved the MHSA Three-Year Program and Expenditure Plan for FY 2020-23 and Annual Update FY 2020-21.

DISCUSSION:

The MHSA Annual Update is intended to describe any changes to the programs and expenditures plans as was submitted in the MHSA Three-Year Plan.

Last year, the State budget projection included a decrease in MHSA revenues due to the COVID-19 pandemic. Given this uncertainty, our MHSA programs and expenditures for FY 2020-21 remained status quo and stakeholders identified and prioritized "housing for individuals living with mental health challenges" as a topic area to engage in deeper strategic planning and to develop recommendations for when revenues increase.

Actual revenue received in FY 2020-21 and future projections for MHSA came in higher than anticipated, which allowed for the following three key updates to the MHSA Three-Year Plan:

1. Housing Initiative Taskforce Funding Recommendations

Between March and May 2021, a Housing Initiative Taskforce was convened to define a housing continuum for individuals living with mental illness, identify housing gaps and recommend activities to fund in order to address prioritized housing-related outcomes. The taskforce members included 30 diverse stakeholders representing clients, family members, community-based behavioral health service providers and County departments including Behavioral Health and Recovery Services (BHRS), Aging and Adult Services, San Mateo Medical Center, Human Services Agency and the Department of Housing. MHSA funding available for the Housing Initiative Taskforce were identified in the amount of \$2.2 million ongoing and \$12 million one-time.

The recommendations include a one-time allocation of \$10 million over two years to the Department of Housing for the development of supportive housing units for BHRS clients and other ongoing supports such as homeless outreach, housing locator services, peer outreach and field-based services to increase client housing retention. The full list of recommendations is included in the Annual Update.

2. Ongoing Budget Increases

There is a proposed \$13.1 million increase to the ongoing MHSA budget over the next two fiscal years. The increases to the ongoing budget are made up of: 1) \$2.6 million for new services recommended by the Housing Initiative Taskforce; 2) \$7.7 million to address existing BHRS systemic needs including programs at risk of losing current grants or other revenues; and 3) \$2.8 million for programs that were being sustained with MHSA one-time funds including the San Mateo County Pride Center, the Health Ambassador Program for Youth, Primary Care Interface, and the Neurosequential Model of Therapeutics program for the Adult System of Care.

3. One-Time Expenditure Plans

The COVID-19 pandemic impacted capacity to implement many of the projects identified in previously submitted One-Time Spend Plans. These have been updated, combined and extended through FY 2022-23 to allow for implementation of any remaining projects. Additionally, given higher than anticipated excess MHSA revenue in FY 2020-21, a new MHSA One-Time Plan was developed with stakeholder input, reviewed, and approved by the MHSARC. The One-Time Plan includes \$10.1 million in Housing Initiative Taskforce recommendations and \$1.6 million in COVID-19 related mental health surge needs.

The resolution has been reviewed and approved by County Counsel as to form.

A client is considered "maintained at the current or lower level of care" if, during the fiscal year, they did not have a new admission to a higher level of care or had one or more new admissions to a program with the same or lower level of care. It is projected that 85% of Full Service Partnership (FSP) clients shall be maintained at a current or lower level of care.

PERFORMANCE MEASURE:

Measure	FY 2020-21 Actual	FY 2021-22 Estimated
Percentage of FSP clients maintained at a current or lower level of care	84% 374 of 445 clients	85% 378 of 445 clients*

*Based on data through 7/8/2021

FISCAL IMPACT:

BHRS received \$33.1 million in MHSA funding in FY 2018-19 and \$31.8 million in FY 2019-20. FY 2019-20 is lower than FY 2018-19 is due to the COVID-19 related tax filing extension. We anticipate an increase in MHSA revenue for FY 2020-21 of \$48.5 million. Funds that are not yet allocated through our internal planning process or Request for Proposals to the community are held in a Trust Account. This account is also used to manage the fluctuations in funding that occur from year to year, as well as to support maintenance of effort and cost increases for current programs. There is no Net County Cost associated with this plan.

RESOLUTION NO. 078387

BOARD OF SUPERVISORS, COUNTY OF SAN MATEO, STATE OF CALIFORNIA

* * * * *

RESOLUTION AUTHORIZING THE APPROVAL AND SUBMISSION OF THE SAN MATEO COUNTY MENTAL HEALTH SERVICES ACT ANNUAL UPDATE FY 2021-22 TO THE STATE MENTAL HEALTH OVERSIGHT AND ACCOUNTABILITY COMMISSION AND THE DEPARTMENT OF HEALTH CARE SERVICES

RESOLVED, by the Board of Supervisors of the County of San Mateo, State of California, that

WHEREAS, In 2004, California voters passed Proposition 63, known as the Mental Health Services Act (MHSA); and

WHEREAS, State legislation requires Counties to seek approval of their MHSA Annual Updates for programs and expenditures from their Board of Supervisors; and

WHEREAS, Behavioral Health and Recovery Services has engaged in a public comment process of at least thirty days and public hearing to review and comment on the plans; and

WHEREAS, the Mental Health and Substance Recovery Commission has reviewed the public comments and recommended approval of the plans to your Board.

NOW THEREFORE, IT IS HEREBY DETERMINED AND ORDERED that this Board of Supervisors accepts the Mental Health Services Act Annual Update FY 2021-

22 and approves its submission to the State Mental Health Oversight and Accountability Commission and the Department of Health Care Services.

* * * * *

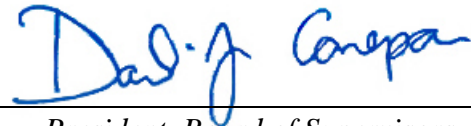
Regularly passed and adopted this 14th day of September, 2021

AYES and in favor of said resolution:

Supervisors: _____ *DAVE PINE*
_____ *CAROLE GROOM*
_____ *DON HORSLEY*
_____ *WARREN SLOCUM*
_____ *DAVID J. CANEPA*

NOES and against said resolution:

Supervisors: _____ *NONE*



*President, Board of Supervisors
County of San Mateo
State of California*

Certificate of Delivery

I certify that a copy of the original resolution filed in the Office of the Clerk of the Board of Supervisors of San Mateo County has been delivered to the President of the Board of Supervisors.



Assistant Clerk of the Board of Supervisors

MENTAL HEALTH SERVICES ACT

Annual Update for Programs & Expenditures,
Fiscal Year (FY) 2021-22



SAN MATEO COUNTY HEALTH

**BEHAVIORAL HEALTH
& RECOVERY SERVICES**

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MHSA COUNTY COMPLIANCE

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: County of San Mateo Three-Year Program and Expenditure Plan
 Annual Update

Local Mental Health Director	Program Lead
Name: Scott Gilman, MSA	Name: Doris Y. Estremera, MPH
Telephone Number: (650) 573-2748	Telephone Number: (650) 573-2889
E-mail: sgilman@smcgov.org	E-mail: destremera@smcgov.org
Local Mental Health Mailing Address: San Mateo County, Behavioral Health and Recovery Services (BHRS) 2000 Alameda de las Pulgas, Ste. 235 San Mateo, CA 94403	

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan or Annual Update, including stakeholder participation and nonsupplantation requirements.

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on September 14, 2021.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached annual update are true and correct.

Scott Gilman, Director, BHRS
Local Mental Health Director (PRINT)

Scott M
Gilman
Digitally signed by
Scott M Gilman
Date: 2021.09.29
16:41:00 -0700'
Signature _____ Date _____

MHSA COUNTY FISCAL ACCOUNTABILITY COMPLIANCE

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION¹

County/City: County of San Mateo

- Three-Year Program and Expenditure Plan
 Annual Update
 Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Scott Gilman, MSA	Name: Juan Raigoza
Telephone Number: (650) 573-2748	Telephone Number: (650) 363-4777
E-mail: sgilman@smcgov.org	E-mail: controller@smcgov.org
Local Mental Health Mailing Address: San Mateo County, Behavioral Health and Recovery Services (BHRS) 2000 Alameda de las Pulgas, Ste 235 San Mateo, CA 94403	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

Scott Gilman, Director of BHRS

Local Mental Health Director (PRINT)

Scott M
Gilman

Digitally signed by Scott
M Gilman
Date: 2021.09.29
16:40:13 -07'00'

Signature

Date

I hereby certify that for the fiscal year ended June 30, 2020, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated December 11, 2020 for the fiscal year ended June 30, 2020. I further certify that for the fiscal year ended June 30, 2020, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

Juan Raigoza

County Auditor Controller / City Financial Officer (PRINT)

by Kim-Anh Le
Deputy Controller

Kim Anh Le
Signature

10/28/2021
Date

¹ Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)

INTRODUCTION TO SAN MATEO COUNTY

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

COUNTY OF SAN MATEO MISSION

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

We are committed to:

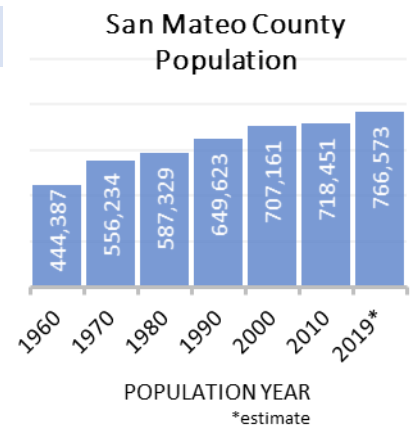
- The highest standards of public service;
- A common vision of responsiveness;
- The highest standards of ethical conduct;
- Treating people with respect and dignity.

The County is committed to building a healthy community. The County of San Mateo Shared Vision 2025 places an emphasis on the interconnectedness of all of our communities, and specifically of our county policies and programs. Shared Vision 2025 is for a sustainable San Mateo County that is 1) healthy, 2) prosperous, 3) livable, 4) environmentally conscious, 5) collaborative community. This MHSA Three-Year Plan supports goal #1; a healthy community where the vision is that neighborhoods are safe and provide residents with access to quality health care and seamless services.

SAN MATEO COUNTY DEMOGRAPHICS

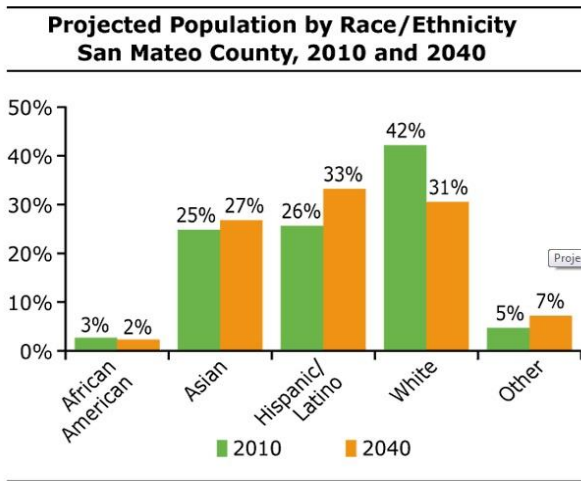
The estimated population of San Mateo County according to the U.S. Census Bureau is 766,573, a 6.7% jump over the 2010 Census. Daly City remains the most populous city followed by San Mateo and Redwood City.

The median age of residents was 39.9 and a median household income of \$124,425. While The town of Portola Valley has the highest median age of 51.3 years while East Palo Alto a much less affluent community has the lowest at 28.1 years.

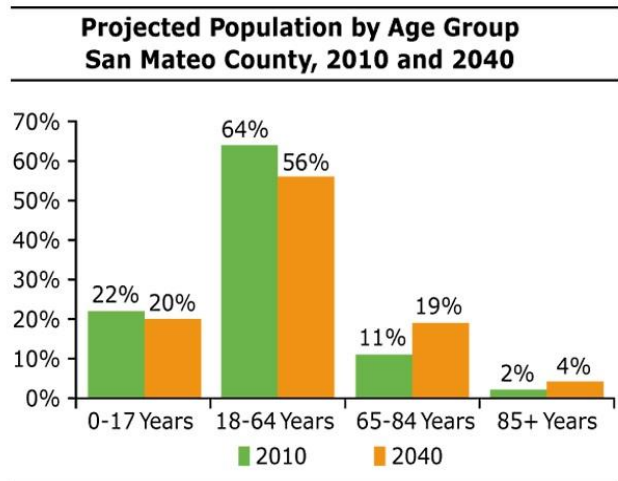


As the County’s population continues to shift, it continues to grow in diversity. 46.3% of residents speak a language other than English at home, and 34.8% are foreign born. San Mateo County’s threshold languages are Spanish, Chinese (Mandarin and Cantonese), Tagalog and Russian (as identified by Health Plan of San Mateo). The Health System identified Tongan, Samoan as priority languages based on a growing number of clients served and emerging languages as Arabic, Burmese, Hindi, and Portuguese.

By 2040, San Mateo County is projected to have a majority non-White population. The White population is projected to decrease by 11%. The Latino and Asian communities are projected to increase by 7% and 2%, respectively¹. Additionally, the projected population by age group shows that residents 65 and older is projected to almost double.



Data Source: State of California, Department of Finance



Data Source: State of California, Department of Finance

BEHAVIORAL HEALTH AND RECOVERY SERVICES

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

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

¹ sustainablesanmateo.org

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

Our Values

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

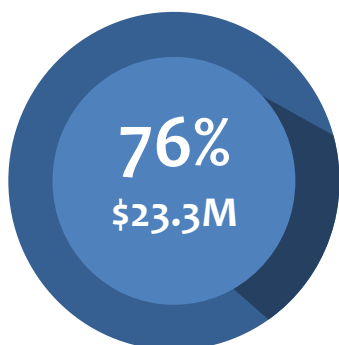
MHSA BACKGROUND

Proposition 63, the Mental Health Services Act (MHSA), was approved by California voters in November 2004 and provided dedicated funding for mental health services by imposing a 1% tax on personal income over \$1 million dollars. San Mateo County received an annual average of \$30.7 million, in the last five years through Fiscal Year 2019-20. MHSA emphasizes transformation of the behavioral health system, improving the quality of life for individuals living with behavioral health issues and increasing access for marginalized communities. MHSA planning, implementation, and evaluation incorporates the following core values and standards:

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

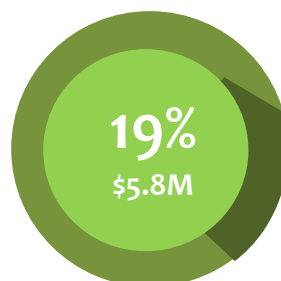
MHSA provides funding for Community Program Planning (CPP) activities, which includes stakeholder involvement in planning, implementation and evaluation. MHSA funded programs and activities are grouped into “Components” each one with its own set of guidelines and rules:

Community Services & Supports (CSS)



CSS provides direct treatment and recovery services to individuals of all ages living with serious mental illness or emotional disturbance.

Prevention & Early Intervention (PEI)



PEI targets individuals of all ages prior to the onset of mental illness, with the exception of early onset of psychotic disorders.

Innovation (INN)



INN funds projects to introduce new approaches or community-drive best practices that have not been proven to be effective.



COMMUNITY PROGRAM PLANNING PROCESS

COMMUNITY PROGRAM PLANNING (CPP) PROCESS

The San Mateo County Behavioral Health and Recovery Services (BHRS) promotes a vision of collaboration and integration by embedding MHSA programs and services within existing infrastructures. San Mateo County does not separate MHSA planning from its other continuous planning processes. Given this, stakeholder input from system-wide planning activities is taken into account in MHSA planning. The Mental Health and Substance Abuse Recovery Commission (MHSARC), our local “mental health board”, is involved in all MHSA planning activities providing input, receiving regular updates as a standing agenda item on their monthly meetings, and making final recommendations to the San Mateo County Board of Supervisors (BoS) on all MHSA plans and updates.

MHSA STEERING COMMITTEE MEETING

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

In 2016, MHSA Steering Committee Roles and Responsibilities were developed to strengthen the representation of diverse stakeholders by including member composition goals related to stakeholder groups (e.g. at least 50% represent clients/consumers and families of clients/consumers; at least 50% represent marginalized cultural and ethnic groups; maximum of two member representatives from any one agency, etc.).

This past fiscal year, in response to ongoing feedback from stakeholders for deeper engagement in MHSA, the MHSA Steering Committee was restructured. On October 7, 2020 the MHSA Steering Committee reviewed a proposed structure that would allow for increased meetings per year and working committees to recommend improvements on MHSA structures and programs. On November 4, 2020, the Mental Health and Substance Abuse Recovery Commission (MHSARC) voted to amend their Bylaws to establish the MHSA Steering Committee as a Standing Committee of the commission and appoint chairperson(s) to work closely with the MHSA coordinator to plan, develop goals and objectives, and report to the broader MHSARC on a monthly basis. The MHSA Steering Committee now meets four times per year in February, May, September and December. See Appendix 1 for the MHSA Steering Committee meeting materials and the Board of Supervisors approved and Amended MHSARC Bylaws.

2020-21 MHSa Steering Committee Members

Stakeholder Group	Name	Title (if applicable)	Organization/Affiliation (if applicable)
Family Member	Jean Perry	Chairperson	MHSARC, Lived Experience Education Workgroup (LEEW)
Family Member	Leticia Bido	Chairperson	MHSARC
Client/Consumer - Adults	Jairo Wilches	Program Coordinator	BHRS, OCFA
Client/Consumer - Adults	Michael Lim		LEEW
Client/Consumer - Adults	Michael S. Horgan	Program Coordinator	Heart & Soul, Inc.
Cultural Competence	Maria Lorente-Foresti	Director	BHRS, Office of Diversity & Equity
Cultural Competence	Kava Tulua	Executive Director	One East Palo Alto
Education	Mary McGrath	Administrator	San Mateo County Office of Educ
Family Member	Chris Rasmussen	Commissioner	MHSARC
Family Member	Judith Schutzman		
Family Member	Juliana Fuerbringer		California Clubhouse
Family Member	Patricia Way	Co-Vice Chair	MHSARC Commission
Family Member	Sheila Brar	Chair	MHSARC Commission
Other - Aging and Adult	Anna Sawamura	Prog Services Manager	SMC Health System, Aging & Adult
Other - Peer Support	ShaRon Heath	Executive Director	Voices of Recovery
Other - Peer Support	Stephanie Morales	Peer Support Worker	BHRS, OASIS
Provider of MH/SU Svcs	Adriana Furuzawa	Division Director	Family Service Agency
Provider of MH/SU Svcs	Cardum Harmon	Executive Director	Heart & Soul, Inc.
Provider of MH/SU Svcs	Chris Kernes	Managing Director	Health Right 360
Provider of MH/SU Svcs	Clarise Blanchard	Director	StarVista
Provider of MH/SU Svcs	Joann Watkins	Clinical Director	Puente de la Costa Sur
Provider of MH/SU Svcs	Melissa Platte	Executive Director	Mental Health Association
Provider of MH/SU Svcs	Michael Krechevsky	Family Support Specialist	Family Service Agency
Provider of Social Svcs	Mary Bier	Coordinator	North County Outreach Collaborative

STAKEHOLDER ENGAGEMENT

MHSA Steering Committee meetings are open to the public and diverse stakeholder participation is promoted through various means, including flyers, emails, announcements, postings, community partners, clients/consumers, community leaders, and the general public. The following demographics represents unique participants in MHSA Steering Committee meetings. When comparing race/ethnicity demographics to San Mateo County census data, all but Asian (underrepresented by 17%) and White (overrepresented by 10%) are comparable. Communities of color are also often engaged in MHSA planning via the Office of Diversity and Equity and the Health Equity Initiatives.

San Mateo County Census Race/Ethnicity		Steering Committee Participation Race/Ethnicity	
Asian	30%	Asian Indian/South Asian, Chinese, Filipino*	13%
Black or African American	2%	Black/African-American	4%
Hispanic or Latino	24%	Hispanic/Latino/x	20%
Native Hawaiian or Pacific Islander	1%	Native Hawaiian or Pacific Islander	1%
White alone, not Hispanic	38%	White/Caucasian	48%
Two or More	5%	Two or More*	7%
		Another Race/Ethnicity	11%

* combined to allow for comparison as per MHSa legislation but, represented uniquely below

MHSA Steering Committee Participant Demographics

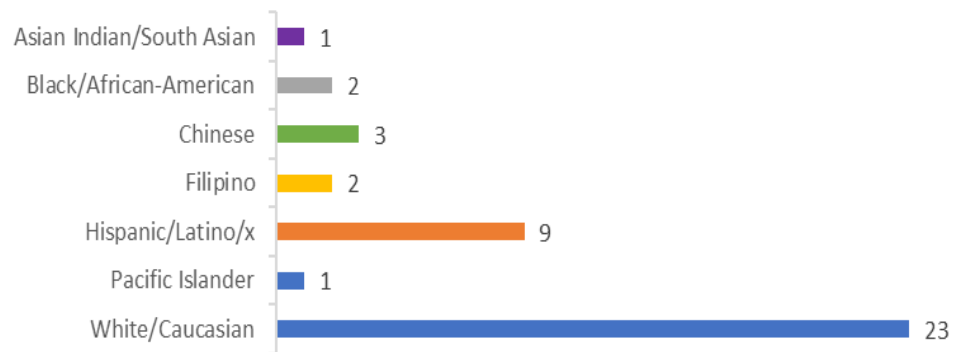
Age Range

16-25	2%
26-59	56%
60+	42%

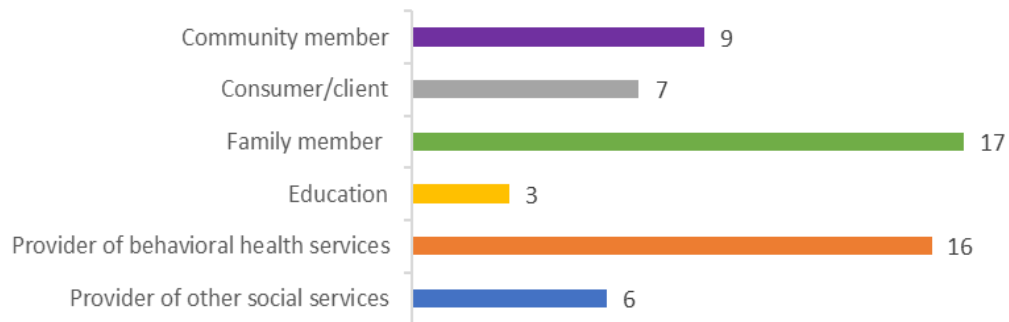
Gender Identity

Female/Woman	70%
Male/Man	23%
Gender Non-confirming	5%
Another Gender Identity	2%

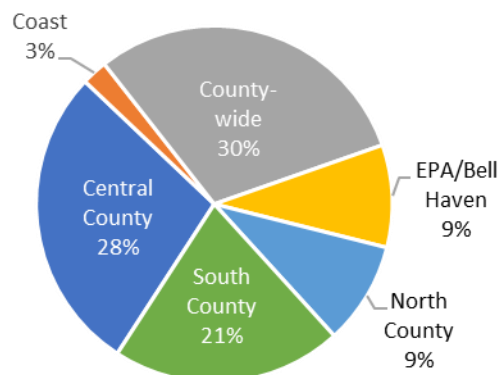
Race/Ethnicity



Stakeholder Group



County Region Represented



Peer, Client/Consumer and Family Engagement in MHSA

MHSA is committed to engaging individuals with lived experience in planning, implementation and evaluation. Participation and expertise of individuals with lived experience is promoted and compensated with stipends. For the FY 2019-20 reporting year of this MHSA Annual Update, the following stipends were provided to clients and family members of clients participating in MHSA-funded activities.

Activity	Stipend \$ Amount Distributed	# unique clients
Health Equity Initiatives	\$4,015	30
Help@Hand	\$925	16
Housing Taskforce	\$300	7
Lived Experience Education Workgroup	\$3,315	21
Mental Health Awareness Month	\$315	8
MHSA Steering Committee	\$190	6
Photo Voice	\$1,200	10
Suicide Prevention Planning	\$760	10
TOTAL	\$11,120	

30-DAY PUBLIC COMMENT AND PUBLIC HEARING

MHSA legislation requires counties to prepare and circulate MHSA plans and updates for at least a 30-day public comment period for stakeholders and any interested party to review and comment. The San Mateo County MHSA Annual Update FY 2021-22 (covering data from FY 2019-20) was presented to the MHSA Steering Committee on May 6, 2021 and to the MHSARC on June 2, 2021 for a vote to open a 30-day public comment period closing with a Public Hearing on July 7, 2021. The MHSARC voted *unanimously* to submit the plan to the Board of Supervisors. Please see Appendix 2 for the MHSA Annual Update materials presented and all public comments received.

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

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

- Announcements at internal and external community meetings;
- Announcements at program activities engaging diverse families and communities (Parent Project, Health Ambassador Program, Lived Experience Academy, etc.);
- E-mails disseminating information to an MHSA distribution list of over 1,800 subscribers; and the Office of Diversity and Equity distribution list of over 1,500 subscribers;
- Word of mouth on the part of committed staff and active stakeholders,
- Postings on physical bulletin board at BHRS clinics, wellness/drop-in centers, and community-based organizations
- Posting on the MHSA webpage smchealth.org/MHSA, the BHRS Blog, smcbhrsblog.org, and the BHRS Wellness Matters Newsletter, smchealth.org/WM, which reaches over 2,000 subscribers.

PROGRAM PLANNING HIGHLIGHTS

MHSA priorities identified by stakeholders in the previous FY 2017-2020 MHSA Three-Year Plan that had not been implemented, remained top priorities in this current MHSA Three-Year Plan. The last two priority expansions that remained to be implemented included the Coastside Multicultural Wellness Program (The Cariño Project) and the Youth S.O.S. Team. Both projects had gone through extensive community input processes and a Request for Proposal (RFP) process and were pending contract award and negotiations.

THE CARIÑO PROJECT

The Cariño Project in Half Moon Bay soft-launched July 1, 2020, in the midst of the COVID- pandemic, devastating wildfires. The lead organization, Ayudando Latinos A Soñar (ALAS), found itself with increased demand for mental health services. The Cariño Project brought increased culturally-responsive mental health services, peer support groups, art and wellness activities, capacity building, outreach, and linkages to behavioral health services and resources for marginalized Latinx and farmworker communities. A virtual ribbon-cutting event was held in September 2020 to acknowledge the launch of The Cariño Project. Most recently, a Request for Quotes (RFQ) process was facilitated in collaboration with the Healthcare for the Homeless and Farmworker Health (HCH/FH) Program to identify the co-occurring substance use service provider for The Cariño Project. The services will include co-occurring substance use case management and early intervention services.



The Coastside community was at the center of the creation of this project as it was a need identified by the BHRS Community Service Area during the MHSA Three-Year Plan Community Program Planning process. To further build on the community input received, a comprehensive needs assessment was conducted by bilingual and bicultural peer, interns and community health planner staff, which facilitated honest and vulnerable conversations. Through one-on-one interviews and “platicas” (community dialogues), a total of 210 participants including adults and youth were engaged via 12 sites that included community agencies, affordable housing complexes, faith-based locations, school-based settings, and areas of recreation. See Appendix 4 for the Coastside Needs Assessment summary and infographic.

YOUTH S.O.S. TEAM

The Youth Stabilization, Opportunity & Support (S.O.S.) Team start-up activities began in March 2021 with full implementation scheduled to launch July 1, 2021. The Youth S.O.S team is a non-law enforcement, trauma-informed, culturally-responsive response to youth (age 0-21) who may be in a crisis anywhere in San Mateo County. The team will be dispatched via the StarVista Crisis Hotline, available 24 hours-per-day, 7 days-per-week. The Youth S.O.S. Team consists of a triage clinician and a family partner to help improve the families’ level of comfort and trust, and support linkages and warm hand-off’s for youth and families.

In response to the Family Urgent Response System (FURS), established by Senate Bill 80 and amended by Assembly Bill 79, which requires counties to develop and implement a mobile response system for current and former foster youth and their caregivers, BHRS and the Human

Services Agency partnered to implement a coordinated effort. For current and former youth in foster care, the Youth S.O.S. Team will provide an immediate, in-person, 24/7 response. A comprehensive input process for Youth S.O.S. came after County-wide budget constraints and concerns related to ensuring an integrated approach to youth crisis response, led to the withdrawal of the RFP opportunity. Starting in October 2019, the Youth Committee of the Mental Health and Substance Abuse Commission (MHSARC) met monthly to plan an integrated approach to youth in crisis. See Appendix 5 for the Youth S.O.S. Team Scope of Work and Flow Chart developed as part of this planning process.

MENTAL HEALTH STUDENT SERVICES ACT (MHSSA)

In July 2021, BHRS in partnership with the San Mateo County Office of Education (SMCOE) were awarded \$6 million over four years as part of the Mental Health School Services Act (MHSSA) grant to implement Success for Youth and Schools through Trauma-Informed & Equitable Modules (SYSTEM) Support. SYSTEM Support will provide 12 school districts (Bayshore, Jefferson Elementary, Jefferson Union, Pacifica, San Bruno, Hillsborough City, Burlingame Elementary, Cabrillo Unified, San Mateo Foster City, San Carlos, Sequoia Union and Ravenswood) with Social Emotional Learning (SEL) Curriculum, Community Resiliency Model (CRM) Training for all district staff and data collection support. Additionally, under resourced and high need districts will receive more tailored and culturally responsive SEL curriculum, mental health care coordination services and counseling staff.

Since the launch of SYSTEM Support in October 2020, all 12 school districts have received their SEL curriculum and begun implementation to prevent, and provide for early identification of, mental health challenges. Additionally, twenty-five educators trained by the Trauma Resource Institute as trainers for the Community Resiliency Model (CRM) and have already begun conducting trainings for not only the 12 districts participating in the MHSSA grant, but also the remaining 12 districts in San Mateo County. Participants learn not only how to help themselves but how to help others within their wider social network. Care Solace mental health care coordination services launched and expanded to all districts countywide with additional resources from the Peninsula Health Care District and the Sequoia Health Care District. Care Solace, a live 24x7 concierge line assist students, their family and school staff get connected to local mental health-related services.

TECHNOLOGY SUPPORTS AND DIGITAL MENTAL HEALTH LITERACY

MHSA Stakeholders recommended available one-time MHSA monies to support COVID-19 related client needs, this was submitted with the previous MHSA Annual Update. One notable project was securing technology supports (devices and data plans), for one year, for clients and family members of clients that would benefit from telehealth and/or other behavioral health services but do not have the resources to purchase the technology needed. With both MHSA one-time funds and Coronavirus Aid, Relief, and Economic Security (CARES) Act funds, BHRS secured and distributed 290 tablets with a one-year data plan to 15 contracted behavioral health service agencies. 13 agencies were also awarded funding to procure phones and accessories (hotspots, headphones, screen protectors, styluses, etc.) that support clients' use of

the technology for behavioral health supports. BHRS also distributed phones, tablets to clients, including 30 tablets for residential Board and Cares.

Based on feedback from staff, agencies, clients, community members, and faith leaders, we learned that our communities most impacted by COVID-19, and those supporting them, require the digital literacy to best utilize technology resources. Providers requested advanced technological support to learn how to run a zoom meeting or webinar, host a Facebook live and how to support community with connecting to telehealth appointments. To address the needs identified, BHRS contracted with Painted Brain, a peer-run organization, to provide a series of trainings as follows:

- **Community Tech Cafe's** are for clients and community members and/or anyone who needs basic device supports; downloading apps, setting up e-mail and basic use of telehealth and Zoom.
- **Digital Literacy Training for Peers** to provide technical support to equip peer and family partners that are distributing devices to clients.
- **Advanced Zoom topics** for staff, providers, agencies and faith leaders. The first series of trainings was offered in June 2021 - Liberation Practices for Virtual Meeting Spaces to help build empowerment, and equitable strategies for facilitating virtual meetings.

Additional sample training topics are listed below:

Sample Tech Café's Topics

- How to Set-Up a Gmail Account
- Email Maintenance
- Professional Emailing
- Tips on How to Scan a QR Reader
- How to Download an App (Application)
- Tips on Using Your Phone Camera
- Online Safety & Privacy
- Tips on Privacy Settings (Mobile Phone & Social Media)
- Telehealth and Telehealth Etiquette
- Zoom Teleconferencing Basics

Advanced Zoom Topics

- How to set-up an manage ZOOM registration for meetings/webinars
- How to manage and utilize the breakout rooms
- Zoom and Telehealth
- How to live stream meetings/webinars (Facebook, YouTube, etc.)
- How to utilize custom interactive polls for meetings/webinars
- How to generate registration, attendee, and poll reports
- Learn about host capabilities to include managing all ZOOM functions and attendees.
- Best practices to ensure safety measures when utilizing ZOOM
- Equitable practices when facilitating meetings on ZOOM

HOUSING INITIATIVE TASKFORCE

Early fiscal projections anticipated a recession due to the COVID-19 pandemic. Given this uncertainty, a strategic approach to addressing the input received during the MHSA Three-Year Plan development was proposed. Twenty-two strategies prioritized by stakeholders were organized under 5 MHSA Strategic Initiatives with the intent to engage stakeholders in deeper planning and develop strategy direction for MHSA investments for when revenue improved. Housing was the initiative prioritized by the MHSA Steering Committee. A Housing Initiative Taskforce was convened, between March and May 2021, to accomplish the following goals:

1. Define a housing continuum of services for individuals living with mental illness
2. Identify gaps at all levels of support or intensity in treatment
3. Articulate and prioritize broad housing-related outcomes
4. Identify and prioritize activities to fund under each prioritized outcome

Taskforce members included 30 diverse stakeholders (listed below) including clients, family members, service providers and County departments:

MHSA Housing Initiative Taskforce Members

Name	Organization or Affiliation
Amanda Russell	Caminar
Carl Engineer	Solutions for Supportive Homes
Carolyn Shepard	Solutions for Supportive Homes
Chris Rasmussen	Mental Health and Substance Abuse Recovery Commission (MHSARC)
Cristina Ugaitafa	Aging and Adult Services
Dyshun Beshears	Aging and Adult Services, Adult Protective Services
Ellen Darnell	Lived Experience Education Workgroup (LEEW)
Irene Pasma	SMMC Healthcare for the Homeless and Farmworker Health Program
Jean Perry	Mental Health and Substance Abuse Recovery Commission (MHSARC)
John Butler	Lived Experience Education Workgroup (LEEW)
Kate Loftus	One New Heartbeat, Inc.
Kristina Anderson	
Lanajean Vechhione	Lived Experience Education Workgroup (LEEW)
Latifunisa Lilani	Caminar
Lee Harrison	BHRS, Office of Consumer and Family Affairs
Linder Allen	Solutions for Supportive Homes
Lisa Dominguez	
Mariana Rocha	BHRS Adult and Older Adult Services
Marie Adorable	Edgewood Center
Mary Bier	North County Outreach Collaborative; MHSA Steering Committee
Melinda Henning	Solutions for Supportive Homes
Melissa Greenfield	HealthRight 360
Melissa Platte	Mental Health Association; MHSA Steering Committee
Michael Lim	LEEW; MHSA Steering Committee
Natasha Phillips	BHRS, Office of Consumer and Family Affairs
Pat Way	Mental Health and Substance Abuse Recovery Commission (MHSARC)
Rose Cade	SMC Department of Housing
ShaRon Heath	Voices of Recovery
Suzanne Moore	Pacifica Housing for All
Tennille Tucker	BHRS Forensics

The Housing Initiative Taskforce began with a series of informational presentations including “Housing for BHRS Clients” and “Board and Care Housing Supports.” Members then convened once a month, led by an MHSA housing consultant and the MHSA Manager. See Appendix 3 for all materials of the taskforce including the Housing Continuum developed, presentations, handouts, question and answer documents and notes. As the Housing Initiative Taskforce progressed, MHSA funding available were identified in the amount of \$2,200,000 ongoing and \$12,000,000 one-time. Listed below are the final Funding Recommendations in order as prioritized by the taskforce members:

MHSA Housing Initiative Taskforce Prioritized Funding Recommendations

Prioritized Funding Recommendations	One-Time Funding Amount	Ongoing Funding Amount
1. Establishment of an ongoing Housing Fund with Department of Housing for the development of Supportive Housing Units for clients	\$5,000,000 Year 1 \$5,000,000 Year 2	
2. Mental health workers for Homeless Outreach Teams		\$325,000
3. Supportive services for new housing units developed		\$375,000* for 25 units
4. Housing locator contract to oversee: a) Maintenance of BHRS Housing website services with real-time housing availability information; b) Linkages to BHRS case managers; c) Landlord engagement; d) Community mental health 101 education to housing agencies; and e) three housing locator positions (mental health counselors), three peer navigators + admin		\$ 575,000
5. Transitional housing supports and training to adequately serve SMI population, including special populations		\$100,000
6. Outreach and field-based services to support ongoing and long-term housing retention; a team of Occupational Therapist and Peer Counselor with co-occurring capacity to support independent living skills development and recovery		\$500,000
7. Flexible funds for housing related expenses (moving costs, deposits, first month rent)		\$100,000*
8. Development of an online BHRS Housing webpage with comprehensive one-stop housing information (including data dashboard for unmet need) for clients and staff	\$100,000	
9. Increase FSP housing funds		\$258,662 (\$8,097/client)
10. Incentives and supports for licensed Board and Cares to improve quality of services		\$50,000
11. Increase Full Service Partnerships (FSP) slots for children/youth and transition-age youth		\$607,835 for 10 Children/Youth and TAY FSP slots
TOTAL for FY 21/22 to 22-23	\$10,100,000	\$2,416,497

**Item #3 (supportive services) is not included in the total budget amount for FY 21/22 to 22/23 because implementation will occur in future years once new housing units are developed; item #7 (housing-related flex funds) is also not included because there is a separate revenue source identified for this item.*

NEW INNOVATION PROJECTS APPROVED

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

Of the five anticipated and planned new INN projects for San Mateo County; three were approved by the Mental Health Oversight and Accountability Commission as listed below. The Addiction Medicine Fellowship proposal was not approved for funding and the Older Adult Homelessness Prevention due to Economic Stress proposal was withdrawn due to decreased Aging & Adult Services Agency staff capacity to manage the approval and implementation.

1. Social Enterprise Cultural and Wellness Cafe

Approved August 27, 2020; Estimated Project Amount & Length: \$2,625,000 / 5 years

The proposed project is a cultural arts and wellness-focused Social Enterprise Cafe that offers youth development and mental health programming on site. The Social Enterprise Cafe will hire and train at-risk youth from northern San Mateo County and serve as a culturally affirming space for Filipino/a/x youth and community. The social enterprise model has proven to be a more sustainable funding approach.

Annual projected number of participants served: 2,000 unique visitors; 300 referrals; 150 receive behavioral health services; 90 participate in services; 40 in full programming

2. Co-location of Prevention and Early Intervention Services in Low-Income Housing

Approved November 17, 2020; Estimated Project Amount & Length: \$925,000 / 4 years

The proposed project will provide prevention and early intervention services including behavioral health resources, supports, screening, referrals and linkages to young adults, ages 18-25, on-site at affordable housing properties, minimizing stigma and reducing barriers to accessing behavioral health care.

Annual projected number of young adults served: 150

3. PIONEERS Program

Approved December 10, 2020; Estimated Project Amount & Length: \$925,000 / 4 years

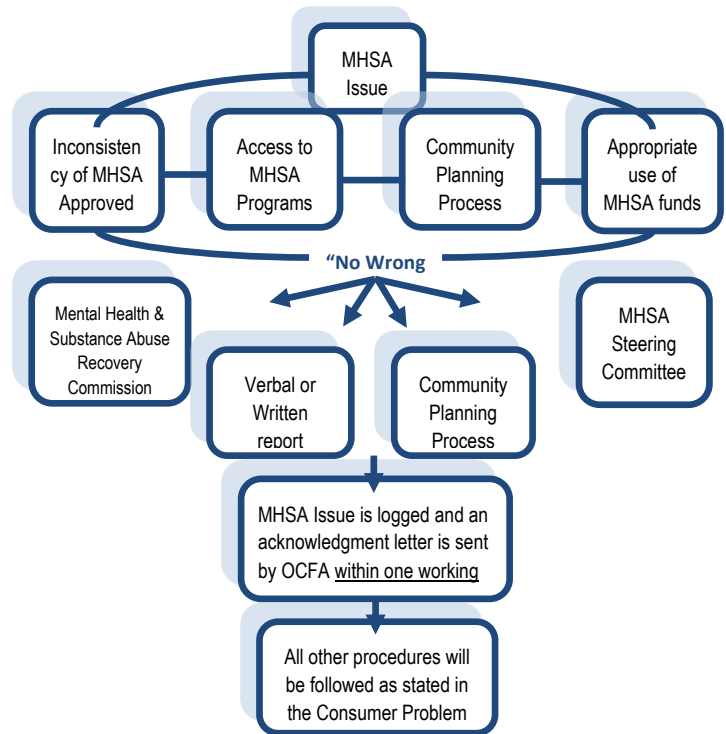
The proposed project, Pacific Islanders Organizing, Nurturing, and Empowering Everyone to Rise and Serve (PIONEERS) provides a culturally relevant, behavioral health program for NHPI college-age youth that prioritizes the mental wellbeing of students and their respective communities through empowerment, leadership and advocacy.

Annual projected number of NHPI youth served: 45 direct; 30 through community projects

MHSA Issue Resolution Process (IRP)

The purpose of the MHSA IRP is to resolve process-related issues with 1) the MHSA Community Program Planning (CPP) process; 2) consistency between approved MHSA plans and program implementation; and 3) the provision of MHSA funded programs.

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



For the FY 2019-20 reporting year of this MHSA Annual Update, there were 21 quality of care-related grievances filed with the BHRS Office of Consumer and Family Affairs (OCFA) for MHSA funded programs. There were 0 MHSA process-related grievances.

Category of grievance	# of grievances filed	From the client’s perspective: Was the outcome Favorable, Partially Favorable, Not Favorable?
Access: Service not Accessible and Timeliness of Service	7	5 Favorable; 2 Partially Favorable
Housing Environment: Physical Environment and Peer Behavior	4	2 Favorable; 2 Partially Favorable
Staff Concerns	7	4 Favorable; 3 Partially Favorable
Treatment Issues	2	1 Favorable; 1 Partially Favorable
Operational	1	1 Favorable



FUNDING SUMMARY

FUNDING SUMMARY

The Funding Summary includes MHPA funding requirements and locally-developed guiding principles, revenues and expenditures, available unspent funds, reserve amounts and any updates to the approved MHPA Three-Year Plan for FY 2020-23. It includes the budgeted amount to be spent on MHPA Components and associated categories, as detailed below. See Appendix 6 for the FY 2021-22 Funding Summary by component.

MHPA FUNDING REQUIREMENTS

MHPA funded programs and activities are grouped into “Components” each one with its own set of guidelines and rules:

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

Additionally, Counties received one-time allocations in three additional Components.

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

- Up to 20% of the average 5-year MHPA revenue from the CSS Component can be allocated to WET, CF/IT and Prudent Reserve.
- A maximum of 33% of the average Community Services and Supports (CSS) revenue received in the preceding five years maximum of 33% may fund the Prudent Reserve.
- Up to 5% of total annual revenue may be spent on administration and community planning processes.

MHSA FUNDING PRINCIPLES

MHSA Funding Principles build from the County's and Health division budget balancing principles to guide MHSA reduction and allocation decisions when needed. MHSA funding is allocated based on the most current MHSA Three-Year Plan and subsequent Annual Updates. Any funding priorities being considered outside of the MHSA Three-Year Plan priorities require MHSA Steering Committee approval and stakeholder engagement, which will include a 30-day public comment period and public hearing as required by the MHSA legislation.

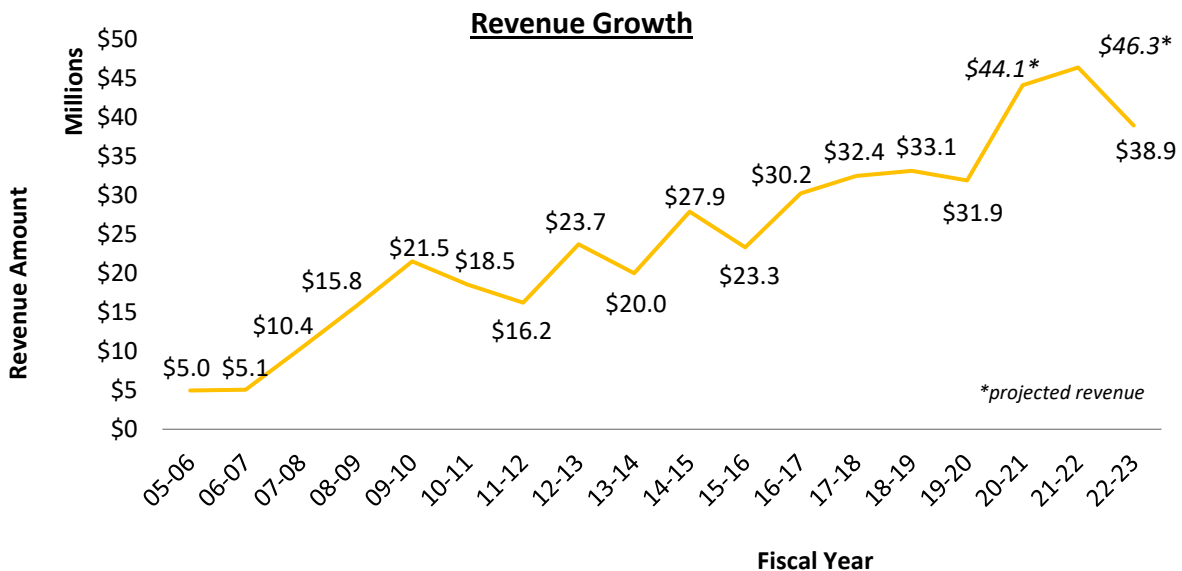
The MHSA Funding Principles were presented to the MHSA Steering Committee in September 2018 for input and comment given a budget reduction planning throughout the County that was expected to have implications for MHSA funding. The Funding Principles will continue to lead budget decisions moving into COVID-19 pandemic anticipated recession.

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

ANNUAL REVENUE GROWTH

Statewide, MHSA revenue represents a little under a third of community mental health funding. In San Mateo County, MHSA revenue represents about 15% of behavioral health funding at a five-year average annual revenue through fiscal year 2019-20 that totaled \$30.7 million. Annual MHSA revenue distributions are difficult to estimate and volatile. MHSA funding is based on various projections that consider information produced by the State Department of Finance, analyses provided by the California Behavioral Health Director’s Association (CBHDA), and ongoing internal analyses of the State’s fiscal situation. The following chart shows annual revenue allocation for San Mateo County since inception. Below are factors that have impacted the decreases and increases in revenues throughout the years:

- FY 05/06 and FY 06/07: funding included Community Services and Supports (CSS) only.
- FY 07/08 and FY 08/09: Prevention and Early Intervention (PEI) and Innovations (INN) dollars were released in those years, respectively.
- FY 10/11 and FY 11/12: the California recession of 2009 led to decreased revenues
- FY 12/13: Counties began receiving monthly MHSA allocations based on actual accrual of tax revenue (AB100), resulting in a “one time” lump allocation.
- FY 14/15: changes in the tax law that took effect on January 1, 2013, led to many taxpayers filing in December 2012 resulting in a “one time” revenue increase.
- FY 19/20: “No Place Like Home” estimated cost for San Mateo County is \$1.3 million, taken from revenue growth or “off the top.” Additionally, there was an extension of filing of taxes to July 2020, due to COVID-19 pandemic.
- FY 20/21 – 21/22: unanticipated increases due to COVID-19 pandemic; FY 20-21 also includes an added increase due to late filing of previous year 2019 taxes.



FISCAL CONSIDERATIONS

One-Time Spend Plan Updates

The FY 2019-20 Annual Update included a \$12.5 million Plan to Spend Available One-Time Funding, that spanned over three-years through FY 2021-22. Last years’ FY 2020-21 Annual Update included additional \$5 million one-time funds allocated to support COVID-related

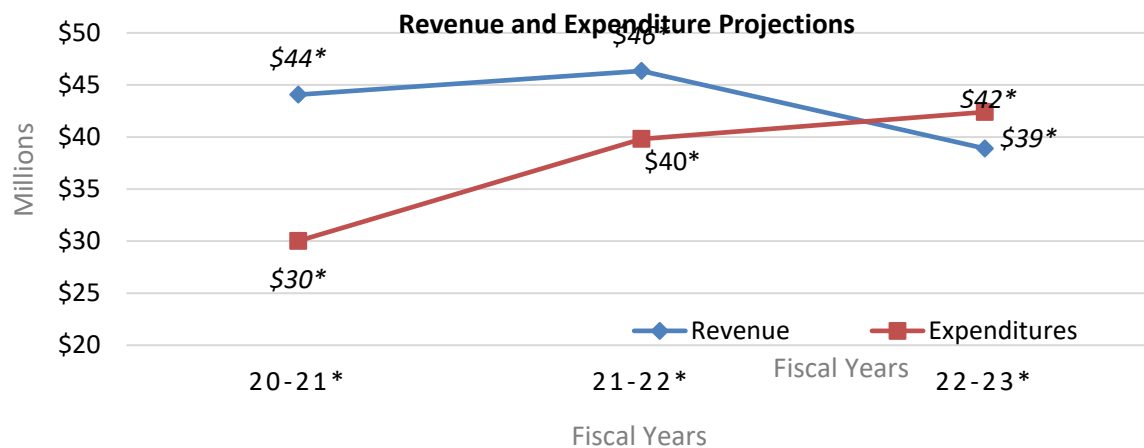
behavioral health impacts in San Mateo County. These plans were developed with stakeholders to spend down excess MHSAs funds.

The COVID-19 pandemic impacted capacity to implement many of the projects identified in the original \$12.5 million One-Time Spend Plan. Concurrently, Counties received unanticipated record-high revenues for FY 2020-21. Given these circumstances, both the \$12.5 million One-Time Spend Plan and the \$5 million COVID One-Time Spend Plan have been updated, combined and extended through FY 2022-23 to allow for implementation of any remaining projects. The updated and combined One-Time Spend Plan totals \$6.9 million and is included in Appendix 7 along with the specific updates to each of the previous plans, as follows:

- Removed one-time expenditures to-date of about \$8 million
- Removed allocated funding that is no longer needed
- Extended the timeline for projects that were delayed due to COVID
- Moved “stop-gap” programs that were being sustained with one-time funding to the ongoing MHSAs budget (e.g. recently completed Innovation projects)

New Available Unspent/Excess Funds

With the COVID-19 pandemic, significant revenue decreases were projected for MHSAs revenues statewide. In San Mateo County, we opted to keep the ongoing MHSAs budget status quo at \$30 million for FY 2020-21, not adding any expansions or new programs. This resulted in significant excess revenue. The funding strategies proposed to align expenditures with the higher revenues are two-fold 1) develop a new \$12 million One-Time Spend Plan and 2) increase the ongoing budget to a slight over-revenue budget by FY 2022-23.



The San Mateo County MHSAs Three-Year Plan states that if revenues increase, funding priorities would include strategies developed as part of the Housing Initiative efforts and strategies identified through a stakeholder input process. On June 2, 2021, the Mental Health and Substance Abuse Recovery Commission (MHSARC) reviewed a preliminary new \$12 million One-Time Spend Plan that includes \$10.1 million in Housing Initiative recommendations, \$1.08 million in PEI unspent and \$920 thousand in CSS unspent. Additionally, stakeholder input continued through June 30, 2021 to engage the following groups in identifying one-time needs:

- Collaboratives (Coastside, East Palo Alto, North County)
- Contractor's Association

- Diversity and Equity Council
- Lived Experience Education Workgroup
- MHSA Steering Committee
- MHSARC and Youth, Adult and Older Adult Committees

On July 7, 2021, the MHSARC reviewed the public comments received and held a public hearing and vote to submit the plan to the Board of Supervisors for approval along with the MHSA Annual Update. The plans are available in Appendix 7; public comments received are in Appendix 2.

Target Reserve

Counties are required to establish a Prudent Reserve to ensure the County programs will be able to serve clients should MHSA revenues drop. The California Department of Health Care Services (DHCS) Info Notice 19-017, released on March 20, 2019, established an MHSA Prudent Reserve level that does not exceed 33% of the average Community Services and Supports (CSS) revenue received in the preceding five years. For San Mateo County, this corresponds to \$6.7 million.

As per our MHSA Annual Update for FY 2019/20, the San Mateo County MHSA Steering Committee, our local mental health board and Board of Supervisors, reviewed and approved a recommended Total Operational Reserve of 50% (Prudent Reserve + additional operating reserve), of the highest annual revenue for San Mateo County, which currently equals \$17 million. For San Mateo County, the MHSA Prudent Reserve remains at \$600,000 and the additional Operational Reserve is in a local MHSA Trust Fund. This allows the flexibility in budgeting for short-term fluctuations in funding without having to go through the State's administrative process to access the Prudent Reserve, in the event that revenue decline is less than the State's threshold or funding is needed in a timely manner.

Reversion

MHSA legislation requires that MHSA funding under the key components (CSS, PEI and INN) be spent within 3-years or it must be returned to the State for reallocation to other mental health agencies. San Mateo County's annual MHSA spending in CSS and PEI targets the 5-year average revenue, keeping us from reversion risk.

INN on the other hand requires project approval by the Mental Health Services Oversight Accountability Commission (MHSOAC) before funds can be expended. Assembly Bill (AB) 114 established that the 3-year reversion time frame for INN funds commence upon approval of the project plans; this will minimize the reversion risk for funds accrued while planning for new projects and/or awaiting approval by the MHSOAC.

AB 114 and a SB 192 allowed Counties to submit a plan by January 1, 2019 for expending funds by June 30, 2020 that were deemed reverted as of July 1, 2017. San Mateo County submitted plans for INN in the amount of \$3,832,545 and WET in the amount of \$423,610. The INN plan was approved through June 30, 2022. The WET funding was expended as proposed.

At the wake of the COVID-19 pandemic, AB81 allowed for some flexibilities in MHSA regulations including reversion of FY 2019-20 funds. In San Mateo County, \$922,534 were subject to

reversion as of FY 2019-20. Since then, three new MHSAs Innovation projects were approved for San Mateo county. These projects will encumber and spend the reverted funds. Therefore, San Mateo County will not be subject to return any INN funds to the State.

Unencumbered Housing Funds

DHCS Info Notice 16-025 required Counties to complete *Ongoing Fund Release Authorization* for both existing and future unencumbered San Mateo County MHSAs Housing Program funds (e.g. funds that are no longer required by a housing project, accrued interest, and/or other funds receive on behalf of the counties). Funds will be released annually to Counties by May 1st. The *Ongoing Fund Release Authorization* was approved by our Board of Supervisors on April 7, 2020. San Mateo County received \$105,039 in accrued interest and loan payments on September 3, 2020.

Counties must spend the housing funds to provide “housing assistance”, rental assistance or capitalized operating subsidies; security deposits, utility deposits, or other move-in cost assistance; utility payments; moving cost assistance; and capital funding to build or rehabilitate housing for persons who are seriously mentally ill and homeless or at risk of homelessness. The Housing Initiative Taskforce identified the need for setting up a flexible fund for housing related expenses (moving costs, deposits, first month rent). These unencumbered housing funds will be used to support the flexible fund.

SUMMARY OF UPDATES TO THE THREE-YEAR PLAN, FY 2020-23

In summary, the following strategies are being implemented in FY 2021-22 and FY 2022-23 to align MHSAs expenditures with the increased projected revenue. See Appendix 6 for the updated FY 2021-22 Annual Update Funding Summary by component.

1. Updated \$6.9 million One-Time Spend Plan (Appendix 7)
2. New \$12 million One-Time Spend Plan (Appendix 7)
3. \$13.1 million increase to the ongoing budget over two fiscal years, to a slight over-revenue budget by FY 2022-23 (Appendix 8). The increases to the ongoing budget are made up of:
 - New Housing Initiative Funding Recommendations (Appendix 3)
 - BHRS systemic needs – existing programs at risk of losing other revenue
 - Projects that were being sustained with one-time funds



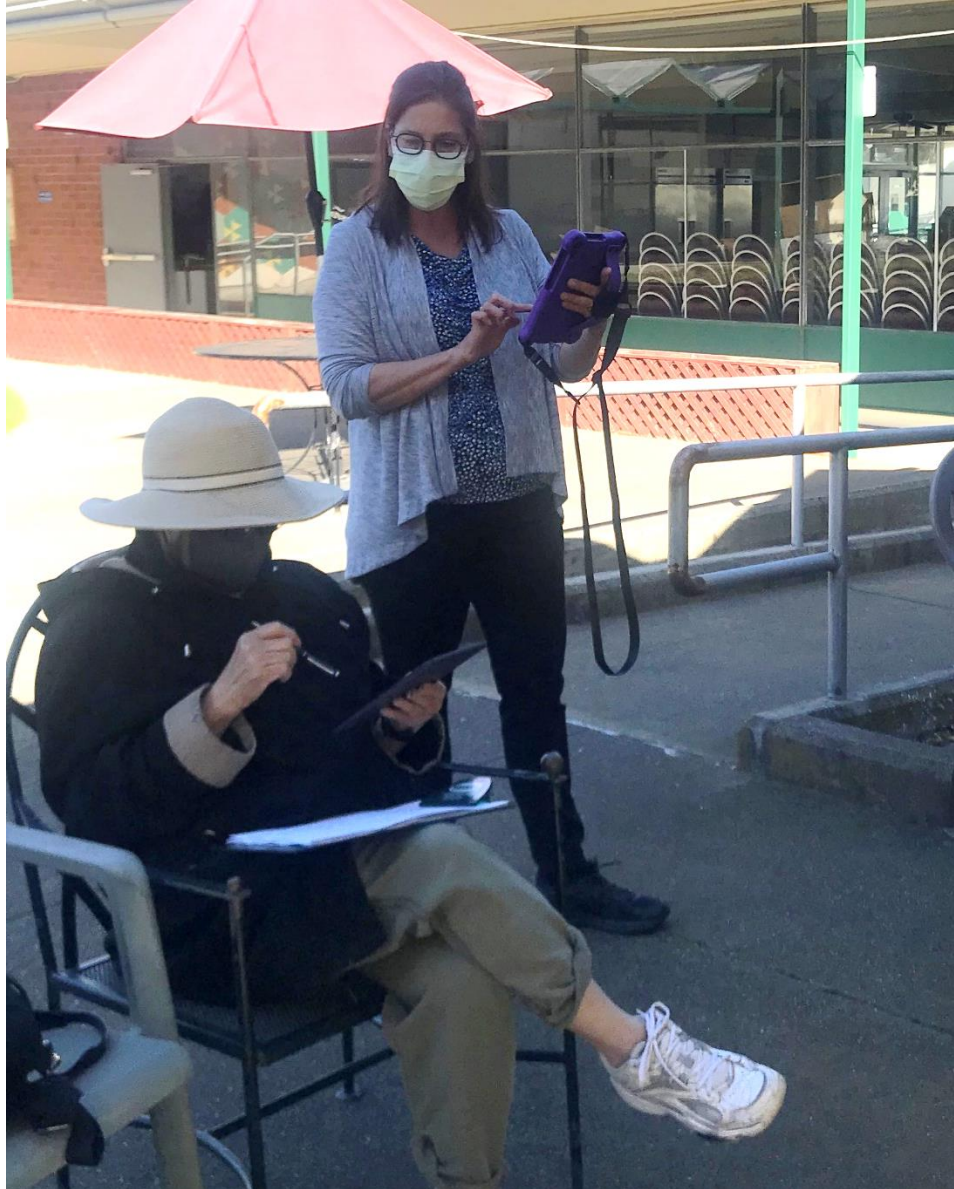
ANNUAL UPDATE

FY 2021-22

(Includes program highlights and data from FY 2019-20 services)

ANNUAL UPDATE FY 2021-2022

Welfare and Institutions Code Section (WIC) § 5847 states that county mental health programs shall prepare and submit an Annual Updates for Mental Health Service Act (MHSA) programs and expenditures. Previously, data for the most recent full fiscal year was not readily available by the deadline to submit Annual Updates to the State in December. This Annual Update includes an attempt to collect and report on the most recent data, therefore program highlights and data include FY 2019-2020.



COMMUNITY SERVICES & SUPPORTS (CSS)

COMMUNITY SERVICES AND SUPPORTS

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

- **Full Service Partnership (FSP)** plans for and provides the full spectrum of services, which include mental health and non-mental health services and supports in order to advance the client's goals and support the client's recovery, wellness and resilience.
- **General Systems Development (GSD)** improves the County's mental health service delivery system. GSS may only be used for; mental health treatment, including alternative and culturally specific treatments; peer support; supportive services to assist the client, and when appropriate the client's family, in obtaining employment, housing, and/or education; wellness centers; personal service coordination/case management/personal service coordination to assist the client, and when appropriate the client's family, to access needed medical, educational, social, vocational rehabilitative or other community services; needs assessment; individual Services and Supports Plan development; crisis intervention/stabilization services; family education services; improve the county mental health service delivery system; develop and implement strategies for reducing ethnic/racial disparities.
- **Outreach and Engagement (O&E)** is to reach, identify, and engage unserved individuals and communities in the mental health system and reduce disparities identified by the County. O&E funds may be used to pay for strategies to reduce ethnic/racial disparities; food, clothing, and shelter, but only when the purpose is to engage unserved individuals, and when appropriate their families, in the mental health system; and general outreach activities to entities and individuals.

FULL SERVICE PARTNERSHIPS (FSP)

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

Based on currently contracted number of slots, the average FSP cost per adult/older adult slots is \$20,758 and per child, youth, and TAY slots is \$59,762. Clients enter and discontinue

participation throughout the year, cost per adult/older adult client served is \$15,952 and per child, youth, and TAY served is \$34,745. These cost figures do not speak to the span or quality of services available to clients either through BHRS or through contracted providers and may overlook important local issues such as the cost of housing, supported services provided, etc.

Program	FSP slots	FY 19/20 Clients Served	Cost per client*
Children/Youth (C/Y) FSP's	80	156	
Out-of-County Foster Care Settings FSP	15	8	\$34,683
Integrated FSP "SAYFE" FSP	25	57	\$53,453
Comprehensive FSP "Turning Point"	40	91	\$60,917
Transitional Age Youth (TAY) FSP's	45	59	
Comprehensive FSP "Turning Point" FSP	45	59	\$60,917
Adult/Older Adult FSP's	302	393	
Adult and Older Adult/Medically Fragile FSP	207	262	\$18,737
Comprehensive FSP	30	34	\$31,346
Assisted Outpatient Treatment "Laura's Law" FSP	50	61	\$26,352
South County Clinic Embedded FSP	15	36	\$8,831

*Calculated based on # of contracted FSP slots and total cost of FSP services (not including housing); there are reimbursements and other revenues sources associated with FSP's that decrease the final MHSA funding contribution.

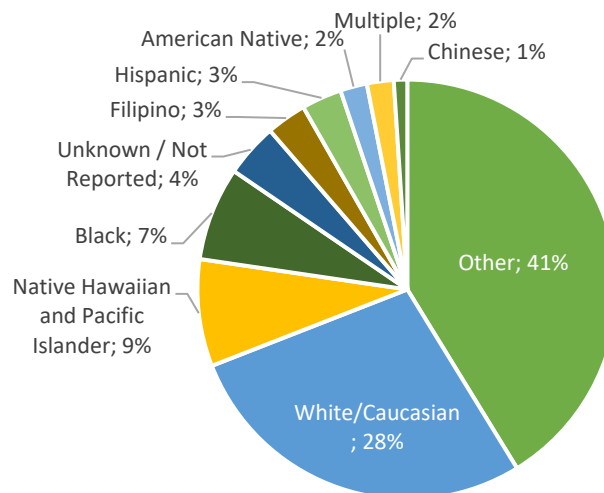
FSP RACE/ETHNICITY DEMOGRAPHICS

Child/Youth and Transition Age Youth FSP Client Demographics

FY 19/20 (total clients = 66)

Percent of FSP Clients by Ethnicity	
Hispanic or Latino	55%
Not Hispanic or Latino	41%
Unknown / Not Reported	5%

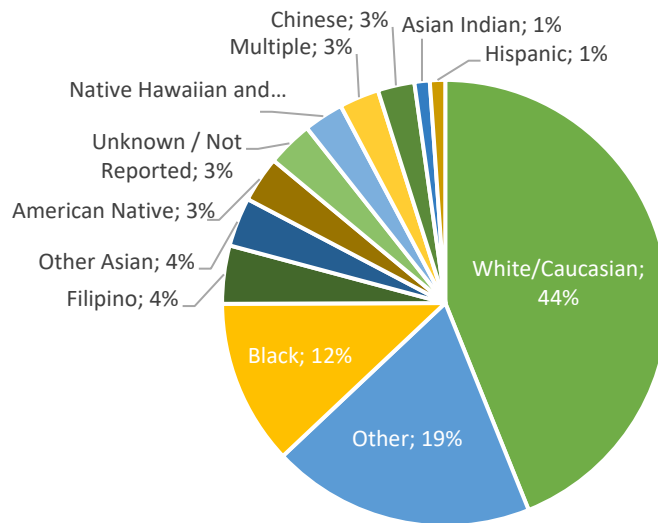
Percent of C/Y and TAY FSP Clients by Race



Adult and Older Adult FSP Client Demographics
 FY 19/20 (total clients = 338)

Percent of FSP Clients by Ethnicity	
Hispanic or Latino	25%
Not Hispanic or Latino	67%
Unknown / Not Reported	9%

Percent of Adult/Older Adult FSP Clients by Race



FSP PERFORMANCE OUTCOMES BY AGE GROUP

As part of San Mateo County’s implementation and evaluation of the FSP programs an independent consultant analyzes FSP data to understand how enrollment in the FSP is promoting resiliency and improved health outcomes of clients living with a mental illness. Year-to-year outcomes are tracked for individual clients in FSPs. Information collected for FSPs include data in 10 domains; residential (e.g. homeless, emergency shelter, apartment alone) education (e.g. school enrollment and graduation, completion dates, grades, attendance, special education assistance), employment, financial support, legal issues, emergency interventions, health status, substance abuse, and for older adults, activities of daily living and instrumental activities of daily living. Data from FSP participants is collected by providers via self-reported intake assessment, key event tracking and 3-month regular assessments. See Appendix 9 for the full FSP Evaluation Report for FY 2019-20. The tables below present the percent improvement between the year just prior to FSP and the first year with FSP, by age group.

Fiscal Year 2019-20 FSP Outcomes*	Child (16 years & younger)	TAY (17 to 24 years)	Adult (25 to 59 years)	Older adult (60 years & older)
<i>Self-reported Outcomes (Survey data)</i>				N/A*
Homelessness	-33%	-9%	-24%	N/A*
Detention or Incarceration	8%	-14%	-38%	N/A*
Arrests	-82%	-82%	-82%	-100%
Mental Health Emergencies	-89%	-77%	-71%	N/A*
Physical Health Emergencies	-93%	-91%	-65%	N/A*
School Suspensions	-52%	-77%		
Grade Ratings	-10%	-3%		
Attendance Ratings	-14%	3%		

Employment			N/A*	N/A*
Active Substance Abuse Problem			-10%	N/A*
Substance Abuse Treatment			23%	N/A*
<i>Healthcare Utilization (EHR data)</i>				
Hospitalization	-70%	-33%	-55%	-25%
Mean hospital days per partner	-91%	-55%	-68%	45%
Psychiatric Emergency Services (PES)	-57%	-36%	-30%	-35%
PES admissions per client	-55%	-30%	-42%	-49%

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

*N/A means insufficient sample size (fewer than 10 observations). Red font indicates outcomes worsened, such as lower school attendance for TAY or more days spent in the hospital for older adult.

CALIFORNIA MULTI-COUNTY FULL SERVICE PARTNERSHIP (FSP) PROJECT

As reported in our previous Annual Update, San Mateo County joined a proposed 4.5-year Multi-County FSP Innovation Project along with Fresno, Sacramento, San Bernardino, Siskiyou and Ventura, with the following five goals:

1. Developing a shared understanding and more consistent interpretation of FSP’s core components across counties, creating a common FSP framework.
2. Increasing the clarity and consistency of enrollment criteria, referral, and transition processes through developing and disseminating readily understandable tools and guidelines across stakeholders.
3. Improving how counties define, collect, and apply priority outcomes across FSP programs.
4. Developing a clear strategy for tracking outcomes and performance measures through various state level and county-specific reporting tools.
5. Developing new and/or strengthening existing processes that leverage data to foster learning, accountability, and meaningful performance feedback in order to drive co

An independent consultant, Third Sector, is facilitating dialogues with all five counties and engaging FSP clients, families and providers in interviews and focus groups to inform the goals.

A progress report through March 2021 is available online here:

https://www.thirdsectorcap.org/wp-content/uploads/2021/03/Multi-County-FSP-INN-Progress-Report_March-2021.pdf.

San Mateo County will be engaging stakeholders via the MHSA Steering Committee in the Fall of 2021 and will report outcomes in the next Annual Update.

INTEGRATED FSP “SAYFE”

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

The Short-term, Adjunctive Youth and Family Engagement (SAYFE) Program serves 25 youth and families at any one time by augmenting and extending the clinical work and existing treatment plan within: (1) the outpatient and Therapeutic Day School (TDS) programs and (2) clients who are currently being served by Behavioral Health and Recovery Services (BHRS) in a Regional county clinic.

Youths are primarily referred to SAYFE program through Human Services Agency (HSA – child welfare), Juvenile Probation, San Mateo County Clinics, and Schools (typically with an IEP for emotional disturbance in place). The treatment is provided in effort to help stabilize a youth in their home environment and prevent (or transition back from) a higher level of care (e.g., psychiatric hospital, residential facility, juvenile hall, etc.). All programs under the umbrella of the Youth FSP are guided by a strong belief in:

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

In the Youth FSP, The SAYFE program, a variety of services are provided to youths and her/his families including family therapy, group therapy, consultation and training to assist in better utilization of services and understanding mental illness and rehabilitation services. The SAYFE program is unique because the team works alongside the Behavioral Health and Recovery Service (BHRS) Primary Clinician.

Also, the families and youths have access to the Crisis Response Services which is available twenty-four (24) hours. The program has access to the After School Intensive Services (ASIS) program (serving to youths aged 6-14), and Behavior Coaching Services.

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

PROGRAM IMPACT & SUCCESSES

The SAYFE program has started providing Family Conferencing in the care planning process. The Family Conference is family driven, strength-based and promotes self-reliance. The focus of the

Family Conference is to explore Decision-Making and Problem-Solving for multi-needs families, and to develop an integrated and comprehensive plan for youth and their families/caregivers. During the FY 2019-2020, Edgewood has been working towards improving and integrating Family Conferencing throughout all Youth FSP programs. The SAYFE program is working on integrating Family Conferencing in treatment to increase engagement and bring forward their voices and choices.

The Youth FSP programs also address the whole family and provides support to parents/caregivers when they have their own mental health or substance abuse needs. The TPCY Family Partners and Care Coordinators facilitate access to services, interfacing with Adult Mental Health Services (MHS) or Alcohol and other Drug Services (AOD) of the BHRS Division. The TPCY team will provide crisis/brief intervention services to those not meeting criteria and referring them to primary care or community resources, as needed.

The SAYFE's treatment team provides peer support and encouragement to the parents/caregivers to enhance the family's community and natural support, transportation services, and supports as identified in the individualized action plan. The Family Partners provide educational support focusing on mental illness, co-occurring disorders and finding resources. During FY 2019-2020, the SAYFE Family Partners successfully provided monthly Parenting Workshop to the SAYFE program and BHRS families.

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

The following success stories highlights the work that the SAYFE Treatment Team (the Family Partner, the Case Manager and the Family Therapist) provides: The SAYFE Treatment Team usually works jointly with the Primary BHRS Clinician and other providers (TBS/Behavioral Coaching, ASIS Program, etc.).

Story #1

The youth was a 17-year-old, Latina female and Spanish-Speaking family referred to wraparound services. The Youth was referred for history of high-risk behaviors that have resulted in multiple hospitalizations due to severe symptoms of anxiety and depression. At the time of the referral, the youth would not attend school due to social anxiety and fear of judgement about her appearance. Family members struggled to understand the youth's symptoms and support her emotional needs.

The youth participated in the SAYFE program and TBS Program. She and her family utilized family therapy, case management, and behavior support services in these two programs. The SAYFE treatment team provided services to the youth and the family alongside the BHRS

primary clinician. During treatment in wraparound services, The SAYFE Treatment team meets with BHRS primary clinician monthly to explore treatment and support to the youth and family.

The youth made significant progress toward treatment goals as evidenced by taking steps toward getting into college and getting a job. The youth has begun utilizing skills to communicate effectively and set boundaries with her family members. The youth's current functioning is stable, and the youth is thriving. The family benefited from support with access to resources for housing and navigating the education system. The youth and her mother improved their relationship and communication in family therapy, and the mother was able to understand the youth's symptoms.

The youth volunteers regularly and works with the public, wants to get a job, and has goals and aspirations of attending college. She has not reported any suicidal or thoughts of self-harm in the last 6-8 months. The youth is no longer at risk.

Story #2

A thirteen-year-old male, Caucasian American referred for SAYFE wraparound services. The youth and his family were involved with wraparound services for 24 months. The youth was referred after multiple hospitalizations due to violent and aggressive behavior towards his mother. The treatment team included a mental health family therapist, a behaviorist, the family partner, the case manager, and utilize the After School Intensive Services (ASIS).

In ASIS, the youth received support with appropriate social interaction and peer relationships. The focus of treatment was decreasing oppositional and defiant behaviors, increasing pro-social activities, and strengthening the relationship between the caregiver and the youth. The caregiver received support with accessing resources to meet client's basic needs. Progress toward treatment goals has not been significant.

The team offered the family all of the additional support services, and both the youth and caregiver struggled to engage in treatment and utilize the interventions that were offered. The team met with this family 2x-3x per week for over 2 years and supported them through many crises. The SAYFE program were able to do graduation with the family and reduce some of the symptoms.

*The name and some identifying factors have been changed to protect the youth's identity.

SAYFE	FY 19/20
Total clients served	57
Total cost per client	\$23,444
Cost per contracted slot	\$53,453

CHALLENGES

There were a handful of challenges during the previous fiscal year (2018-2019) which followed through mid-Fiscal Year (2019-2020). While the program continued to assess and address

ongoing challenges around the ever-increasing cost of living and lack of qualified candidates to fill open positions, the SAYFRE program has additionally been working to address a challenge that has been unique to the program: the high turnover in leadership, and the reduction of the Census due to Plan of Correction from serving 40 families to 25 families.

In the last part of the Fiscal Year (2018-2019), the new Youth FSP Behavioral Health Director was able to turn around the leadership instability, maintain a consistent staffing all throughout the FY 2019-2020, and build positive relationships with external providers and BHRS partners. By improving the relationship with external providers and BHRS contractors, the SAYFE program maintain a high volume of Census throughout the entire FY 2019-2020.

The high cost of living in the Peninsula continues to be a challenge for the program. Additionally, During the FY-2019 to 2020, Edgewood participated in a Plan of Corrections to improve timely access, access to treatment and volume of services. Edgewood successfully met most of the Plan of Corrections, except volume of service. The Youth FSP programs continues working closely with the BHRS oversight team in a monthly and quarterly meeting to improve the volume of services requirements. Due to Shelter in Place, they were not able to address the Units of Services accordingly.

DEMOGRAPHICS

	FY 19/20
Age	
6-17	91%
18-25	9%
Primary Language	
English	72.5%
Spanish	11.8%
Another language	15.7%
Race/Ethnicity	
Asian	2%
Latino	39%
Chicano/Mexican	2%
Black/African/-American	9%
White/Caucasian	9%
Filipino	2%
Pacific Islander	4%
Another race/ethnicity	42%
Decline to state	4%
Unknown	32%

COMPREHENSIVE FSP “TURNING POINT”

Part of the Youth Full-Service Partnership (FSP), Turning Point Child and Youth (TPCY) Program is designed to support the county’s most vulnerable youth and their families in an effort to

maintain and improve the youth's placement. In congruence with Edgewood Center's mission and values, the Full-Service Partnership (FSP) work is informed by a core belief that children, youth, and families are best served and supported in the context of their unique family system, culture, and community.

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

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

The Youth Full-Service Partnership (FSP) Program services are open to all youth meeting the population criteria below. However, it is specifically targeted to Asian/Pacific Islander, Latino and African American Children and Youth. Identified San Mateo County resident populations to be served by the program are:

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

Additionally, all enrollees in C/Y:

- Are ages 6-21 years old;
- Are at risk for placement in a level 10-14 residential facility or "stepping down" from a level 10-14 residential facility; and
- Must be currently involved in Child and Family Services (Child Welfare) or Probation.

PROGRAM IMPACT & SUCCESSES

The Turning Point program aims to reduce stigma and discrimination, increase number of individuals receiving public health services, reduce disparities in accessing care and implement

recovery principles. The TPCY utilizes the Wraparound model of care for children, youth, and families engaged in its program and provides Family Conferencing in the care planning process. Additionally, the Youth FSP programs address the whole family and provides support to parents/caregivers when they have their own mental health or substance abuse needs. The TPCY Family Partners and Care Coordinators facilitate access to services, interfacing with Adult Mental Health Services (MHS) or Alcohol and other Drug Services (AOD) of the BHRS Division.

The TPCY team will provide crisis/brief intervention services to those not meeting criteria and referring them to primary care or community resources, as needed.

The TPCY's treatment team provides peer support and encouragement to the parents/caregivers to enhance the family's community and natural support, transportation services, and supports as identified in the individualized action plan. The Family Partners provide educational support focusing on mental illness, co-occurring disorders and finding resources. During COVID-19, the Family Partners have been instrumental in sending the resources and information via mail and email.

All programs under the umbrella of the Youth FSP are guided by a strong belief in service integration and providing services with a local focus. To this extent the TPCY program provides culturally and linguistically matched services to participating individuals and families.

Finally, the Youth FSP programs provides harm reduction, Stages of Change model for youth with co-occurring disorders. TPCY team will consult with BHRS contractor where substance abuse is determined to be life threatening and will implement more assertive interventions.

PROGRAM SUCCESSES

The following success story highlights the work that is commonplace as it is critical to the work of the TPCY:

A seven-year-old female, African American referred for turning point wraparound services. She and her family were involved with wraparound services for 14 months. The Youth was referred to services from Child welfare and county mental health. At the time of referral this youth had individual therapy services, psychiatric services and support from the child welfare department as she was a dependent placed in a foster home. The youth was placed with her biological sister in a foster home that had the intention to adopt both of the siblings. At the time of referral, the adoption placement was in jeopardy due to journeys behaviors and challenges at home.

The treatment team included a mental health clinician, a behaviorist, family partner, youth specialist, crisis support services, and psychiatry services. The wraparound team partnered in treatment with the foster adoptive parents and the County AAP social worker.

At the time of intake, the youth had a trauma history, developmental concerns, educational difficulties, and health problems. Prior to her current services the youth had received therapy for two years in the County before being placed in her foster home in San Mateo County. The youth would regularly become dysregulated with no apparent prompting triggers. When limits are set regarding household rules the youth will scream, curse, kick, punch, hit and bite the

foster parents. The foster family reported that when the Youth begins to be dysregulated, she becomes hyperverbal, talks gibberish, and only occasionally are they able to calm her down. The parents reported being exhausted and overwhelmed with the youths overwhelming behavioral issues. The child welfare team was concerned that the foster adoptive placement would not go through given the severity of the youth's behaviors.

The Youth's biological family and sister have a reported and long history of child welfare involvement due to general neglect of the children, and domestic violence in the home which began before the youth was born. The youth also experienced sexual abuse and has been in foster care placement since the age of three years old. This youth experienced many losses and changes in her life and has lived into previous foster homes.

The Youth's goals for treatment included helping her to manage symptoms of traumatic stress, such as isolating behavior, social withdrawal and anxiety. The goals were to teach self-soothing and relaxation strategies. In addition, the treatment team intended to teach coping skills and mindfulness. The treatment team also worked on establishing and maintaining appropriate physical boundaries between the youth and others. Also, the treatment team worked to increase the youth effective communication in order to replace her aggressive outbursts and physical tantrums.

During the course of treatment, the clinician worked very closely with the foster adopt family in individual and family therapy. The clinician also recommended an NMT evaluation/Neuro sequential model of therapeutics. This evaluation was agreed to and completed and offered many recommendations and strategies to assist the Youth with regulation and self-soothing. The wraparound team was able to use the recommendations from the evaluation to purchase self-soothing equipment and items for the family. They also guide the family and practice them and using the tools and equipment.

The family partner was very engaged in weekly meetings with the foster adopt parents, guiding them with techniques and strategies to better manage the household and set up the environment to best support the youth. She also worked on the self-care of the parents and validated their feelings and concerns for their daughter. The youth specialist connected directly with the youth and supported with art activities and self-esteem projects.

Overall, the intensity, frequency and severity of the Youth's behavior decreased dramatically during treatment with the wraparound team. The parents were so pleased with the outcomes they were hesitant to end services with the wraparound team even though the treatment goals had been met. During treatment with the youth the foster parents also requested services for their other foster adopt daughter, journey's biological sister. The wraparound team also opened services and provided support and treatment to the sister. Goals were equally met, and her behavior also decreased dramatically in severity, frequency and intensity.

At the conclusion of services, the foster adopt family did agree to and move forward with adopting both children into their forever home. This was a significant and huge milestone for this family and a major sign of the success of wraparound services provided. The treatment

team celebrated with the family prior to the family moving out of the area to another state where they would be closer to other biological relatives and a larger support network. As they moved the family indicated that they were so happy with the wraparound services, they insisted on continuing with wraparound in their new home area to continue working on treatment goals and improving their family dynamics.

Comprehensive FSP	FY 19/20
Total clients served	91
Total cost per client	\$38,581
Cost per contracted slot	\$60,917

CHALLENGES

Due to Covid-19 Shelter in Place, the families who were already experiencing difficult challenges due to living in the Peninsula, such as cost of living, housing, etc., experienced further challenges, such loss of work, financial stress, etc.

The high cost of living continues to present a challenge for our families (and staffs) who are unable to locate affordable and suitable housing. The TPCY program struggled to recruit and retain staffs who were qualified (e.g., had the language capacity, lived experience, or necessary credentials) to adequately treat the families that we served. Meet with clients and families outside of the home, to ensure youths have the emotional and physical space to engage in treatment. Due to COVID-19, staff provided services via telehealth. Additionally, staff will continue to use satellite office to do paperwork to cut down on driving and commute times. And as a Trauma-Informed System (TIS) agency, Youth FSP encourages and attempts to incorporate self-care regularly to avoid burnout.

DEMOGRAPHICS

	FY 19/20
Total Clients Served	91
Age	
6-17	90%
18-25	10%
Primary Language	
English	72.5%
Spanish	11.8%
Another language	15.7%
Race/Ethnicity	
Asian	2%
American Indian	1%
Latino	31%
Black/African/-American	7%
Vietnamese	2%

White/Caucasian	13%
Filipino	1%
Pacific Islander	1%
Another race/ethnicity	2%
Decline to state	2%
Unknown	37%
Gender	
Female	32%
Male	57%
Transgender	1%
Decline to state	10%

OUT-OF-COUNTY FOSTER CARE SETTINGS FSP

East Bay Wrap Full-Service Partnership – (EBW-FSP) is a community-based program serving the needs of youth who are in Foster Care through San Mateo County but no longer live in the county. EBW-FSP, provides intensive community-based care that is rooted in a positive, strengths-based approach. Youth and families receive individualized services (psychotherapy, behavioral interventions, and case management) to maximize the families’ ability to meet their child’s needs, and thereby reduce the potential for residential placement. Because we serve at-risk individuals with services that are difficult for them to obtain “out of county,” the FSP-SM has an “open ended” duration. Staff utilizes a variety of therapeutic approaches, including Cognitive Behavioral Therapy, Behavior Modification, and Motivational Interviewing. All services are trauma-informed and healing centered.

PROGRAM IMPACT

A main facet of the program is to prevent higher levels of care or to help youth live in their homes. Of the 7 total discharges, 6 resulted in a placement at the same level of care as to when the cases were opened. Additionally, during the fiscal year there were no school dropouts.

Out-of-County FSP	FY 19/20
Total clients served	8
Total cost per client	\$34,683
Cost per contracted slots	\$34,683

SUCSESSES

One client stands out as a great example of the program's "do what it takes" philosophy. "J" was a young adult living on her own and had recently given birth to her daughter. While working with "J" staff reflected on how unsupportive and possibly abusive her partner seemed, he often showed signs of intimate partner abuse; however, "J" did not view their relationship in these terms. J eventually came to terms with her boyfriend when he assaulted her. Despite the difficulty, J was able to follow through with criminal charges against him. J's team, including the Care Coordinator, Youth Partner and Program Director from FSP, gave her emotional encouragement and support to deal with this complex issue. The Care Coordinator often spent many hours by her side as she navigated the Court system. J had a significant setback, as she returned to this relationship over a weekend shortly before EBW staff was going to close out services. The boyfriend pressed charges against her and attempted to gain full custody of their child, which was granted while the charges were investigated. EBW staff advocated to extend services understanding from J's past that these taxing situations often spiraled into suicidal ideations and acts. Her supportive and accepting Care Coordinator was again by her side navigating a new Court situation. J indicated that having the support from her FSP team at Fred Finch was instrumental in getting through this dark time. J stated that she was determined to stand strong and knew she had the strength in her to stay positive and focused on managing this situation. The EBW-FSP team did eventually close services as she had aged out, moved back to San Mateo County and had secured new mental health support. Staff recently received a happy call from J indicating she had her baby back and charges against her were dropped. J stated that having our services helped her to "grow up" and trust her better instincts.

CHALLENGES

AB 1299 has reduced enrollment in the EBW-FSP program. Enrollment has fluctuated between 2 to 7 over the past fiscal year. Staff continue to reach out to child welfare to encourage referrals. Due to COVID-19 staff had to quickly adapt services to meet with youth and family safely, including providing services via Telehealth, phone calls and socially distanced meet ups. Some youth adapted well to this modality, while others had a significant challenge with engagement. Since COVID-19 started the program has also adapted to training staff remotely.

Another challenge is the demanding paperwork requirements. Medi-Cal standards are difficult to implement and manage. Most staff express that paperwork demands are the greatest factor they considered when they have left their position. Staff understand the importance of this task but see that this work task is often excessive. EBW-FSP staff meet regularly with their QA department and the QA department with the county. According to staff the county has been quick and clear in their feedback and are supportive with questions.

DEMOGRAPHICS

	FY 19/20
Age	
0-15	38%
16-25	62%
Primary Language	
English	100%
Sex Assigned at birth	
Male	75%
Female	25%
Intersex	
No	100%
Gender Identity	
Male/Man/Cisgender	75%
Female/Woman/Cisgender woman	25%
Sexual Orientation	
Straight or heterosexual	100%
Race/Ethnicity	
Filipino	12%
Chinese	12%
American Indian/Alaska Native	12%
Asian	12%
Guamanian	25%
Veteran	
No	100%

TRANSITION AGE YOUTH (TAY) FSP

ENHANCED SUPPORTED EDUCATION

Caminar's Supported Education program at the College of San Mateo has been highly successful in supporting individuals with mental health/emotional needs in attending college and achieving academic, vocational, and/or personal goals. This program was established in the spring of 1991 from collaboration with the College of San Mateo, Caminar, and the County of San Mateo's BHRS program. The program's unique approach combines special emphasis on instruction, educational accommodations and peer support to assist students to succeed in college. Traditionally, the attrition rate for individuals with psychiatric disabilities has been exceptionally high as a result of anxiety, low stress tolerance, lack of academic and social skills,

and low self-esteem. However, this program has become an innovative leader in reversing this trend. Started in 2016 at Skyline College, Future Views supports potential students with an introductory class and one to one counseling and tutoring.

In addition to the campus presence, the Supported Education program has an extensive presence in the community, with regular groups and outings at Caminar’s residential programs skills group for the case-management programs, Cordilleras MHRC, Edgewood’s Drop- In Centers, the Redwood city library, and California Clubhouse. We also have a weekly Drop-In time for clients to get school and career assistance.

The Supported Education program is also a part of the Diversity and Equity committee and the MHB adult and TAY subcommittees.

PROGRAM IMPACT

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

Students attending Fall and Spring semesters of the Peer Counseling program:

- Achieved an overall GPA of 3.3
- Attained a retention rate of 81%

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

- 100% Reported that their class experience was satisfactory or above
- 5 students are working, 6 are continuing school, 3 are undecided

Overall, the program served 86 unduplicated clients, with 29 TAY (transition-age-adults). 221 Hours of service were provided, 60 groups and activities for TAY clients were offered and 288 engagement activities for TAY were offered (classes, groups, outings, one to one activities).

Supported Education	FY 19/20
Total clients served	86
Total cost per client	\$2,306

SUCCESS

This Spring semester the campus at the College of San Mateo was abruptly closed on Tuesday, March 17th due to the ‘shelter-in-place’ order. The class was transitioned to Zoom on-line format, and re-convened on the following Tuesday, the 24th. The class was able to maintain a

sense of connection to the instructors and each other. Additionally, this also helped them to be able to check-in weekly and become prepared for the covid-19 environment. The entire spring peer counseling class needs to be recognized for their inspiring perseverance, adaptability, engagement, and support of each-other. Whichever direction they chose, they are sure to not only have a positive impact, but also, and most importantly, they will be a support and inspiration to other clients.

CHALLENGES

Shelter in Place

When the ‘shelter-in-place’ order was instituted March 17th, the supported education groups conducted at the residential programs were suspended. They are currently in the process of obtaining a grant for tablets for all of the residents in the 3 programs as well as wifi hotspots to be able to resume groups.

Referrals/Connecting

Conducting outreach and community activities during covid-19 has to be modified. The supported education program has a strong focus on outreach and engagement activities to reach as many clients and programs as possible, and to offer the support and program opportunities available. The Supported Education program will be exploring alternative outreach strategies in the coming year.

TAY (Transition-Age-Youth)

This age group presents challenges in engaging and supporting in life and career goals, as well as the continued housing crisis that has a direct impact on their stability and overall health and well-being. As age-appropriate, TAY often prefer doing activities with other TAY, as well as not wanting to identify with a ‘specialized’ program. While this is important for connection and self-esteem, it represents challenges for helping professionals in engaging, guiding, and supporting. Nonetheless, this is a critical area of focus, as helping to guide and support TAY in their growth, exploration, and development is both essential and highly rewarding.

DEMOGRAPHICS

	FY 19/20
Age	
16-25	15%
26-59	62%
60+	16%
Unknown	7%
Primary Language	
English	86%
Spanish	1%
Cantonese	1%
Unknown	11%

Gender Identity	
Male	49%
Female	36%
Decline to state	2%
Unknown	12%
Two-spirited	1%
Sexual Orientation	
Gay, lesbian, homosexual	3%
Straight or heterosexual	58%
Bisexual	5%
Decline to state	21%
Unsure	1%
Unknown	12%
Race/Ethnicity	
Latino/a	14%
Pacific Islander	3%
Asian	2%
Black/African/-American	8%
White/Caucasian	52%
Filipino	2%
Asian Indian	1%
Mixed Race	1%
Another race/ethnicity	6%
Unknown	9%
Veteran	
Yes	70%
No	2%
Unknown	30%

COMPREHENSIVE TAY FULL SERVICE PARTNERSHIP

The TAY FSP program is a specialized mental health program designed to meet the unique needs of high risk and highly acute 16-25-year-olds. The program receives referrals from San Mateo County BHRS and can serve 45 transition age youth clients at any given time. The purpose of the TAY FSP program is to assist each transition age youth and their family of choice to achieve stability and wellness within the context of their culture and community. Our multidisciplinary team approach provides transition age youth with the opportunity to work with individuals in a variety of specialty areas, ensuring a holistic lens is applied to themselves and their lives. The program applies a person-centered approach, using “whatever it takes” to engage and support the transition age youth in addressing their needs and meeting their identified goals. Specialized services include case management, clinical treatment, skill-building, crisis prevention/intervention, peer/family support, medication management, housing support, community engagement, career and employment exploration, and linkage.

PROGRAM IMPACT

1. Improves timely access & linkages for underserved populations

Referrals for the TAY FSP primarily come through the Youth Transition Assessment Committee (YTAC) meetings. Once referred to our program, we employ numerous strategies for timely access and linkages including;

- Maintaining bilingual and bicultural employees which gives us an opportunity to assign case managers and clinicians who share similar cultural backgrounds as the TAY and families referred;
- Investing time into meeting the youth where they are at which often literally means looking for youth in their usual hang outs, connecting through the Edgewood Drop-in Centers, and searching for their whereabouts on system databases (e.g. court systems); and
- Creating flexibility in our own work hours to accommodate the varied TAY client schedules that also may also include school, work, child care, AOD treatment, etc.

The TAY FSP was engaged with BHRS on a Plan of Correction to address areas of improvement in our Full Service Program services. Specific to the TAY FSP, the areas for timely access and linkages were addressed by working closely with BHRS to revise the referral and opening process to make access to our services more efficient and more accurately reflect our caseload. We also worked with BHRS to clarify our challenges with providing quicker access to our internal psychiatric services. BHRS has been a valuable partner in ensuring that referrals include pertinent medication and diagnostic information which facilitates a quicker transition from the County's psychiatric services.

1) Reduces stigma and discrimination

As an agency, Edgewood uses the Bronfenbrenner Ecological Systems Theory when engaging clients and their families. The TAY FSP works to reduce stigma and discrimination through ongoing education and flexible, individualized approaches to treatment that address every system that impacts the client's life.

- Individual work includes setting our pace for engaging and clinical work based on each individual TAY's readiness to participate in services. At the point that TAY come into our program, they often have been victimized by and are untrusting of programs or systems that have stigmatized their mental illness and limited their hopes for the future. Taking the time to prove our investment in their vision of the future engages TAY in a way that typically helps them reach beyond where they or others have ever thought they could go in their own wellness and functioning.
- Microsystem work includes educating those closest to the client about serious mental illness and the other intersecting factors that contribute to the complexity of each client's behaviors and treatment. These factors, which are also often highly stigmatized, could be identifying with the LGBTQ community, neurodiversity, physical abilities, trauma history, and ethnicity, to name a few.
- Exosystem work includes participation in workgroups/committees and community initiatives and having Edgewood Center presence at

community events such as the *Soul Stroll*, *Pride Fest*, and *Transgender Day of Remembrance*. Community involvement helps us to advocate and give voice for our clients in spaces that they may not be or feel welcome, as well as keeps this sometimes unseen population at the forefront of people’s minds. It has also included outreaching to police departments to partner on mental health crisis responses.

- Macrosystem work includes advocacy on the county, state and federal level for policies and funding that will positively impact TAY.

2) Increases number of individuals receiving public health services

As mentioned above, each TAY is unique including the barriers to receiving public health services. Their treatment team, also tailored to the needs and interests of each TAY, works together to connect our clients with services available in the community. TAY FSP Case Managers stay abreast of public health resources that will meet the needs of our clients. Behavior Support Specialists work to decrease behavior that may get in the way of accessing or engaging with health services. Independent Living Skills specialists are available to work on very logistical components to accessing services such as using public transit, getting and maintaining important documents (i.e. identification cards), or managing an appointment calendar.

3) Reduces disparities in access to care

Our strength in reducing disparities is creating the most flexible, engaging programmatic structure that we can. There is no “one way” or predetermined course in our program. Our providers are not easily discouraged by behaviors that others may label as “uncooperative”, inconsistent participation, or regression in progress. We celebrate engagement on any level and build on upon it. This helps our team establish trust. We also employ a culturally and ethnically diverse workforce that have a wide variety of educational and experientially backgrounds. Diversity in our workforce brings diversity to our understanding of each individual client and approaches to treatment.

4) Implements recovery principles

The TAY FSP program integrates trauma informed practices and harm reduction with wraparound principles to support TAY through their treatment with us. We partner with substance use programs within the county as needed.

Comprehensive TAY FSP	FY 19/20
Total clients served	59
Total cost per client	\$38,851
Cost per contracted slot	\$60,917

SUCCESSSES

Following are two stories that highlight the success of each treatment team and recognize the growth of each transition age youth. Terry (preferred pronoun-they) is a transgender TAY who has been in the program since 2018. Shortly after coming into the program, they were homeless due to strained relationships with their parents, with whom they had been living. Terry presented with severe depression, self-harm behaviors, and substance use that interfered with their ability to maintain a job. They formed very unhealthy attachments to peers that they would consider friends but whom often left them in very unsafe situations. The TAY FSP treatment team consisted of a case manager, clinician, behavior support specialist, and an independent living skills specialist. The team was able to support Terry to move into one of the housing programs in the community. Terry was successful there; meeting regularly with the team to work on their treatment goals. During the course of the treatment, Terry became more open to examining their relationships and, most importantly, their role in the volatility of those relationships. Over time, Terry was able to establish healthier contact with their parents and start setting boundaries with peers. Terry is close to graduating from our program having successfully managed independent living for over a year.

Emilia (preferred pronoun-she) was in the FSP program from 2017 to 2020. At the time of referral, Emilia had been hospitalized numerous times suffering from PTSD due to a prolonged and complex trauma history. Emilia's tendency was to be aggressive and verbally abusive to providers and had, therefore, burned many bridges to services available to her in San Mateo County. Recognizing this barrier to engagement, the team initial only consisted of the clinician for the assessment phase and then only a behavior support specialist for several months. The intention was to slowly help Emilia be able to regulate her behavior before introducing more members of the treatment team. The behavior support specialist attempted engagement with Emilia for weeks before having an actual session. The first session, which was a half hour of quietly drawing, led to a second and third session where Emilia started to engage in some talk about her art. Those first few sessions led to more sessions focused on art, visiting sites with community art projects, and eventually, more open discussions about how her behavior has been impacting her ability to access the services that would support her goals for the future. When Emilia was ready, the behavior support specialist skillfully introduced the clinician to the team. The team continued to build as Emilia was able to learn to trust one provider then another from our team. Emilia had been engaged with her whole treatment team for a few months when her family moved out of the county and, with their support, was able to do a warm handoff to the next treatment team. This is considered a success as Emilia continues to engage with the services *in her new county- her behavior no longer an obstacle to receiving the supports that she needs.*

Additionally, the implementation of telehealth in response to the COVID-19 pandemic has been a success for some and a challenge for others (challenges included below). We equipped all providers with agency issued cell phones and laptops and deployed videoconferencing technology. For some TAY clients, telehealth is working well in that it is easier for some to connect via video versus meeting in person.

CHALLENGES

Maintaining the Family Support Team (Family Partners and a Family Support Manager) has been challenging this past year for a few reasons. Edgewood Center for Children & Families is committed to hiring people with lived experience to provide support for parents/caregivers. The pool of potential candidates who are interested in this work is small. Additionally, they are not able to pay a competitive salary, especially if the applicant lives in San Mateo County and is still a primary caregiver to a youth, TAY or other family member. *Mitigation:* The TAY FSP Leadership team is actively strategizing on different approaches to caregiver/parent support including ways to facilitate connections with each other to build into the program the crucial element of peer support.

As mentioned above, there have been some challenges with moving to a primarily telehealth model during the pandemic. In addition to some of the universal challenges many people are experiencing (internet service overload in households, unreliable equipment, or crowded homes that do not allow for a quiet, isolated space to do sessions), telehealth has been particularly challenging for trans TAY who have body dysphoria or those who have severe paranoia. Having to use a video camera or a microphone with the capability to record or broadcast can be very challenging. *Mitigation:* With guidance from the Medical Director and in accordance with local and state guidelines, Edgewood is planning for how to safely conduct in person services in the community.

DEMOGRAPHICS

	FY 19/20
Age	
16-25	99%
26-59	1%
Primary Language	
English	100%
Sex Assigned at Birth	
Male	47%
Female	46%
Decline to state	7%
Gender Identity	
Male/Man/Cisgender	46%
Female/Woman/Cisgender woman	45%
Transgender male	1%
Transgender woman	1%
Decline to state	7%
Race/Ethnicity	
Pacific Islander	6%
South American	46%

Arab/Middle Eastern	3%
Black/African/-American	8%
White/Caucasian	22%
Filipino	3%
Unknown	10%
Another race/ethnicity	2%
Veteran Status	
No	100%

TAY DROP-IN CENTERS

Located in San Bruno and Redwood City, the Drop-in Centers are community resource centers catering to individuals between the ages of 18-25 years (up to their 26th birthday). Each peer-led site serves as a safe and confidential space offering free resources, activities and workshops, and opportunities for socialization and peer connection.

The Drop-in Centers provide regularly scheduled programming such as community outings, social activities, personal growth and wellness workshops, as well as access to computers, the internet, a clothes closet, and food. Most importantly, Peer Partners lead activities that support 18-25-year-old participants in building the necessary skills to successfully transition to adulthood.

Peer Partners, young adults who have been through similar life experiences, are an invaluable resource to the Drop-in Center participants. Employing people with lived experience in peer worker roles to support others brings a tremendous range of benefits. Peer workers know what it is like to go through uniquely difficult situations and life experiences and can share their experiences of recovery, growth, and resilience. Peer Partners who are living well represent hope that is often missing in the Drop-in Center participant's lives. Peer Partners facilitate a safe and welcoming environment through the use of empathy, validation, constructive feedback, and unconditional support; Peer Partners are trained in youth development, harm reduction, and peer counseling techniques. Peer Partners offer support and peer mentorship; give resources; and plan, implement, and co-facilitate groups and activities.

Success at the Drop-in Centers is measured individually and is fluid according to how each transition age youth participant defines self-efficacy. The primary focus is on building quality relationships with all individuals, so each may feel empowered and capable of voicing their needs and apply what they have learned to all facets of their lives. Goals include:

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

PROGRAM IMPACT

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

Lynn is a gender-fluid individual who has been living in a local parking lot. They used to live with their family and was very active in the dance community. When Lynn began to suddenly experience extreme psychosis, they were kicked out of their family's home. As a result, Lynn's hygiene and health began to decline and they became distant from their friends and other support systems. The first night that Lynn came to the Drop-in Center, they attended the Back to School Fair and won a Chromebook. After that they came to the Drop-in's on a regular basis to charge their Chromebook, grab a bite to eat, and play games with the Peer Partners. Over time, Lynn's hygiene, health, and confidence vastly improved. Now Lynn spends Tuesdays and Thursday at their family's home to charge their Chromebook and have dinner with their family.

Jacob is a TAY FSP client that suffers from social anxiety. Jacob's anxiety limited his interactions with others; however, he has formed relationships with Peer Partners and other participants over the last year. Jacob attended a Resume Workshop that was hosted by one of the Peer Partners. After he completed his resume, he worked on filling out applications with a Peer Partner. The next day Jacob turned in an application at the local grocery store and set up an interview. After some additional coaching and a new pair of pants from the closet, Jacob nailed the interview and the job!

TAY Drop-In Center	FY 19/20
Total clients served	116
Total cost per client*	\$49,889

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

SUCSESSES

Positive Youth Development continues to be the drop-in center's approach in working with the San Mateo County TAY community. The holistic, positive and preventative nature of the youth development philosophy has yielded positive outcomes which include feeling valued and included in what happens at the Drop-in Center. Participants are encouraged to give feedback on programming, giving them a sense of ownership of the weekly groups and activities.

The drop-in center also continues to establish partnerships with community organizations and businesses. Without these partnerships with local educational institutions and community-

based organizations the drop-in center would not be able to hold their annual events which include the Back to School Fair and Career Fair. Representatives from Bay Area colleges and universities spread throughout our DIC sites on fair days. Food, raffle items, and new backpacks filled with school supplies are a result of donations from individuals and local entities including Help One Child, Jersey Mike's and EA Sports.

Unfortunately, due to the COVID-19 pandemic, the annual Career Fair, which was scheduled in late February, was canceled. The drop-in center is planning to revive the fair in the next reporting period 20-21. While the COVID-19 pandemic forced the center to suspend their day to day activities, they were able to adjust services and continue provide support to the TAY community. Basic needs supplies like food, hygiene and self-care items were made available through the on-site "grab and go" distribution at both Drop-in Centers. They also provided delivery services to TAY who were unable to make the trip to one of the sites. Basic needs supplies are an important resource to many of the TAY who have limited financial support. This reporting year, the drop-in center also launched a Drop-in Center social media page through Instagram. The Instagram page provides the ability to stay connected with the TAY community and announce all the services and activities that are offered.

CHALLENGES

In FY 2019-2020 the drop-in center experienced similar challenges to previous years as well as additional challenges from COVID-19.

Ongoing Challenges:

- The cost of living in the Peninsula continues to present as a challenge for the Drop-in Center participants and staff;
- The lack of short-term and emergency TAY-specific housing means efforts are focused on supporting participants to find housing through: efforts to identify friends or peers they can stay with, providing sleeping bags and rain gear to those who must sleep outside, and finding bus/train routes to TAY-specific shelters in San Francisco and Santa Clara Counties.

New Challenges

- COVID-19 and SIP Order restricting access to the Centers. Lost connection with regular TAY community members due to lack of contact info;
- Communication and outreach to TAY community providers for collaboration and resource support;
- Holding Back to School Fair, Resource Fairs, Health Fairs while practicing safety and social distancing guidelines;
- Capacity to deliver services to monolingual Spanish speaking TAY;
- Utilization of Drop-in Center sites for in person activities;
- Reaching more Community TAY who are isolated during this time and lack the communication resources to connect with our DIC team.

DEMOGRAPHICS

	FY 19/20
Age	
16-25	100%
Sexual Orientation	
Gay, lesbian, homosexual	3%
Straight or heterosexual	16%
Bisexual	8%
Queer	1%
Questioning or unsure	1%
Another sexual orientation	1%
Decline to state	71%
Gender Identity	
Male/Man/Cisgender	29%
Female/Woman/Cisgender woman	16%
Transgender male	1%
Transgender woman	1%
Decline to state	53%
Race/Ethnicity	
American Indian/Alaska Native/Indigenous	1%
Asian	%
Latinx	%
Pacific Islander	3%
Eastern European	%
European	6%
Arab/Middle Eastern	1%
Black/African/-American	4%
White/Caucasian	3%
Asian Indian/South Asian	2%
Central American	2%
Chinese	3%
Mexican/Chicano	8%
Filipino	1%
Japanese	1%
South American	2%
Another race/ethnicity	62%
Decline to state	2%

ADULT AND OLDER ADULT/MEDICALLY FRAGILE FSP

The FSP program, overseen by Telecare, Inc., provides services to the highest risk adults, highest risk older adults/medically fragile adults. Outreach and Support Services targets potential FSP enrollees through outreach, engagement and support services. These programs assist consumers/members to enroll and once enrolled, to achieve independence, stability and wellness within the context of their cultures and communities. Program staff are available 24/7 and provide services including: medication support, continuity of care during inpatient episodes and criminal justice contacts, medical treatment support, crisis response, housing and housing supports, vocational and educational services individualized service plans, transportation, peer services, and money management. Services specific to Older Adult/Medically Fragile include maximizing social and daily living skills and facilitating use of in-home supportive agencies. Telecare FSP, via the integrated teams model uses daily morning huddles to assertively coordinate and track the various service needs for every individual the teams serve. Including benefits acquisition, psychiatric appointments and medication, case management and evidence-based rehabilitation and other promising practices, the teams proactively identify needs and gaps in service and provide, broker or advocate for those necessary services or resources. The concentrated effort of each team affords the opportunity to engage in continual improvement for clients lives by circling back on progress made in all the areas identified.

PROGRAM IMPACT

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

SUCSESSES

Mr. M has been a client with Telecare for just over one year. When he came to Telecare he had numerous active suicide attempts, he was experiencing homelessness, struggled with substance abuse, rejected by his family for his sexuality, felt unloved and had no desire to live. Mr. M had been admitted to the hospital numerous times. He had attempted stays at short term crisis stabilization programs, and struggled which resulted in discharging and not returning each time. When Mr. M was referred, he had again attempted suicide and thankfully, was unsuccessful. He was admitted at an acute psychiatric unit for a few weeks and then referred and accepted at a Crisis Residential House. Telecare engaged Mr. M upon his stay at the Crisis Residential site and began building rapport with him in addition to supporting him by taking one step at a time toward moving forward in his recovery.

As time went by, Mr. M began to trust the Telecare team as well as the process. He continued to take steps and partnered with the team in obtaining his necessities all while finding his strength and desire to live. The more he trusted the team, the more they were able to empower him and help him determine what he wanted his life to look like. After succeeding at the Crisis Residential site, Mr. M was accepted and admitted at a social rehab residential program where he could receive continued support and opportunities to rebuild his basic life skills, and continue to find his strength and courage to move forward. During his time at the social rehab residential program, he continued to strive and do well, choosing to return to school and start college classes in addition to engaging in therapy at the school. He received extensions due to his continued resilience and receptance to learning and utilizing the practical skills he was being taught. There were definitely hiccups along the way, but each time Mr. M was able to come back, reengage, and find his will to live. Mr. M graduated currently and is supported at a supportive residential site where he receives medication reminders and case management but is able to live independently otherwise. Mr. M has learned that he has supports, a team who cares about him, and that there are reasons to live!

Telecare Adult/Older Adult FSP	FY 19/20
Total clients served	262
Total cost per client	\$14,804
Cost per contracted slots	\$18,737

CHALLENGES

As reported in previous reports, the current program funding has not kept pace with the program’s operational costs. While the contract continues to be extended the program’s hiring rate is often well below the range of competing agencies and tragically below the cost of living in the area. A lack of funding has meant the program has had to relocate twice in the past fiscal year, impacting services. The second, obvious challenge, is the global pandemic of COVID-19. This has caused a serious interruption in business and the program had to adapt to providing services via telehealth very quickly. Fortunately, the program has a robust housing continuum in which they are able to house just over half of their members. Since Telecare staffs these sites, they have been able to provide some face to face visits. This has been both immensely stabilizing for the members and afforded the program to leverage with the county health to complete baseline testing at the locations.

DEMOGRAPHICS

	FY 19/20
Age	
Up to 23	.5%
24-34	14%
35-44	27%
45-54	20%
55-64	23.5%

65+	15%
Sex Assigned at Birth	
Male	65%
Female	32%
Other	1%
Race/Ethnicity	
American Native	1%
Black	16%
Chinese	1%
Filipino	.5%
Japanese	.5%
Korean	.5%
Other Asian	1%
Pacific Islander	3%
Other	23%
White/Caucasian	51%

COMPREHENSIVE FSP FOR ADULTS AND OLDER ADULTS

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

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

Consumer treatment includes a variety of modalities based on consumer needs, including case management, individual, group or family therapy, psychiatric medication prescription, and general medication support and monitoring. Consumer self-help and peer support services, include money management, assisting with employment opportunities, social rehab and assistance with referrals and housing. Caminar also provides community based-nursing to assist clients with improving medication compliance. FSP services are delivered by a multidisciplinary team, which provides 24/7, crisis response support, including in-home support services and services at other consumer locations as appropriate. Case managers help to plan for linkage to

and coordination with primary care services, with the intent of the strengthening the client’s ability to access healthcare services and ensuring follow up with detailed care plans.

PROGRAM IMPACT

Caminar reduces suicide by rapid and consistent engagement with clients and their collateral providers, case conferences, increasing contact with clients who may be decompensating, 24/7 availability and CPI protocol and training. The program limits school failure and drop out through the Supported Education program and helps to lower unemployment by utilizing the Jobs Plus program, which provides skills training and referrals to employers looking for workers. Homelessness, as we are all keenly aware, is a pervasive problem in the Bay Area and in San Mateo County, in particular. Through the Supported Housing program, Caminar provides housing options to clients in need for independent apartments and shared apartments. In collaboration with BHRS, FSP links clients to multiple housing options: Licensed Board and Cares, SRO rooms, shelters, and unlicensed room and boards.

By utilizing the social rehabilitation model, which provides for a non-judgmental, normalized environment which emphasizes the client as the lead in their care, Caminar works to reduce the stigma and discrimination their population often faces. They further ensure linkage to outside community providers for primary care and insure ongoing collaboration with said providers and our staff; this helps insure that clients are receiving public health services. By partnering with other non-profit agencies, Caminar helps reduce the disparities in access to care. Finally, they utilize Harm Reduction, MI, DBT and WRAP to help strengthen the gains made by clients and to implement the principles of recovery throughout all of our programs.

Caminar Adult/Older Adult FSP	FY 19/20
Total clients served	34
Total cost per client	\$27,659
Cost per contracted slot	\$31,436

SUCCESSSES

Covid-19 Pandemic safety measures: As a result of the Covid-19 Pandemic Caminar FSP has increased its support to clients to reduce the risk of infection to the high-risk population. These services include increased weekly phone contact with the Case managers, field visits for clients who are in crisis and need in-person support, the initiation of Supervisor of the day to support clients in crisis both in the clinic and in the field, and home food deliveries. Caminar FSP has equipped staff with technology to support clients who have the desire and resources to engage in telehealth.

Cultural responsiveness trainings and addressing racism in our community: As a response to the need to increase staff’s competency of racism in our community and the need to be culturally responsive to provide the best quality of services to FSP diverse population Caminar increased their staff’s attendance at Caminar’s monthly Diversity and Equity Committee. Caminar has also implemented an Organization Wide Committee –on Structural Racism, Diversity. Equity and

Inclusion. Weekly Staff meetings now include time to discuss staffs own personal experience with racism, biases, and allows space for staff to share their own culture with their team with the purpose of also celebrating our staff's diversity.

Complex Case Conferences: Complex Case Conferences have increased to weekly. The conference is comprised of a multi-disciplinary team, including case managers, psychiatrists, nurse practitioners, registered nurses, licensed vocational nurses, family members, County providers, etc. The purpose of this conference is to discuss client crises, safety concerns, clients requiring a higher level of services, etc. The outcome of this meeting has been increased collaboration among team members, gathering input from all members of the team and identifying action steps and responsible parties to complete follow up tasks.

Hiring Clinical Case Managers: There has been an increase in applicants and we have been able to keep the FSP program staffed with one Clinical Case manager to provide both thorough psycho social assessments and individual, family, and group therapy.

Client Story #1: Previously, Jane required regular hospitalizations due to her mental health disability. These included one hospitalization that included the need for a Tarasoff warning to two members of the community. Jane also struggled with a meth addiction that exacerbated her mental health symptoms. With Caminar FSP support, Jane has become an inspiration in many ways, as she has substantially improved her ability to manage her mental health symptoms and eliminate her meth use, all while undergoing chemotherapy for breast cancer. Jane now enjoys engaging in coping skills such as lighting candles, meditating, engaging in prayer, and exercising. Jane attends all of her psychiatry and therapy appointments, as well as regular meetings with her case manager. Jane enjoys painting, journaling, and collecting stamps. She has successfully maintained housing for over ten years.

CHALLENGES

Telehealth: Due to a lack of technology and data plans available to many clients have limited resources to engage in video telehealth for Case Management services, psychotherapeutic, and psychiatric. Caminar has identified clients that can follow CDC guidelines for wearing masks and social distancing to provide face to face visits. They will also be applying for the Cares funding through BHRS to provide clients with the technology and data plans to engage in video telehealth services.

Housing: The limited housing options for clients given the continued increase in housing costs in the Bay Area along with their low incomes continues to be the biggest challenge for FSP. The closure of three Licensed Board and Cares over the past year has increased the wait time for clients to access appropriate level of housing. In addition, clients reflect an aging population and as such have an increase in medical needs and their medical issues become a dominant component of their lives.

Housing subsidies: Housing subsidies that are linked to FSP have been a barrier to stepping down a number of clients. If they are stepped down to a lower level of care, they lose their housing subsidy, which means they lose their housing. FSP continues to seek alternate forms of non-program dependent housing subsidies and/or vouchers that are not tied to the FSP program.

Comorbidity: Clients are continuing to experience major medical concerns in our FSP program. These clients will need long term medical assistance, but are currently being managed in the community or temporarily placed in SNFs in the hopes of returning to the community. All FSP clients are continuing to be seen weekly for at least two hours by their case managers, nurses, psychiatrists, assistant case managers and/or wellness support specialists. Many of these clients may need to be assessed for IHSS services so they can continue to live independently, but also lively safely in their environment and to ensure their needs are met.

DEMOGRAPHICS

	FY 19/20
Age	
16-25	3%
26-59	74%
60+	29%
Sex	
Male	%
Female	%
Language	
English	94%
Spanish	6%
Race/Ethnicity	
Asian	12%
Black	6%
Latino	12%
Multiple	3%
Pacific Islander	6%
Unknown / Not Reported	3%
White/Caucasian	59%
Sexual Orientation	
Bisexual	6%
Heterosexual	76%
Other	9%
Unknown	9%
Veteran	
No	97%
Yes	3%

ASSISTED OUTPATIENT TREATMENT “LAURA’S LAW” FSP

The purpose of Assisted Outpatient Treatment Full Service Partnership (AOT FSP) is to provide services to individuals with serious mental illness who currently are not receiving treatment and may or may not require court intervention to receive treatment. AOT FSP services are based on the Assertive Community Treatment model (ACT).

AOT target population are adult San Mateo County residents living with serious mental illness who meet the eligibility criteria listed below as specified in Assembly Bill 1421 : Clients unable to "survive safely" in the community without "supervision;" History of "lack of compliance with treatment" as evidenced by at least one of the following : a. Hospitalized/incarcerated two or more times in the last 36 months due to a mental illness; or b. Violent behavior towards self or others in the last 48 months. Clients who were previously offered treatment on a voluntary basis and refused it or are considered "deteriorating."

Program activities include engaging Individuals who have not had a successful and lasting connection to treatment and recovery services. Diversion from the criminal justice system and/or acute and long term Institutional levels of care (locked facilities) SMI and complex Individuals with multiple co-morbid conditions that can succeed in the community with sufficient structure and support. Caminar offers a "whatever it takes" to engage complex adults and older adults with SMI in a partnership to achieve their Individual wellness and recovery goals, using alternative models of care which offer greater benefits to them, increasing the likelihood that they will experience positive outcomes.

PROGRAM IMPACT

AOT (Laura’s Law) FSP	FY 19/20
Total clients served	61
Total cost per client	\$21,600
Cost per contracted slot	\$26,352

SUCCESSSES

The AOT program has had many successes over the last year including:

- Increasing support to clients to reduce the risk of coronavirus infection by increasing weekly phone contact, field visits for clients in crisis and home food deliveries;
- Increased staff attendance at monthly Diversity and Equity Committee meetings and implemented an Organization Wide Committee of Structural Racism, Diversity, Equity and Inclusion;
- Increased complex case conferences to weekly increasing collaboration among team members, gathering input from all members of the team and identifying action steps and responsible parties to support tasks;
- Hiring additional clinical case managers.

Client Story #1: Over the past few months during COVID-19 shelter-in-place John has been able to successfully obtain housing for the first time in years due to his mental health disability (Schizophrenia & Trauma related Dx) and has been doing a great job maintaining it. John has been engaged with treatment team including case managers and has gotten to all of his psychiatry appointments during shelter-in-place. It has been brought up with by the previous PD that client can possibly be stepping down from AOT due to outstanding progress shown over the past year. John's goal has been to reduce/abstain from alcohol consumption and with the help of AOT team, he has been able to utilize positive coping skills to avoid alcohol use. John has successfully been going out to the community and trying social skills. Currently, he reports still being "shy" but is trying his best to make friends and interact with his new neighbors while working on social skills with his case manager.

CHALLENGES

- **Staffing turnover rate:** The turnover rate of staff on the AOT team has been very high. The level of acuity and behavioral issues that the client's exhibit have led to a faster rate of burnout. The staff endure verbal and physical threats as well as damage to their personal property. The new Program Director has been working diligently to staff the AOT team. The Program Director and Director of Case Management work closely with the staff to identify clients who require 2:1 for the safety of the staff, increase discussion with the BHRS AOT team and county contractor for clients who are escalating in verbal threats and physical violence. Safety procedures continue to be priority and ongoing conversations with staff. Self-care and burn out are weekly discussions in staff meetings and individual supervisions.
- **Telehealth:** Due to a lack of technology and data plans available to our clients they have limited resources to engage in video telehealth for Case Management services, psychotherapeutic, and psychiatric. AOT has identified clients that can follow CDC guidelines for wearing masks and social distancing to provide face to face visits to have eyes on the clients. AOT will be applying for the Cares funding through BHRS to provide clients with the technology and data plans to engage in video telehealth services.
- **Housing:** The limited housing options for clients given the continued increase in housing costs in the Bay Area along with their low incomes continues to be the biggest challenge for AOT. The closure of three Licensed Board and Cares over the past year has increased the wait time for clients to access appropriate level of housing.
- **Housing subsidies:** Housing subsidies that are linked to AOT have been a barrier to stepping down a number of clients. If they are stepped down to a lower level of care, they lose their housing subsidy, which means they lose their housing. AOT continues to seek alternate forms of non-program dependent housing subsidies and/or vouchers that are not tied to the AOT program.

DEMOGRAPHICS

	FY 19/20
Age	
16-25	18%
26-60	80%
61+	8%
Sex	
Male	72%
Female	28%
Race/Ethnicity	
White	56%
Latino	7%
Asian	14%
Black/African American	18%
Unknown	3%
Hawaiian/Pacific Islander	2%
Primary Language	
English	96%
Korean	2%
Spanish	2%
Sexual Orientation	
Bisexual	5%
Gay	2%
Heterosexual	80%
Unknown	13%
Veteran	
Yes	5%
No	92%
Unknown	3%

MATEO LODGE: SOUTH COUNTY INTEGRATED FSP

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

Mateo Lodge is contracted to provide 50 hours of Intensive Case Management (ICM), services per week for 3 different levels of intensity (A - Task oriented case management 1-2 months, B - Supplemental case management 4-6 months, and C - FSP clinical case management 6 - 12months). The clients within the program receive 1–3 hours of contact per week based on level of care needed and/or need identified to support client. ICM is a clinic referral-based program. The referring party completes a referral form indicating 'ICM Service Requested'. The ICM engages with the client within one week of the referral to complete a client focused needs assessment based on clients' stated need. The best outcomes for ICM clients exist when there is a warm handoff from the referring clinical team. The ICM collaborates with the treatment team to ensure targeted service that is based on client and referring party identified needs are addressed. Full Service Partnership (FSP) level C is utilized for clients that are high risk of self-harm, loss of placement, or poorly engaged with outpatient services. The FSP level of care is initiated prior to referring clients to other FSP providers in attempts to service clients within BHRS outpatient clinics and to evaluate mental health level of care needed.

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

PROGRAM IMPACT

During FY 2019 - 2020, a total of 36 unduplicated clients were served. Of which, 25 clients were carried over from FY 2018-2019, 6 new referrals, and 5 voucher-based clients. Of the 36 clients, 25 were closed during this reporting period. The housing voucher programs supported include Permanent Supported Housing (PSH), Housing Readiness Program (HRP), Moving to Work (MTW), and Mainstream Vouchers.

There are currently 9 Embedded Intensive Case Management (ECM) clients, of which 1 is also receiving voucher support effectively increasing the community-based case management for the various voucher programs to 4 clients. At the close of the fiscal year, there was no waitlist for services. The voucher-based clients receive quarterly home visits, monthly phone check in, and assistance with negotiation with landlords, etc. in preparation for annual housing inspections, relocation if needed and redetermination paperwork/appointments. Each ECM client meets with their embedded case manager and completes a "Needs Assessment" to

facilitate client goals to targets case management tasks/activities and updates LOCUS bi-yearly for evaluation of level of care. Embedded CM closed 25 cases during this reporting period.

Level of Care Provided	# of Clients FY 19-20
A - Task Oriented	4
B - Supplemental	17
C - FSP	12

Remarkable outcomes are noted with a flat reporting of 32% of clients stabilized back to their treatment team and 8% reduction in clients' who moved out of county or AWOL as compared to FY 2018-2019 reporting. The consistent outcomes to relinking client's back to treatment team are indicative of CM removing client barriers such as sourcing phone services for clients, teaching clients to utilize Lyft services to appointments, and community outreach with partner agencies such as Life Moves and Whole person Care to assist with locating the homeless.

Integrated FSP – South County	FY 19/20
Total clients served	36
Total cost per client	\$3,680
Cost per contracted slot	\$8,831

SUCSESSES

During this reporting period, ECM hours were impacted with staff shortages and employee out on medical leave. From July 2019 till January 2020, ICM program was fully staffed for 50 hours weekly. From January – March 2020, staffing was reduced to 40 hours per week after one staff resignation. Under Covid 19 precautions, we were unable to onboard new staff identified for program. From April – May 2020, the ICM staff was on medical leave, returning to 40 hours per week in June. The yearly average hours per week provided by ECM was 38.7 hours as opposed to the contract of 50 hours and an increase from the average of 35.4 hours in FY 2018-2019.

Time Frame	Service Hours
July 2019 – January 2020	50/week = 1,500
February – March 2020	40/week = 344
June 2020	40/week = 172
Total Hours	2016 hours

Outcome	# of Clients FY 19-20
Stabilized back to team – Achieved Goals	8
AWOL - Did not engage with ICM	7
Assaultive Client toward or Conflict of interest with CM	3
Declined ICM services	2
Higher level of Care – FSP/Locked	2
Voucher CM assigned to another agency	2
Moved out of County	1

ECM staff are bilingual in Spanish and participate in professional development including: Cultural Competency, SOGI, Assaultive Behavior, Motivational Interviewing, BHRS required documentation and compliance trainings. Additionally, ECM CM attend quarterly meetings with Mateo Lodge, weekly county supervision, and bi-weekly staff meeting at South County Clinic. Staff development is targeted to further strengthen ECM awareness of community services, improve cultural appropriate services, and to deepen clinical knowledge of the population of clients served to employ best strategies/practice.

CHALLENGES

South County has complex impaired SMI clients as the catchment area services the county jails, Redwood House crisis residential, Cordilleras, there social rehabilitation board & care placements, three inpatient SUD treatment programs, and two homeless shelters. The main barrier for the clients served through Embedded Case Management are limited housing, communication by telephone due to homelessness, co-occurring SUD disorders, trust issues stemming from mental health diagnosis and limited resources for undocumented clients. Most of the referrals for the ECM program are to improve client’s engagement with their treatment teams (not making it to appointments) and/or are not stable. The difficult to engage client is typically medication non-compliant and/or homeless with limited family/social support. Use of culturally appropriate community agencies (faith based, Club House, pride center) has helped support recovery when limited financial and family support exists. Assisting clients with task activities such as obtaining cell phone, assistance to coordinated entry, and other community resources improves client outcomes through building a working rapport and trust with the CM.

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

DEMOGRAPHICS

	FY 19/20
Age	
16-59	94%
60+	6%
Race/Ethnicity	
White/Caucasian	%
Latino	%
African American	%

Iranian	%
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HOUSING INITIATIVE

AUGMENTED BOARD AND CARES

The purpose of the 14 contracted Board and Cares (B&C) is to provide a supported living environment for clients with severe mental illness (SMI). Board and Cares serve adults that have completed a social rehabilitation program or are stepping down from a locked setting. Clients are psychiatrically stable, compliant with medications and in need of a supported living environment. Clients are Health Plan of San Mateo members, and either have SSA or GA benefits. The B&Cs provide three meals a day, medication management which includes storing and administration of medications. They regularly collaborate with the client’s treatment team and conservator (if there is one) about client’s progress and address any issues that impact the client’s placement. The B&C Operators work in close collaboration with the BHRS B&C Liaison. The B&C Liaison develops and coordinates a training schedule for the B&C Operators. The trainings increase the B&C Operator’s capacity to address the needs of the SMI clients in their care as well as fulfilling their CEU requirements. In addition, the Board and Cares provide and facilitate a series of mental health groups for clients at the B&C. Curriculums for these groups include Seeking Safety, Illness and Recovery Management, Dual Diagnosis, and Wellness Recovery Action Plan (WRAP).

PROGRAM IMPACT

Board and Cares report reduced incarcerations by 21% and homelessness by 27%.

Board and Cares	FY 19/20
Total clients served	94
Total cost per client	\$22,357

SUCSESSES

Raul is a young adult who identifies as Mexican and currently lives at one of the contracted BHRS B&C. Raul was born in Urapan in the State of Michoacan, Mexico. He is one of four children. He immigrated with his grandmother, father and three sisters to the United States at the age of 3. He grew up primarily in the Redwood City area and attended Menlo Atherton High School. When he was 23 and living in Emeryville in an apartment with friends, with his own job, he started to experience hearing voices. He was still able to maintain a job and an apartment for three more years but eventually became homeless in San Mateo County. It was at that time, while not being treated for his mental health symptoms and under the influence of Marijuana, that Raul was charged with a crime and ended up in jail. Raul ended up being referred to the BHRS Pathways Program. At the Pathways Program, Raul was linked to Mental Health and Substance Use Treatment and referred to our contracted B&C. Raul was soon

released from jail and moved to Bruce Badilla. Raul graduated from the Pathways Program in 2017. Raul continues to live today at Bruce Badilla. He is in treatment at the North County Mental Health Clinic where he attends groups and AA/NA Meetings in the community. Raul has been clean and sober for 4 years. Raul likes living at Bruce Badilla and appreciates the support from the staff. Raul would like to get a job and have a girlfriend. One of Raul’s goals is to save up and buy a used car that he can fix up himself.

Ruth is an older adult who identifies as African American and her preferred language is English. Ruth currently lives at a contracted BHRS B&C. Ruth was born the oldest of 5 children in rural Louisiana. Ruth moved to Northern California with her family in the 1960’s. Ruth was previously married and divorced. Ruth first began to experience paranoia and delusions with the birth of her only child in the 1970’s. Ruth went on to have multiple hospitalizations and multiple placements as her illness progressed. In 2005 Ruth was discharged to her current BHRS B&C from Cordilleras, a locked facility. She has been stable and hasn’t had any hospitalizations in five years. Ruth likes her current B&C and likes being with people her own age. Ruth enjoys spending time with her son and when the shelter in place restrictions lift, she would like to return to the Senior Center.

CHALLENGES

Referrals continue to exceed the current bed capacity. There has been a significant shortage of beds for older adults, specifically female older adults, females under 60 and older adults that have complex medical issues. Over the past year, a couple of B&C operators retired and as a result, two B&Cs closed. COVID-19 especially affected older adult clients. A couple of the facilities were not able to take new admissions and many of the community groups and activities, and mental health support groups were not available in person. This was very challenging for many clients. In response, remote modes of contract and treatment delivery were used, such as Telehealth. The centers received some donations of personal protective equipment that were used and staff distributed care packages that included activity kits and coping tools for clients in all B&Cs. Finally, the B&C Liaison and B&C Operators check in weekly on clients and the program has been able to implement two therapy groups in person.

DEMOGRAPHICS

	FY 19/20
Age	
26-59	74%
60+	26%
Race/Ethnicity	
Chinese	1%
Filipino	15%
Black/ African- American	10%
White/Caucasian	47%
Latino/Mexican/Chicano	19%

Japanese	2%
Another race/ethnicity	2%
Unknown	4%
Sex assigned at birth	
Male	79%
Female	21%
Primary Language	
English	81%
Spanish	16%
Tagalog	2%
Arabic	1%
Intersex	
No	100%
Gender Identity	
Male/Man/ Cisgender	79%
Female/ Woman/ Cisgender	
Woman	21%
Sexual Orientation	
Gay, lesbian, homosexual	2%
Straight or heterosexual	98%

GENERAL SYSTEM DEVELOPMENT (GSD)

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

OLDER ADULT SYSTEM OF CARE

OLDER ADULT SYSTEM OF INTEGRATED SERVICE (OASIS)

The OASIS Program purpose is to provide outpatient field based mental health services for home-bound elderly individuals with severe mental illness and co-occurring medical diagnoses and functional limitations. The program assists elderly individuals to live in the community independently with improved quality of their lives. The targeted population served is the elderly ages 60+ with severe mental illness and co-occurring diagnosis due to mobility issues and functional limitations. Primary program activities provided include interventions such as psychiatric assessment and treatment, psychiatric medication evaluation and on-going monitoring, clinical case management, rehabilitation counseling, individual or family therapy, peer support, psychoeducation, and collateral support with other community services.

PROGRAM IMPACT

In FY 2019-20, OASIS served 200 cases, this included 146 clients who carried over, 31 new enrollments and 23 clients were discharged from the program. 36 cases non-duplicated. Because of the fragility and complication of medical problems experienced by clients, the program lost 34.8% of their clients to unexpected deaths. 26.5% of clients were transferred to Skilled Nursing Facilities to receive higher levels of care. Of the 23 clients who were discharged, 13% of patients refused to engage with mental health providers but did agree to be followed by primary care providers for mild symptoms of depression and/or anxiety. 21.7% were given a diagnosis of dementia and were supported by primary care and Landmark medical group for continued treatment. There were also 4.3% of clients who moved out of the county to live with family members or moved to more affordable areas with lower housing costs.

OASIS	FY 19/20
Total clients served	31
Total cost per client	\$32,731

SUCCESSSES

Lucy was in her 60s', when she was referred to the OASIS team. She was first seen at her apartment by a case manager and psychiatrist from the OASIS team. At the time of the first visit, Lucy appeared disheveled wearing sweatpants. She was notably thin, the white of her eyes was bright yellow caused by hepatitis. She stated that she was mourning the death of her older brother, she was tearful and stated that she felt hopeless and lacked motivation to live her life. She explained that she was currently in a dysfunctional and abusive relationship. She had no income and tried to find a job but due to the health complications she was unable to secure a job. She also struggled with alcoholism, she explained that she started drinking at the age of 7 after her mother died by suicide, and her father introduced her to beer.

A short time after accepting services from Oasis program, Lucy was hospitalized for falling while intoxicated. She was transferred to a skilled nursing facility for rehabilitation. With OASIS continued support and home visits, Lucy started to comply with her prescribed antidepressant medication. The ongoing therapeutic therapy sessions via each home visit from case manager and psychiatrist, Lucy was able to concentrate working on her recovery goals.

Lucy reported that she was feeling hopeful for the future, she described having a new sense of autonomy. She had new insight and acknowledged old patterns of self- destructive behavior such as drinking and being involved in abusive relationships. She explained that she did not want to waste more time with poor decision making, she said that she wanted to gain new employment, and to be independent again. With the support from the case manager, soon she reconnected with her sister after a lack of communication for years. She also discovered new coping mechanism, such as mindfulness and meditation. Almost two and a half years with the support from the OASIS team, Lucy was hired at a new catering job. She eventually was discharged from OASIS. At the termination visit, Lucy expressed to the case manager that she

was extremely grateful for efforts made by case manager and psychiatrist and for the ongoing support she received from Oasis team.

CHALLENGES

One of main goals for OASIS services is to support their clients to stay in the community as long as possible. However, because many clients have many physical and medical conditions, the level of care and needs required continues to be a big challenge. There are a limited number of assisted living care homes and affordable home care providers causing many clients to relocate to cheaper residential areas or to move out of the county.

Currently the county is working on speaking with the owners of assisted living care homes (private one) to see if they may be willing to contract with the county. At the same time the team is increasing its networking strategies and closely working to develop partnerships with the Institution of Aging (IOA) to provide financial support/assistance to clients.

The COVID pandemic has also caused many challenges. Many clients live alone, with their family and adult children in small apartments or in care home facilities. Many OASIS clients are facing isolation and many restrictions on social gatherings, increasing their stress. Some have struggled to continue to engage in OASIS services. Additionally, some clients are overly eager to engage in any type of social encounter and as a result are at a higher risk of receiving verbal or financial abuse by family care givers or internet users. In this situation local police officers or APS social workers have had to intervene to protect the older adult clients.

DEMOGRAPHICS

	FY 19/20
Age	
26-59	2%
60+	98%
Primary Language	
English	66.5%
Spanish	16%
Chinese	15.5%
Russian	.5%
Korean	.5%
Another language	1%
Sex Assigned at birth	
Male	24%
Female	76%
Decline to state	-

SENIOR PEER COUNSELING

Senior Peer Counseling (SPC), Peninsula Family Service is comprised of specially-trained volunteer counselors, more than 100 in total, to provide weekly visits to older adults to help manage transitions and life changes such as health concerns, mobility issues, caregiver needs, and grief. Special care is taken to connect participants with someone who shares similar life-experiences and perspectives, with support offered in languages such as English, Mandarin, Cantonese, Spanish, and Tagalog, and to participants who identify as LGBTQ+. The program provides weekly drop-in support groups such as Stages in English, Platica in Spanish and Kapihan in Filipino, are also provided in various locations throughout San Mateo County such as in community centers, housing sites for older adults and the Pride Center. The program targets San Mateo County older adults in the underserved populations, 55 years and older, who may be isolated, depressed, or suffer from anxiety. Volunteer peer counselors receive 36 hours of intensive training and undergo a thorough background check before being matched with a participant. Monthly clinical supervision is provided to the trained peer counselors. In addition, the program provides a variety of in-service training to volunteers during the year.

PROGRAM IMPACT

Clients and counselors both felt that the program, generally, has done a good job meeting their needs.

- 92% of the volunteers were satisfied with the program
- 93% of the participants said the program was valuable to them.
- The majority of the participants feel that the program increased their ability to ask for help (89%), make an important decision (91%), share issues that they face (89%) and deal with grief (88%).

The Senior Peer Counseling Program is a program that is preventative. Program staff make when a participant needs a higher level of care a referral to an appropriate resource. Volunteers attend monthly clinical supervision where they receive oversight and guidance in working with their clients. In supervision, Peer Counselors discuss clients who may be suicidal, at risk of homelessness, or abused. Referrals are made to the proper resource and follow ups are conducted to make sure the resource was accessed.

Senior Peer Counseling	FY 19/20
Total clients served	329
Total cost per client	\$522

SUCSESSES

- Initiated the Loneliness Scale with all participants to determine the impact of peer counseling;
- The Recognition Luncheon was attended by 90;
- Provided Group Facilitation Training for interested peer counselors;
- Trained 18 new volunteers (cancelled Spanish and second English training due to shelter in place);
- Conducted Focus Group 2020 to determine needs of older LGBTQ+ adults at virtual annual Pride Celebration;
- Created Spirit Care partnership to meet the spiritual needs of participants;

- Outreach provided to the Hindi, Japanese and Pacific Islander Communities;
- Initiated wellbeing calls for older adults in San Mateo County calling the I&A line
- Developed extensive resource listing for peer counselors, participants and residents;
- Offered well-being calls to 50 SPC participants on the wait list;
- Trained peer counselors to use Zoom;
- Initiated two new community groups (church related);
- In-services via Zoom on Anxiety, Motivational Interviewing provided to SPCs, facilitated by clinical consultants.

An additional success story includes one participation Tony who was depressed about the COVID pandemic and shelter in place situation. The daily updates in the news caused him some stress. Weekly wellbeing calls to Tony gave him an assurance that support and resources are available. The Peer Counselor was successful in diverting his attention to something that interests him. He enjoys the outdoors and after eight weeks he was helping his neighbor with gardening and lots of outdoor activities. He feels confident now that he can cope with the situation.

CHALLENGES

The two largest challenges for the Senior Peer Counseling Program include;

1. The LEV program coordinator left in Nov 2019 and the program has been unable to fill her position. Temporary staff are currently supporting the position during shelter in place.
2. The Chinese Clinical Consultant left and the position has not been filled. Currently the Program Manager is providing clinical support to the group with the help of a bilingual staff member.

DEMOGRAPHICS

	FY 19/20
Primary Language	
English	45%
Spanish	26%
Mandarin	13%
Cantonese	2%
Tagalog	8%
Another language	5%
Race/Ethnicity	
American Indian/Alaska Native/Indigenous	.3%
Asian	18%
Black/African American	.6%
White/ Caucasian	36%
Central American	5%
Chinese	13%
Mexican/Chicano	14%
Filipino	8%

Japanese	1.2%
South American	2%
Korean	.3%

CRIMINAL JUSTICE INTEGRATION

PATHWAYS COURT MENTAL HEALTH PROGRAM + HOUSING

Pathways is a partnership of the San Mateo County Superior Court, Probation Department, District Attorney, Private Defender Program, Sheriff’s Office, Correctional Health, National Alliance on Mental Illness, and Behavioral Health and Recovery Services. Pathways is an alternative path through the criminal justice system for those with serious mental illness. The criteria for eligibility include statutory eligibility for probation, San Mateo County residency, diagnosis of a functionally impairing major mental illness, voluntarily agreement to participate, and age 18 or older. Program activities include intensive case management (treatment and recovery plan services, medication linkage, supportive housing services, treatment and recovery support for co-occurring mental health/substance use, psycho-educational/recovery services, service coordination including assistance/linkage with health care services, peer support, family education and support) and intensive monitoring and probation supervision.

The vast majority of the programs clients represent traditionally underserved populations; all have experience with the criminal justice system and a mental health diagnosis, many are low-income, and many have suffered discrimination and health disparities related to ethnic and gender identity. The Pathways case manager’s work with clients individually and intensively to ensure that they are connected in a timely manner with a warm handoff provided to needed services. Each client develops an individually-driven treatment plan to address client-specific needs that are sensitive to history of minimal access to resources. Pathways also proactively works to combat stigma and discrimination, particularly with regard to mental health diagnoses and difficulties. Pathways encourages participants to speak openly about their experiences and partners with organizations such as the National Alliance on Mental Illness to participate in activities such as the annual NAMI awareness walk, mental health month, and suicide prevention initiatives. Further, Pathways utilizes the peer support worker model to reinforce the recovery and human-centered approach to treatment.

PROGRAM IMPACT

In this reporting period, Pathways served 57 clients, including 15 program graduates, 18 new admissions, and 4 exclusions. Pathways graduates receive certificates signed by the judge and get their court costs deleted in recognition of their work. Some graduates also receive expungement of their legal charges. Since Pathways began in 2006, 130 participants have graduated. In this reporting period, all 57 of current clients were able to reduce the duration and severity of mental illness through their active participation in Pathways support and

treatment groups as well as through intensive case management. Specifically, many clients also addressed concrete negative outcomes that result from untreated mental illness:

- Pathways is an alternative to incarceration; all enrolled clients are able to avoid incarceration by obtaining mental health treatment. Over the reporting period, 7 clients were booked into custody on probation violations. 3 of those were readmitted to the program without future violations, and 4 were excluded;
- 25 clients obtained employment;
- 14 clients obtained stable housing; of those, 7 obtained permanent housing vouchers, 4 joined sober living environment, and 3 are in social rehabilitation or board and care;
- 16 clients newly obtained employment;
- 8 clients enrolled in school and have continued via online learning during the pandemic;
- 2 clients were able to maintain children in their homes, and 2 without previous contact with their children have been able to resume contact

Pathways has two contracted bed at Maple Street Shelter, one dedicated for male clients and one for female clients; 11 clients occupied male bed, 2 clients occupied female beds.

Pathways	FY 19/20
Total clients served	57
Total cost per client	\$3,289

SUCSESSES

Pathway’s intensive case management joined with clinical support in close partnership with probation continues to be a sweeping success to support clients with an otherwise long history of disengagement and disenfranchisement. One success story that brings this partnership to light is that of a client who has been with Pathways for almost three years and is set to graduate in one month. Prior to joining Pathways, this client had been homeless for over a decade with dual diagnoses of a psychotic disorder and severe methamphetamine abuse. He was known to the county as someone who came into custody in a “revolving door,” primarily for stealing bikes. He had lost contact with all family and friends. Once he joined Pathways, however, he was released from custody into a dual diagnosis residential treatment program. For the first time since the onset of his symptoms, he reported feeling truly supported by his team of clinicians, case managers, and probation officers. Over time, he completed treatment. He did not relapse into substance use once throughout his time with Pathways. After completing treatment, he was supported to obtain permanent housing for residents coping with severe mental illness. From there, he went onto full-time employment at a detox facility, stating that he wanted to help others who were suffering struggles he had once survived. He now still works there while also attending school to obtain certification in drug and alcohol counseling. He was recently able to save money from his benefits and support with money management to purchase a car. Finally, he has resumed contact with his adult daughters, who are proud of his success.

CHALLENGES

Reduced funding and the COVID19 pandemic have been the primary challenges over the past fiscal year. Before the pandemic hit, the county was still faced with budget shortages and was not able to supplement other resources to provide clients with appreciation parties and outings on the scale they had in the past. In order to still acknowledge and incentivize clients, Pathways has adjusted by planning smaller gatherings that involve appreciation of outdoor space. For example, clients greatly enjoyed outings to free museum days in Golden Gate Park. Since the shelter in place order that took place in March 2020, the end of this fiscal year showed previously unimaginable challenges. Pathways was no longer able to have groups of clients meeting indoors, which was a major component of treatment and community. Further, many staff began to shift to working from home with a recommendation to reduce face to face contact. For clients already struggling with mental illness, the threat of isolation was a major concern. However, Pathways quickly adapted by going online when they could. The program now conducts all groups using a HIPAA-compliant telehealth platform. Further, Pathways has found ways to move some limited in-person contact outdoors.

DEMOGRAPHICS

	FY 19/20
Age	
16-25	17.5%
26-59	78.9%
60+	3.5%
Primary Language Spoken	
English	91%
Spanish	7%
Russian	2%
Race/Ethnicity	
White/Caucasian	49.1%
Latino/Hispanic	12.3%
Black/African-American	12.3%
Asian	10.5%
Eastern European	1.8%
European	45.6%
Arab/Middle Eastern	1.8%
Asian Indian/South Asian	1.8%
Fijian	1.8%
Central American	3.5%
Chinese	3.5%
Mexican/Chicano	17.9%
Filipino	5.3%
Samoan	1.8%
South American	1.8%
Another race/ethnicity	8%
Sex Assigned at Birth	
Male	75.4%
Female	24.6%

Intersex	
No	100%
Sexual Orientation	
Gay, lesbian, homosexual	1.8%
Straight or heterosexual	93%
Bisexual	5.3%
Decline to state	14%
Gender Identity	
Male/Cisgender	73.7%
Female/Cisgender woman	24.6%
Transgender Woman	1.8%
Disability/Learning Difficulty	
Difficulty seeing	1.8%
Difficulty hearing or having speech understood	3.5%
Developmental disability	1.8%
Physical/mobility disability	1.8%
Chronic health condition	8.8%
No disability	8.2%
Veteran	
Yes	0%
No	100%

G.I.R.L.S PROGRAM

StarVista’s G.I.R.L.S. (Gaining Independence and Reclaiming Lives Successfully) is a court-mandated, intensive program that provides assessment, counseling, and case management services for incarcerated girls aged 13-18. Participants learn how to deal with significant substance abuse and mental health issues. Adolescent girls are valuable and worthy of community support. Sustainable resources and programs are provided that promote the process of healing, educating and empowering each girl to achieve her greatest potential in her community. Services include: Individual counseling, Family counseling, Adolescent group counseling, Multifamily group counseling.

PROGRAM IMPACT

This year, in order to improve access to services for clients who would struggle to get to Camp Kemp for services, Star Vista provided individual and family therapy both in their office in San Mateo and at other community locations such as BHRS offices close to a client’s home. Star Vista refers clients to a range of providers, including Rape Trauma Services, other StarVista programs, such as Your House South, Daybreak, Insights, and the Counseling Center. We also refer to other nonprofit community agencies, such as Teen Success, Outlet, the Prep team, or to Family Partners or Pre to Three through BHRS. Additionally, GIRLS reached out to StarVista Early Childhood Department to provide resources for pregnant youths at GIRLS.

GIRLS Program works closely with other collaborators such as The Art of Yoga Project, BHRS, and Rape Trauma Services to provide high impact services to clients. In an effort to normalize mental health services to youths and their families, each family/youth participates in individual, family, case management, and group therapy. As mentioned above, StarVista offers mental health services that focuses on family dynamics, communication, trauma, substance use and relationship dynamics. Moreover, StarVista’s groups emphasize communication skills, anger management, anti-bullying, as well as uses a wide range of modalities to engage clients. During their time at GIRLS, StarVista has observed a demonstrable increase in engagement for both client and their families. Additionally, clients are engaged in school and have made academic progress, increase in cooperative family unit, increase in positive peer relationships, and increase in pro-social activities. Outcomes are measured by self-report, family report, probation report, school report, and client surveys. Outcomes based on girls completing the 6-12-month GIRLS program indicate:

- Increase in positive individual engagement 93%
- Increase in positive family unit 60%
- Increase in positive academic engagement 73%
- Increase in positive peer relationship 80%
- Increase in pro-social activities 73%

GIRLS Program	FY 19/20
Total clients served	17
Total cost per client	\$5,257

SUCCESSSES

StarVista is proud to support youth in the G.I.R.L.S program at Camp Kemp. This year, 17 youths successfully participated in the GIRLS Program. There was a very strong team this year reflecting the efforts made to recruit interns that can thrive within the Camp Kemp environment and improvements in the training program. It was also helpful that the multi-disciplinary team was so welcoming and supportive of the new interns. Generally, the interns were skillful at building rapport with the youth, families and the multi-disciplinary team. The collaboration within the multi-disciplinary team is at the highest point seen. The MDT meetings are now a space where each client’s situation is discussed with all parties involved. Also, the clinical collaboration between BHRS, Rape Trauma Services and StarVista is at a high point as reflected by the way the teams have been able to co-facilitate groups together.

Star Vista continued to provide Alcohol Other Drugs (AOD) group therapy (funded by probation) which has been well received by the clients who have been highly engaged. Additionally, AOD individual therapy was provided to six youths (funded by probation). The integration of AOD Individual counseling service in collaboration with individual, family, and group counseling services provided a significant amount of support to youths struggling with substance use. Finally, Star Vista successfully utilized the GIRLS Circle curriculum.

In March 2020, COVID-19 and Shelter-in-Place ordinance greatly impacted StarVista’s ability to provide services to youths. StarVista worked diligently with Probation and BHRS and was able to quickly provide all mental health services via phone and video therapy. Moreover, StarVista was ready and able to provide group therapy services via video conferencing when this possibility became available. StarVista has worked collaboratively with Probation in order to have a smooth transition to remote services.

CHALLENGES

During FY 2019-2020, StarVista navigated the transition to virtual service delivery due to COVID-19 and Shelter-in-Place ordinance. Although, StarVista was ultimately able to transition to virtual services, challenges were encountered such as, youths not having internet, phone or computer access, youths no-showing to schedule sessions, and pauses on group therapy meetings. GIRLS program has continued to build relationships with BHRS and SMC Probation in order to coordinate mental health treatment to youths and their families. During COVID-19, GIRLS program was able to shift all mental health services to phone or video sessions and provided additionally meeting depending of family/youth need.

DEMOGRAPHICS

	FY 19/20
Primary Language	
English	88%
Spanish	12%
Age	
0-15	35%
16-25	65%
Race/Ethnicity	
African-American	12%
White/Caucasian	12%
Latino	71%
Filipino	5%
Sexual Orientation	
Gay, lesbian, homosexual	12%
Decline to state	88%

CO-OCCURRING SERVICES

CO-OCCURRING RECOVERY SUPPORT SERVICES

Voices of Recovery San Mateo County (VORSMC) is a non-profit 501© 3 peer-led organization that was established in 2010 with the purpose of advocating for and supporting the recovery community; people overcoming drug and/or alcohol addictions. VORSMC creates peer-led opportunities for education, wellness, advocacy and support services for individuals in or in need of long-term recovery from alcohol and other drug addictions, equally sharing these

opportunities and support services with impacted families. The program strives to coordinate local, state, and federal advocacy efforts. VORSMC partners with treatment providers, government entities and officials, community non-profits, faith-based organizations, and other organizations that provide recovery support services to individuals and impacted families.

PROGRAM IMPACT

VORSMC honors and embraces all unique strengths and challenges along the journey of recovery. They create peer-led opportunities for education, wellness, advocacy and support services for individuals in need of long-term recovery from alcohol and other drug addictions, equally sharing these opportunities and support services with impacted families. VORSMC provides recovery support services to residents from the urban core of San Mateo and Redwood City, to the historically underserved coastal regions, geographically isolated from services and long-standing networks of support. VORSMC has expanded their services to include WRAP aftercare, the WRAP Facilitators facilitate groups and then provide ongoing peer-support and care coordination to help ease the transition from active treatment to recovery. Programs are intentionally designed to create peer feedback loops that keep leadership informed of the impact of their services and their continuing relevance to.

Voices of Recovery	FY 19/20
Total clients served	403
Total cost per client*	\$409

SUCSESSES

My name is Veronica, I am a young woman dedicated to maintaining my sobriety. I am fortunate to have love and support all around me as I continue on this journey and figure out what I want from life. In my early teens I started experimenting with drinking and different drugs. Even then I felt a little different from others I partied with, I always drank/used to excess. Fun didn't feel like fun unless getting loaded was involved. This progressed very quickly, by the end of high school I was using harder drugs on a daily basis during classes. Part of the reason I was able to get away with this behavior was because my family had felt with the loss of my maternal grandparents and it was a very hard blow. I was shown by example from my closest family members that dealing with a sad situation like this involved drugs to numb the feelings. These ideas and behaviors are what paved the way for me into my late teens and early twenties.

I hadn't done much with myself post high school and tried a demographic change that didn't last long. During the first week or after moving back to the Bay Area I was in a head on fatality accident that changed the path of my life again. After this I became very quiet, sad, and scared of what the future would be. So I did what was most comfortable to me. I had no idea what wellness was or that I'd even been missing out on happiness because my life was consumed with a lot of doubt and fear. I was asked my parole officer to get into a residential treatment facility. Hope House is where I was introduced to Voices of Recovery and Wellness Recovery Action Plan (WRAP). The environment they created during the group helped me to feel comfortable enough to share my experiences and what was on my mind as I went through the

process of changing the way I thought. This group was key to me getting back on track and developing the self-love I have and continue to build on today. By breaking down the crisis plan and really digging into the material I was able to get to know myself really well. The facilitators that came in spoke with confidence and were very encouraging and I appreciated all they had to share. When it came closer to the day I would graduate the program I kept in mind that the opportunity to volunteer at Voices of Recovery was an option. After going to the Recovery Happens month events hosted by Voices of Recovery, I joined the team to volunteer and have been a part of Voices ever since. The hope Voices and my team give me and allow me to put back into the community fills me with happiness. Although it is challenging at times I find the ability to challenge myself and grow every day working at Voices of Recovery as a Recovery Coach and a certified WRAP Facilitator. I am met with support and care every day I go into work in this position that helps me and helps others in the community.

CHALLENGES

Many program participants are monolingual Spanish residents, so Spanish translations are necessary and a challenge. The program also continues to be challenged by limited office space to accommodate the needs of participants.

The program also lacks the capacity to develop new trainings, hold educational trainings for staff, volunteers and the community because of the lack of equipment and adequate space.

DEMOGRAPHICS

	FY 19/20		
Primary Language		Sexual Orientation	
English	28%	Straight or heterosexual	29%
Spanish	4%	Homosexual	.25%
Decline to state	67%	Decline to state	70%
Age		Bisexual	1%
0-15	5%		
16-25	4%		
26-59	66%		
60+	6%		
Decline to state	19%		
Race/Ethnicity		Veteran	
African-American	5%	Yes	1%
White/Caucasian	13%	No	25%
Asian, Native Hawaiian or Other Pacific Islander	3%	Decline to state	74%
More than one race	.25%		
Decline to state	66%		
Other	13%		
Gender			
Male	17%		
Female	13%		
Decline to state	69%		

CO-OCCURRING CONTRACTS & STAFF

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

PROGRAM IMPACT

Clients served by co-occurring staff	FY 19/20
Total clients served	1770
Total cost per client*	\$146

PEER AND FAMILY PARTNER SUPPORTS

PEER SUPPORT WORKERS & FAMILY PARTNERS

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

PROGRAM IMPACT

There are currently 18 peer positions and 10 family partners throughout BHRS:

- 1 Senior Community Worker on the Adult Services Team
- 10 Peer Support Worker positions in the BHRS adult system funded by MHSA. They are distributed throughout the system in a variety of clinical and prevention program teams: Older Adult system of Integrated Services, Pathways and the five County Regional Clinics. One part-time Peer Support Worker position was made full time.
- 6 Peer Support Workers on the Adult Clinical Services Teams (full time civil service positions)
- 1 Peer Support Worker is in the Older Adult System of Integrated Services (OASIS) Team (part time civil service position)
- 1 Senior Community Worker on the Pathway Team (full time civil service position)
- 7 Family Partners are embedded on the youth clinical services teams. (full time civil service positions)
- 1 Family Partner on the Office of Diversity and Equity (3 year grant funded position).

- 1 Family Partner is on the Adult Pathways Mental Health court team. (full time civil service position)
- 1 Family Partner on the Pre-3 Program. (part time civil service position).

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

Peer Support Workers facilitate groups such WRAP Groups; WRAP for Housing; Dual Diagnosis Group; Welcome Registration/Orientation; Stress Management; Exercise; Peer coaching (physical health). Peer Support Workers bring their lived experience to the broader community by participating in community groups and County BHRS Health initiatives such as African American Initiative; Latino Collaborative; Lived Experience Speakers Academy; Lived Experience Education; Workgroup; Housing Operations and Policy Committee.

Family Partners represent diverse cultural and linguistic experience including bicultural and bilingual Spanish and Tongan, as well as English speaking African American. BHRS Family Partners can be referred to provide support for families who are not receiving services on the teams that they are embedded on. Cultural and linguistic matches are a key factor in making these assignments. Family Partners provide individual support to parents of youth and young adults, sharing their lived experience with the families they serve. Some case management is part of their support of families. They also provide group support to parents/caregivers by providing educational activities around children and their mental health.

Family Partners also bring their lived experience to the broader community by participating on the following community groups and initiatives: African American Initiative, Latino Collaborative, Pacific Islander Initiative, North County Outreach Committee, Immigration Forum, Community Service Area Meetings, Pride Initiative and Pacific Islander Task. Groups co-facilitated by Family Partners during 2019-2020 include

- 1 Nami Basics in Spanish - 6-week program meeting weekly (22 parents/caregivers)
- 1 NAMI Family to Family in Spanish – 10-week program meeting weekly (14 Parents /caregivers of adults)
- 1 Well-Being Academy in Spanish – 4-week program meeting weekly, about mental health awareness, Stigma, and well-being of families. (40 parents/caregivers)
- 8 Monthly Support Group in Spanish in Redwood City for Parents/Caregivers of adult clients (10 participants)
- 4 Monthly Support Group in Spanish in East Palo alto for parents/caregivers of adult clients

- Grief Support Group in Spanish – 6-week group meeting weekly (6 parents/caregivers, and Community Members per group)
- 9 monthly Parent Café's in Spanish - Coastside Clinic with (6-10 parents/caregivers per group)
- 4 Parent Cafés in Spanish – South San Francisco (4 parents/caregivers per group)
- 10 weekly Virtual Parent Café's in Spanish - Coastside Clinic (6-10 parents/caregivers per group)
- 9 monthly Parent Café's in Spanish - South Youth Shasta Clinic (6-8 parents Per group)
- 7 bi-weekly Virtual Parent Café's in Spanish - South Youth Clinic (4-6 parents per group)
- 7 Weekly Virtual Parent Café's in English- (2-3 parents/caregivers per group)
- 1 Stigma Free Presentation in Spanish – (27 parents/caregivers)
- 4 DBT groups for parents in Spanish (4 participants per group)
- 1 Seven-week Virtual Lived Experience Academy for Parents/Caregivers in Spanish (15 Participants)
- Familia y Bienestar Durante COVID-19-Facebook Live Event – (More than one thousand participants joined via Facebook Live)

Some of the trainings/conferences the Family Partners participated in during 2019-2020:

- Community and Family Engagement Café for Providers Working with Families
- Intentional Peer Support training 5-day Training for Peers and Family Partners
- Respect Conference 1-day Conference
- NAMI California Multicultural Symposium 1-day Conference
- Domestic Violence 101 Training from CORA
- A Culture of Care - Trauma Informed Practices for Family Serving Systems 1-day training
- Families in Transition: Presentation by Dr. Belinda Arriaga
- Cultural Humility 101: Building Bridges to Diversity & Inclusion
- WRAP – 5-Days Facilitator Course
- 2019 Annual Update - BHRS Confidentiality and HIPAA for MH & AOD
- NMT - 14 hours Training
- Mastering the Communication Process - 4 hours training
- Serving Multigenerational Customers - 4 hours training
- Coding Groups & Group Progress Notes Mental Health Staff and Contractors Webinar
- *"How to Support Caregivers of Children with Autism."* Training
- Recovery 101 Virtual Training
- What is Peer Support? - Virtual Training
- MHSA Three-Year Plan Prioritization Meeting
- World Café – Eight-hour virtual training
- Compliance Training for BHRS
- Fraud, Waste, & Abuse Training for BHRS
- 10 Peer and Family Partner Staff attended to the 2-day Virtual California Mental Health Advocates for Children and Youth Conference (CMHACY).

Some of the committees for outreach and support to the community the Family Partners participated during 2019-2020:

- 12 monthly Immigrant Forum
- Tabling in various community events and resources fairs
- Presentation for housing providers “Children Living with Mental Health Conditions and Working with their Families”
- South San Francisco Community Collaboration for Children’s Success - Family Engagement Workgroup
- Bay Area & Youth System of Care Meeting
- Integrating Families into the Treatment Plan (Virtual Training for Interns)
- Google Grant Planning Meeting for Community Navigators/Promotoras

Peer and Family Partners	FY 19/20
Total clients served	365
Total cost per client	\$4,257

SUCSESSES

Family support transitioned to virtual meetings during the pandemic including virtual support groups and educational groups to support these families with emotional support and essential community resources to survive during COVID-19. The following are three of the parents/caregiver’s personal histories about family support:

“I am from Guatemala and it has been difficult for me to navigate the system with my children and now that I am the legal guardian of my six-year-old nephew who is receiving mental health services through school. Since I am receiving support from my Family Partner, I have less stress as she has guided me to be more organized to support my nephew in his health, school and therapy needs. Unfortunately, I cannot read or write, and my Family Partner is always available to help me complete the forms that are needed for the school, my nephew's doctor and even for my youngest daughter who also has special needs, especially during COVID-19. My Family Partner is very kind and listens to me when I am stressed out and sometimes feel hopeless. She is concerned about my self-care and I have learned some skills about for self-help that I didn’t know. She has been a great support for me, and I don't know what would do it without her support.” Margarita, Redwood City, CA

“I have been receiving support from my Family Partner for twelve months. I am a single mom of three children and one of them is very hard to deal with. I am from the Philippines and it’s difficult for me to understand mental health. My Family Partner listens to my concerns and has thought me things about mental health that I didn’t know, so this has helped me to be able to understand my son’s needs. When I call her, she is always available to listen. I also have a daughter with existing conditions, and I have been struggling with her health insurance. She has been a great support during the pandemic as she calls me every week to check if I need support and resources. She has given me resources for housing, health insurance for my children, EBT Pandemic Card, and other resources available during the COVID-19 pandemic. All these

resources have helped me and my family financially. Without a doubt, it would be very hard for me to maintain stable housing without her support.” Cristina, Daly City, CA

“I have been receiving support from my Family Partner for a couple of years. I am from Mexico City, I have three children and all three have received mental health services. Since my Family Partner has been supporting me, things have improved with my children, because she has thought me some skills to better guide them and has also helped me to believe in myself. She invited me to take a few of her workshops such as Parent Project, NAMI Basics, Wellness Recovery Action Plan (WRAP), and participate in her support groups. Other workshops she encouraged me to take was Youth Mental Health First Aid and Know the Signs of Suicide. All these classes have been provided in Spanish. My Family Partner has guided me in how to improve my communication with my children's therapists, explained the IEP process and guided me in how to advocate for the education of my children. She has also given me information about workshops to improve my finances. Furthermore, she has provided legal resources for immigration and I was able to obtain my legal status in this country, which significantly changed the stability of my home.” Maria, Moss Beach, CA.

CHALLENGES

Due to COVID-19, most of the challenges the families have faced difficulties in accessing mental health services for their children due to the lack of community resources to access a sustainable device with internet access, in order for them to have their virtual therapy sessions. In addition, several of the families from underserved communities are technology illiterate and have difficulties in helping their children with medical appointments, therapy appointments, and education support. San Mateo County BHRS in collaboration with ODE are planning to coordinate a program to provide cellphones with data plan in order for these clients to have access to telehealth.

CALIFORNIA CLUBHOUSE

California Clubhouse is a community-centered organization where people with mental illness can go every day during business hours to work on overcoming the obstacles they face. It offers support, training, education, healthy social interaction and positive reinforcement through collegial relationships and work. Since the onset of COVID-19, all programming is now virtual and includes activities in the evenings and weekends. The Clubhouse provides a variety of structured vocational rehabilitation opportunities for members. While helping to run the Clubhouse, members learn, practice, and polish new and exciting job and life skills that will both enhance their lives and help them potentially to become successful employees. In this time of shelter in place, with all our programming being virtual, the California Clubhouse is focusing their efforts on Wellness, Young Adults and Career Development & Support using the principles of the Work-Ordered Day.

PROGRAM IMPACT

Research shows the overall impact of a member's participation in Clubhouse naturally leads to reduced hospital visits, shorter hospital stays, reduced recidivism, less incarceration, and reduced suicides. Clubhouses yield better employment rates (double the average rate for people in the public mental health system), improved Well-Being compared with individuals receiving psychiatric services without Clubhouse membership, and better physical and mental health.

Working side-by-side with staff, members develop a sense of achievement, gain self-confidence and many begin to realize that what once seemed an impossible dream of part-time or even full-time employment may be possible after all. Thus, participation in the work-ordered day prepares many members to take the next steps toward workforce re-entry, aligned with their skills and interests, and readies them to participate in the Career Development Center which can lead to a future as an employed member of the local community. The Career Development Center provides supports for education, volunteer work, transitional and supported Employment.

Key outcome evaluation indicators from our Member Satisfaction Survey are as follows:

- **What brings you back to California Clubhouse on a regular basis?**

Social/ evening chats/holidays 86%	Employment Support 36%
Virtual programming 59%	Wellness Works 45%
Meal program/cooking 36%	Young Adult Program 14%
Education Support 23%	
- **I have noticed an improvement in my mental health after attending California Clubhouse regularly?**

Strongly agree 30%	Disagree 0%
Agree 60%	Strongly disagree 0%
Neither agree or disagree 9%	
- **I do meaningful work what I am at California Clubhouse?**

Strongly agree 35%	Disagree 0%
Agree 44%	Strongly disagree 0%
Neither agree or disagree 22%	
- **I am learning new and useful skills at California Clubhouse?**

Strong agree 30%	Neither agree or disagree 18%
Agree 52%	Disagree 0%
- **California Clubhouse lives up to its mission?**

Strongly agree 65%	Agree 30%
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Disagree 4%

Strongly disagree 0%

• **I belong to a supportive community at California Clubhouse?**

Strongly agree 61%

Neither agree or disagree 4%

Agree 35%

Disagree 0%

• **California Clubhouse promotes employment and enables members to obtain paid work?**

Strongly Agree 44%

Neither agree or disagree 13%

Agree 43%

Disagree 0%

• **California Clubhouse assists members to reach their vocational and educational goals?**

Strongly agree 43%

Neither agree or disagree 22%

Agree 26%

Disagree 4%

• **California Clubhouse assists members in securing, sustaining and improving their employment outcome?**

Strongly agree 48%

Neither agree or disagree 18%

Agree 35%

Disagree 0%

California Clubhouse	FY 19/20
Total clients served	188
Total cost per client*	\$1,644

SUCCESSSES

In 2020 California Clubhouse has navigated sewer floods, addressing extensive damage to their building, shelter in place and transitioning services to virtual formats. Despite significant challenges, participants speak highly of the services and relationships built at California Clubhouse.

“California Clubhouse has helped me by giving me an opportunity to socialize safely through Zoom and occupy my days with something constructive to do which helps my mental health and well-being. I have volunteered for several projects and have given back feedback for wellness which helps me feel better being able to contribute”– Alan, Clubhouse Member

“I am happy the Clubhouse exists. You have done everything possible to talk to me every other day [during this time]. Members have called me too. I have never seen this before. You have no idea how much this means to me.” – Elka, Clubhouse Member

“As a 30 year San Carlos resident, and California Clubhouse Board Member, I can vouch for the wonderful work the Clubhouse is doing to help local adults living with serious mental illness recover their lives, find a community, and reclaim their future”-Deborah

Rion was first introduced to California Clubhouse by a case manager, but, at first the program didn't win them over. Rion mentioned they "weren't ready to connect with people, they [were] coming out of isolation." They were used to being a lone wolf and hesitated to join the kind of community that California Clubhouse builds. However, when Rion returned to California Clubhouse a few months later, they felt different about the environment the Clubhouse creates. Now, Rion is an active member of the Hospitality Unit. They attend on a daily basis and spend most, if not all, of the day at the Clubhouse. They used their various skills to improve the community, such as creating a flower arrangement station, building a stage for the talent show and replacing the food preparation tables. Also, they support the Young Adult Program with their talents, adaptability and initiative. Rion has changed from lone wolf to 'part of the team'. Rion says the 'Clubhouse has uplifted me' and in times of hardship they know they are able to sit down, regroup and join the community. While Rion's journey has not been an easy one, they have remained connected. During a recent hospitalization they called the Clubhouse every day to chat with unit members. Rion mentions that "Clubhouse has helped me understand that people have different ways of thinking and being" and "Clubhouse helps me feel part of and think of the community, not just myself." The Clubhouse has allowed Rion to focus on the day to day feelings and has allowed Rion to be themselves. Rion continues to be an active member leader even during this period of virtual programming due to COVID.

CHALLENGES

Challenges California Clubhouse continues to address are related consistent data collection and software used to organize data. California Clubhouse continues to address this challenge and is working to integrate new methods of data collection and organization.

DEMOGRAPHICS

	FY 19/20		FY 19/20
Age		Sex Assigned at birth	
16-25	3%	Male	52%
26-59	66%	Female	48%
60+	30%		
Primary Language		Veteran	
English	94%	Yes	8%
Spanish	2%	No	92%
Mandarin	.5%		
Cantonese	.5%		
Tagalog	.5%		
Tongan	.5%		
Another language	.5%		

THE BARBARA A. MOUTON MULTICULTURAL WELLNESS CENTER

The Mouton Center provides behavioral health clients and their family members, culturally diverse community-based programs, support and linkages to services and resources as needed in the East Palo Alto community. To that end, the program creates a safe and supportive environment for adults with mental illness and/or co-occurring addiction challenges and their families who are multiracial, multicultural and multigenerational through various strategies.

PROGRAM IMPACT

- Reduces stigma and discrimination - Through the Mental Health First Aid program, culturally responsive peer support groups, WRAP groups, etc., participants engaged in these programs reduce stigma and discrimination towards themselves and others by facilitating open and sharing discussions about mental health, which understanding resulting in empathy and authentic concern for those suffering with a mental illness and empowers them to speak-up on behalf of others.
- Increases number of individuals receiving public health services - The Mouton Center staff facilitate connections between people who may need mental health and/or substance abuse services or other professional services to relevant programming and/or treatment by conducting the following:
 - Performing initial screening and engaging potential clients
 - Providing brief interventions to motivate more extensive assessment and intervention
 - Referring members who may need behavioral health services to appropriate agencies in the behavioral health system of care for assessment and follow up treatment as needed.
- Reduces disparities in access to care- The Mouton Center opened its doors in June, 2009 to reduce the disparities in accessing mental health services in East Palo Alto as well as to reduce the stigma associated with mental health. To this end, The Mouton Center has been a safe haven for consumers to gather, pursue leisure activities and be in community with one another without judgement. The program has been the connection to mental health services for our consumers and through its programs, services and classes reduce disparities in access to care and the stigma associated with being identified as one needing mental health services.

Mouton Center	FY 19/20
Total clients served	202
Total cost per client	\$963

SUCSESSES

“Since 2012, I’ve been able to help our families. One family stands out -- Gloria has six people in her house, and five of them are disabled. Gloria herself has development disabilities and four of her kids have other issues. Still, she works so hard to care for them. She really tries her best to be a good mother. She’s also very proud that her family has lived in the same house for more than 10 years. As hard as Gloria tries though, it’s not easy. Sometimes, she doesn’t have enough food in the house to feed her kids and she can’t always pay her bills so she comes to TMC. TMC

helps her out as much as we can. We've helped her with bills such as PG&E through our HEAP program, and we've provided her family with food through our food distribution program. I've also referred her family to other community resources so she can find additional assistance. I've also worked with her on improving her money management skills. Finally, Gloria has been participating in our Spiritual Support & Interfaith Prayer Group. TMC is a place where we can help everybody in the community. According to Gloria, "TMC helps my family every time. I never thought I'd need to go to Mouton Center. Here (TMC), people have the hope that they can get the help they need." Ms. Tinei adds that she thanks God for giving her a way to help people in the community.

CHALLENGES

The on-going challenge, that began in the year 2018-2019 and has carried over, has been the shift in the model of and new expectations for all staff to provide peer-to-peer programming. This year, the program experienced staff transitions and position vacancies. Because of the new focus, The Mouton Center staff has been engaged in intensive training to peer-to-peer support programming principles, development of facilitation skills, peer support interviewing, and other topics, primarily for the staff that is now expected to provide peer support programming. COVID-19 brought all services, with the exception of the Thursday Food Distribution Program, to a halt. The Mouton Center has had to create online programming to serve the community. There has been a significant learning curve including trainings on how to use technology such as Zoom, teaching consumers how to log into computers and smartphones remotely and establishing times that support consumer participation. Another challenge is providing programming for family members. The consumers we serve do not want their family members to participate. Family members will not access services due to the stigma of having a family member with mental health challenges. This is an area where we need support. During COVID the Mouton Center staff has been able to connect with other providers through the COVID-19 Peer Support Tasks Force that meets twice a month. The relationships are supportive and inspiring and generate good ideas for programming and problem-solving strategies.

DEMOGRAPHICS

	FY 19/20		FY 19/20
Age		Disability/Learning Difficulty	
16-25	5.4%	Difficulty seeing	1.5%
26-59	75.8%	Difficulty hearing or having speech understood	1.5%
60+	18.3%	Developmental disability	1%
Decline to State	0.5%	Learning disability	2%
Primary Language		Chronic health condition	1%
English	75.7%	I do not have a disability	93%
Spanish	13.3%		
Samoan	9.4%		

Tongan	1.5%		
Sex at Birth		Veteran	
Male	25.5%	No	100%
Female	74.8%		
Race/Ethnicity		Gender Identity	
American Indian/Alaska Native	0.5%	Male/Man/Cisgender	25%
White	29%	Female/Woman/Cisgender Woman	74%
Black	14%	Transgender Woman	0.5%
Mexican	20%	Sexual Orientation	
Asian Indian/South Asian	1%	Gay, lesbian, homosexual	2%
Chinese	3%	Straight or heterosexual	90%
Filipino	2%	Bisexual	3.5%
Fijian	05%	Decline to state	3%
Japanese	1%	Queer	0.5%
Korean	2%	Questioning or unsure	1%
Central American	1.5%		
Vietnamese	1%		
Samoan	12%		
Tongan	8%		
Native Hawaiian	0.5%		
Another race/ethnicity	3%		
Unknown	%		

OTHER SYSTEM DEVELOPMENT

CHILD WELFARE PARTNERS

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

Child Welfare Partners	FY 19/20
Total clients served	36
Total cost per client*	\$6,871

PUENTE CLINIC

Puente Clinic was created in 2007 under the Behavioral Health & Recovery Services (BHRS) of San Mateo County Health System to accommodate the sudden increase of psychiatric service need due to the closure of Agnews Developmental Center and relocation of many intellectually

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

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

PROGRAM IMPACT

1. Improves timely access & linkages for underserved populations
Puente Clinic and GGRC have jointly created a “Referral Form” to facilitate recording and transmitting of comprehensive referral information. This special arrangement allows dedicated attention to clients dually diagnosed with intellectual disability and mental illness, as this client population often gets ignored and underserved due to limited ability to self-advocate and self-refer. A GGRC social worker sends this “Referral Form” to the Puente Clinic to initiate a screening process to identify Medi-Cal clients. Once the Puente Clinic receives this form, the case is quickly reviewed for appropriate level of service and treatment provider. Clients with limited communication ability tend to stay with the Puente Clinic providers, but clients with fair communication skills could also be served by other BHRS regional clinics. When a client’s symptoms are in the Mild-to-Moderate range, referral to our Private Provider Network is made.
2. Reduces stigma and discrimination
Puente Clinic was established to create a special workforce with expertise in treating clients with both intellectual disability and severe mental illness in a timely fashion. By removing barriers to care, this clinical team helps to reduce stigmatization and

discrimination that clients with intellectual disability often experience. Co-location of Puente Clinic and several other BHRS clinical teams helps to normalize a sense of being welcome when these clients come to our clinic location, as they are treated with the same attention and respect as others. In addition, the Puente Clinic providers regularly offer training to other BHRS teams to inform skills and knowledge that help working with clients of this population. Puente Clinic also actively participates in the training of LMFT/LCSW interns on best practice in working with intellectually disabled clients, as a way to reduce resistance of mental health providers in serving this client population.

3. Increases number of individuals receiving public health services
Over the past few years, the census of the Puente Clinic has continued to increase annually. But in addition to enhancing referral pathways to help with access to behavioral health treatment, the Puente Clinic providers also facilitate connecting clients with primary care providers and other specialty services that are covered by Medi-Cal benefits. In addition, there is a communication channel among the leadership of Puente Clinic, GGRC, and the Health Plan of San Mateo (HPSM) to resolve conflicts that cause barriers to care. Minimally every quarter these three entities meet to discuss ways to improve public health services to the intellectually disabled population.
4. Reduces disparities in access to care
Puente Clinic clients come from diverse social backgrounds. Each provider has received multiple Cultural Humility trainings and applies the learning to clinical care and service coordination involving clients, families, caretakers, and parallel professionals. The Puente Clinic providers constantly help clients who can't advocate for themselves to pursue ancillary services that cover needed social benefits. In clinical sessions, interpretation services are provided as needed through phone or in-person arrangement, which includes sign-language interpretation.
5. Implements recovery principles
The Puente Clinic providers infuse hopefulness in clients, families, and caretakers, to help each client to achieve the highest level of functioning one could get. The successful outpatient treatment model that Puente Clinic provides helps client to live in the least restrictive setting in the community. Many clients of the Clinic came out of institutional settings, such as a Development Center, where clients often experienced multiple types of trauma of verbal and physical nature, but Puente Clinic helps these clients to process their trauma experience, and to recover over time. When a client is cognitively capable, supportive psychotherapeutic treatment is always provided to enhance personal agency in achieving life goals. The Clinic works closely with GGRC and Department of Rehabilitation to find the best educational and vocational opportunities for clients, and works with local community groups to promote social connection and increase of educational resources for clients.

One of the outcome data Puente Clinic continues to track is the utilization of Psychiatric Emergency Services (PES) at the San Mateo Medical Center, which is the triage center for acute psychiatric emergency in the county. One Puente Clinic's tasks is to ease the transition of intellectually disabled clients with aggressions that endanger self or others from a locked or highly structured institutional setting to the much less restricted community environment. To

achieve this, individual psychotherapy, medication management, and close collaboration with GGRC and its support teams are needed to reduce disruptive and aggressive behaviors and to maintain stability in high-risk clients.

In Fiscal Year (FY) of 2019-2020 (July 2019 through June 2020), the total number of clients who needed PES intervention was 9, which is 3% of the Puente Clinic total caseload. This is 4 clients fewer than last fiscal year and about 2% less of the total caseload. These continuously low percentage numbers indicate that Puente Clinic has been able to provide effective outpatient-level services to avoid the use of higher-level interventions, such as PES, and to maintain the stability of most clients in its caseload. In more detailed analysis, of the 9 clients who needed PES services, the total number of PES visits was 28 in the FY 2019-2020, which is 15 PES visits fewer than FY 2018-2019.

Puente Clinic – Dual Diagnosis	FY 19/20
Total clients served*	279
Total cost per client	\$1823

**increase of 15 from the year before*

SUCSESSES

Client was opened to Puente clinic July of 2019. The reason for the referral was that client was behaving very aggressively at his behavioral group home. Initially he was seen by Puente clinic therapist then referred for medication management. He had a PES visit September 2019. Client was newly diagnosed with bipolar disorder type 1, by Puente psychiatrist. He has been stabilized on medications. Currently he is doing well.

MB: Client had one PES contact September 2019 following an argument at her group home. Since the pandemic, she has been living with her sister. This change seems to have decreased interpersonal stressors.

MT: Client was taken to Mills Peninsula PES on October 25th 2019 due to agitation and insomnia. In November she was started on lithium for possible bipolar disorder as evidenced by agitation, irritability and insomnia. Since starting lithium she has been much more stable. On March 19 2020 she did sustain a hand laceration by punching a window and went to the medical emergency room. It is believed that she became agitated due to chronic GI issues, specifically constipation. After primary care adjusted bowel regimen, she has been calmer.

CHALLENGES

AK: Client was first opened to BHRS August 2014. Client was seen at a regional clinic for about 1 year. On September 2015 client was transferred to Puente clinic as they needed higher level of care. Within time frame July 2019 to June 2020, client has had 3 PES Contacts, June 2019 which led to a hospitalization at San Mateo Medical Center (SMMC), July 2019 (PES only), and Dec 2019 lead to hospitalization at SMMC. Client is under the care of her mother. Mother prefers not to have a set residence. They rotate through various motels throughout our County. It is believed that psychiatric decompensations are attributed to medication nonadherence, lack of

behavioral care plan and frequent environmental changes. In addition, client is serviced by San Andreas Regional Center (SARC), which has fewer resources compared to GGRC. After the latest hospitalization in December 2019, treatment team has implemented the following changes: teaching the family basics of behavioral intervention and redirection, and importance of medication adherence. Puente psychiatrist stays in contact with SARC social worker to advocate for client for additional support. It appears these interventions have decreased further decompensation and subsequent need for hospitalization.

MW: Client came to Puente after receiving services at another specialty behavioral health clinic. Client appeared to have a mood and anxiety disorder, but clinician suspected a bipolar history. Client agreed to psychiatric medication and psychotherapy care. Client requested female providers because he felt uncomfortable with males and reported being intimidated and insulted by men in the past; however, it was learned from the previous clinic that he had tried to form an inappropriate relationship with the female provider. It was difficult to get the client to adhere to his medications and to attend appointments regularly. There were frequent no-shows and sometimes he would show up without an appointment, insisting to be seen. Client also declined the offer of Independent Living Skills from GGRC. He confided in the therapist that he did not like to be associated with people with intellectual disabilities, and this perhaps contributed to his inability to engage fully in treatment. He eventually stopped attending appointments and did not respond to several attempts at outreach.

DEMOGRAPHICS

	FY 19/20
Age	
20-29	11.9%
30-59	57.8%
60+	30.6%
Sex at Birth	
Male	59.9%
Female	40.5%
Race/Ethnicity	
American Indian/Alaska Native	0.3%
White/Caucasian	32.7%
Black/African American	8.5%
Chinese	2.0%
Filipino	3.4%
Japanese	0.7%
Korean	1.0%
Other Asian	0.7%
Other Race	8.8%
Unknown	44.9%

EVIDENCED-BASED PRACTICE (EBP)

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

Evidence-Based Practice Clinicians	FY 19/20
Total clients served	572
Total cost per client	\$1,999

CONTRACTOR'S ASSOCIATION

The Contractor's Association Grant Funding program exists to fund organizations that contract with BHRS to be able to:

1. Improve capacity to provide integrated models for addressing trauma and co-occurring disorders;
2. Improve its capacity to incorporate evidence-based practices into day-to-day resources;
3. Improve its cultural competency; and
4. Improve its capabilities to collaborate, partner and share resources and information with other Association Members.

Caminar acts as the fiscal agent, oversight and accountability to this program. See Appendix 10 for the data on each funding recipient and what needs were met.

OUTREACH AND ENGAGEMENT (O&E)

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

MATEO LODGE: FAMILY ASSERTIVE SUPPORT TEAM (FAST)

FAST is an in-home, outreach and support services program. FAST's purpose is to assess, educate, assist, support and link families and adult mental health/AOD consumers that are living with their family (two or more people with close and enduring emotional ties) to

appropriate mental health and substance abuse services and a myriad of other resources and opportunities suitable to the individuals needs and goals.

PROGRAM IMPACT

In FY 2019-20, there were 72 clients served by FAST; 100% diagnosed. Of these, there were:

- Zero homicides and zero suicides;
- The rate of hospitalization and incarceration were higher pre-contact with FAST and Reduced-Post contact with FAST;
- Of the 72 clients 49 of them had zero contact or connection with mental health services. The remaining 23 had some history of mental health services ranging from months/years/decades prior to contact with FAST but had dropped out of treatment;
- 41 were successfully connected to outpatient mental health services. The majority of others not connected to outpatient mental health services were however connected to some level of social services, benefits, housing, medical, etc;
- The collected locus scores indicate majority of clients were SMI with significant disability and need for intensive treatment and adjunct Case Management services post FAST;
- The ethnicity of clients served would appear to reflect demographic distribution not far from averages of the San Mateo County. The negative outcomes and concomitant suffering for individual and family alike were diminished from contact with FAST.

Pre-Crisis (FAST)	FY 19/20
Total clients served	72
Total cost per client	\$4,392

Pre/Post Hospitalization and/or jail



SUCCESSSES

Family testimonial: Hi Bonnie, we hope you are well! We wanted to email you directly to tell you how valuable you and the FAST team's services and support have been to our family! It can seem so frustrating not knowing where to turn, or who to turn to when in family crisis, your team was such a ray of hope! In taking us out of the loop with our severely depressed adult son, who was isolating and not seeking any help, we could put all of our energies in supporting him in what he was doing with you! You dealing directly with our son, encouraging him to go out of his room and gradually, eventually to seek therapy, was so instrumental to him making progress! We cannot begin to thank you enough for all of your help, we truly believe it was a lifesaving effort on your part. Thank you from the bottom of our hearts!

Sincerely,

Parents of Client

Client testimonial:

To Whom it May Concern,

I am incredibly grateful for and indebted to the services and support I've received from the FAST organization. As an adult experiencing a severe mental health crisis, I was despondent, with no idea where to turn for help. Bonnie and the FAST team provided me with incredibly knowledgeable and sensitive support. She gently coached and guided me in the direction of what have become extremely useful mental health services (psychiatry and therapy) through San Mateo County mental health services via the South San Francisco Clinic. Bonnie, through FAST, has supported and encouraged me every step of the way and I would not have direction, plan or support without her and the FAST services. The program and organization are vitally important and I wholeheartedly endorse their mission and services.



Sincerely,

Client

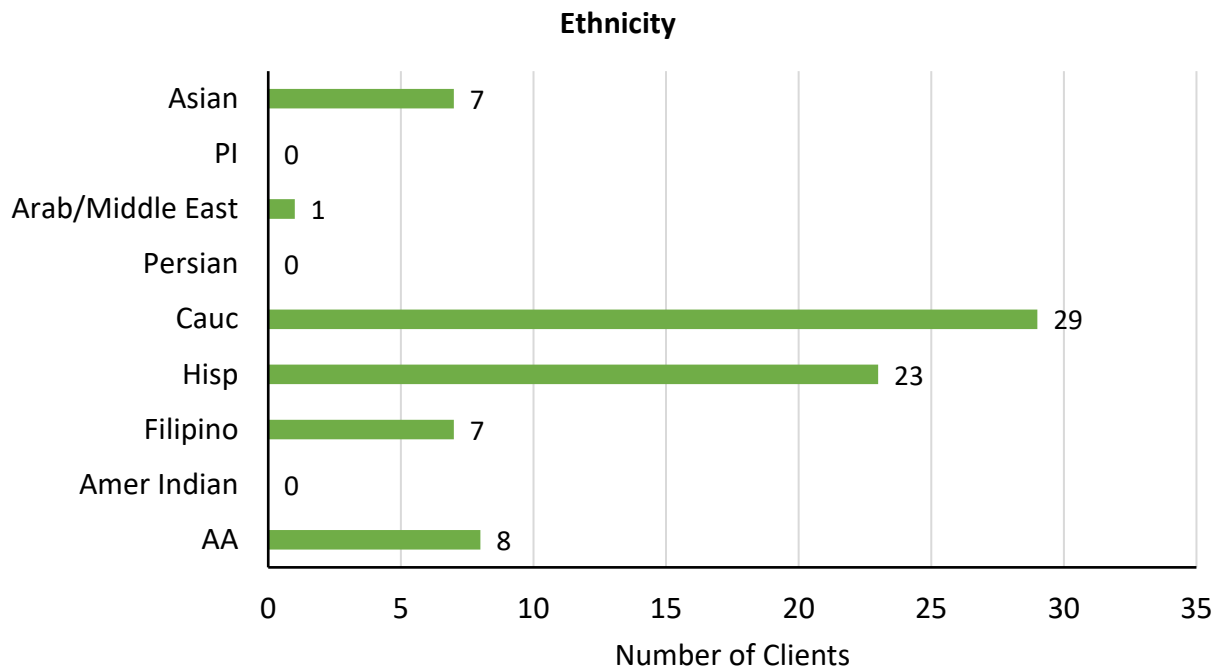
CHALLENGES

One challenge in the work of FAST, is the symptom of anosognosia, “the inability or refusal to recognize a defect or disorder that is clinically evident”. This is something that FAST encounters regularly in its work. *It is* expected and understandable. But the biggest challenge or impediment to successful outcomes for FAST is premature discharge from inpatient hospitalization (5150) while the client is seriously impaired as well as discharge without a coherent and cogent discharge plan. This *is Not* understandable, seemingly unethical and sometimes dangerous. It is also not fiscally prudent as these clients get repeatedly 5150d and tax the entire system. This is including exasperated clinicians, paraprofessionals and families alike, usually after many hours orchestrating such an intervention. This repeatedly happens despite FAST consultation and recommendations to hospital personnel and imploring from the family of said clients. Peninsula Area Hospital PES’s need to rethink their policies and protocols. The human as well as financial cost is too high. Solutions to this conundrum would have to be evaluated by top level behavioral health officials and hospital administrators with input by a committee of concerned clinicians, paraprofessionals, family members and community leaders.

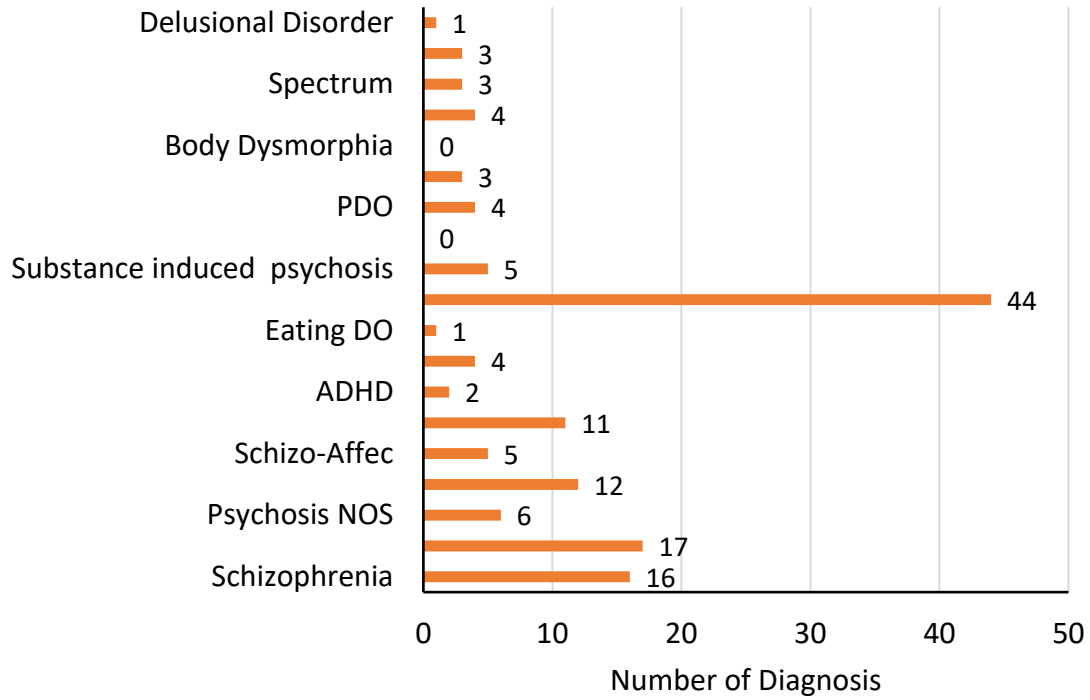
2019-2020 FY has also been unprecedented and difficult for FAST to improve upon its former accomplishments of the past. COVID 19 limited the program’s ability to effectively function in the field due to inherent dangers of the COVID virus and its spread, as well as some families and clients not wishing personal contact and the innate risks. Despite this challenge, FAST providers have persevered and had a successful year by any measure. As virus threats diminish, this will resolve itself.

DEMOGRAPHICS

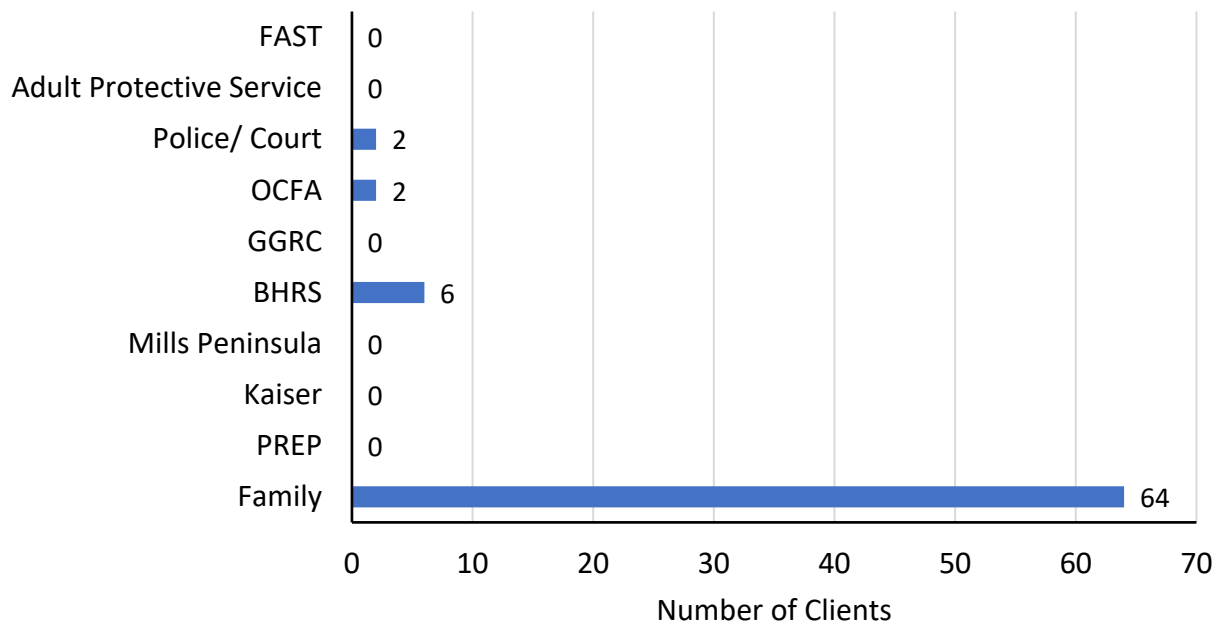
Age		FY19/20
	18-30	53%
	31-45	25%
	46+	22%
Sex		
	Male	31%
	Female	69%



Diagnosis



Referral Source



RAVENSWOOD FAMILY HEALTH CENTER

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

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

Ravenswood	FY 19/20
Total clients served	340
Total cost per client	\$125



PREVENTION & EARLY INTERVENTION (PEI)

PREVENTION AND EARLY INTERVENTION (PEI)

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

- **Early Intervention** programs provide treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence. Services shall not exceed eighteen months, unless the individual receiving the service is identified as experiencing first onset of a serious mental illness or emotional disturbance with psychotic features, in which case early intervention services shall not exceed four years.
- **Prevention** programs reduce risk factors for developing a potentially serious mental illness and build protective factors for individuals whose risk of developing a serious mental illness is greater than average and, as applicable, their parents, caregivers, and other family members. Services may include relapse prevention and universal strategies.
- **Outreach for Recognition of Early Signs of Mental Illness** to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.
- **Access and Linkage to Treatment** are activities to connect individuals with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.
- **Stigma and Discrimination Reduction** activities reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services.
- **Suicide Prevention** programs are not a required service category. Activities prevent suicide but do not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness.

PEI AGES 0-25

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

EARLY CHILDHOOD COMMUNITY TEAM (ECCT)

The Early Childhood Community Team (ECCT) aims to provide targeted, appropriate, timely responses to the needs of underserved families with children ages 0 through 5 or pregnant mothers in the Half Moon Bay community. ECCT focuses on the parent/child relationship as the primary means for intervention. Team members also focus on child development and strive to individualize services to ensure each child and family's unique needs are met. Identifying challenges early and providing families with the proper assessments, interventions and supports can make a difference in a child's earliest years and for many years thereafter.

PROGRAM IMPACT

ECCT staff work together to support families and their overall needs in order to enable families to live in stable environments. ECCT Mental Health Consultants work with caregivers and teachers to support and maintain children's placements to prevent suspensions or expulsions in preschool settings. Mental Health Clinicians work with families around traumas, mental health issues, family discord and child/caregiver relationship repair and building capacity while the Community Worker provides support around housing needs, financial support resources within the community and employment resources. In total of the 38 families receiving mental health services 6 reported an improvement in multiple areas related to their child's development and/or behavior. There are currently 11 in the process of completing the initial pre-test and the remaining 6 have completed the pre-assessment only. By enhancing parenting skills and promoting healthy child development, providing early childhood home visiting and treatment to prevent problem behavior we aim to reduce child abuse and neglect.

The Community Worker provided 16 families with linkages to community resources, parenting education and support. In addition, 46 families also participated in Parent/Child Activity groups and 32 families participated in two separate workshops. The parenting skills and focus on family relationships provided in these groups reduces the risk of child abuse and/or neglect for families as well as providing an opportunity for caregivers to build relationships and a support network to prevent isolation of caregivers and children.

The Mental Health Consultants collect end of the year surveys from teachers and school staff to learn more about their experiences with services.

- 93% of teachers report that the consultant was effective in increasing their understanding of the child's experience and feelings;
- 87% of teachers reported the consultant was effective in contributing to their willingness to continue caring for an identified child;
- 83% of teachers reported the consultant was effective in helping them to find services that the child and/or family need(s)

- 93% of teachers reported the consultant was effective in contributing to your understanding of the family’s situation and its effects on the child’s current behavior
- 87% of teachers reported the consultant was effective in helping them think about how to support all children in your classroom
- 100% of teachers would recommend consultation services to other programs

Among elaborated responses and comments were the following:

- *“Our S.V. consultant has been a vital tool in our program. She supported the staff with communication between each other and parents. I appreciate the support!”*

Consultants also collect data through annual parent surveys obtained at the end of the school year. Results from the 2019-20 Parent surveys found the following:

- 100% of parents indicated the consultant was effective in supporting their relationship with their child;
- 100% of parents reported the consultant was effective in increasing their understanding of their child’s behaviors and needs;
- 100% of parents reported the consultant was involved in helping them find additional services for their child and 100% of them stated these services were helpful;
- 100% of parents reported the consultant was effective in supporting their relationship with their child’s teacher;

Among elaborated responses and comments were the following:

- *“They were helpful because my mental health wasn't at its best, so having someone understand me and my child was a blessing”*
- *“It has helped my family work together better to achieve a common goal of being happy and healthy”*
- *“(The Consultant) was wonderful in lifting my self-esteem as a parent and reassuring that I am on the right path with my son.”*

Number of unduplicated clients served:

- 28 families received Mental Health only;
- 6 families received Community Worker Services only;
- 10 families received both Mental Health & Community Worker services;
- 106 children in Consultation services;
- 27 staff receiving Consultation services.
- 46 families in groups

ECCT	FY 19/20
Total clients served	106
Total cost per client	\$4,174

SUCCESSSES

One success highlights the collaboration between the mental health clinician, community worker and mental health consultant. The client is a 4-year old who lives with his mother, his 17-year-old sister and 11-year-old brother. The client's father is temporarily living in the home to help out after the client's mother had surgery. Both parents are immigrants from Mexico and currently unemployed. There is a history of trauma in the family related to the caregiver's mental health needs and parental stressor, a family history of substance use, employment instability and previous caregiver incarceration.

When therapy sessions began, the client's mother reported the client had difficulty expressing himself and would be come easily dysregulated. The client was reported to have speech delays that were causing stress for the mother and seemed to fight constantly with his siblings. During the sessions the clinician provided psychoeducation, coping skills and parenting skills to support the mother in understanding and supporting the client. The clinician also supporting the mother in process her own trauma. The mother has been open to attending workshops and parent training courses in the community and has brought back lessons she learns.

The Community Worker has supported the family for over a year. Prior to COVID 19 they supported the family in getting scholarships for swimming, affordable childcare and afternoon programs. During COVID-19 the community worker has also supporting the family in applying for unemployment, find food pantry resources and navigating grocery delivery services. The Mental Health Consultant heard about this family through colleagues and met mom after leading a workshop on parental stress and the importance of mental health in caregiving. The mother requested to meet with the mental health consultant 1:1 and opened up about her own trauma history and the overwhelming process of having her child assessed by Stanford. The consultant continued to support mom with these things while also meeting with dad to support him with his own stressors. Finally, the consultant also supported the school staff.

The family support staff and consultant often collaborated on supporting the family. The mental health consultant was a critical support system to the family and the family's caregiving team. Over the course of treatment, the mother has remained engaged in weekly sessions despite shifting to Telecare during COVID-19. Overall, the client's speech, language and ability to express his feelings have improved. The mother reports, "My son knows that I am constantly here for him, I am firm and that makes him feel secure and he knows that I love him." She has also shared that therapy has helped her build her parenting skills and helped her develop her own coping skills. Overall the mother has reported feeling very supported and express that she has learned how to understand what her son is expressing through his words and behaviors and that she understands herself better as well. Mom has demonstrated her commitment to therapy and her support to her children.

CHALLENGES

Prior to the COVID-19 pandemic, one of the major challenges for families was the cost of living in the Bay Area. Multiple families have had to move in with other families in order to mitigate the cost of rent, this increases stressors in the home but also limits the family's level of comfort and availability to meet for in-home visits. Additionally, the EECT team only has a small shared office space, making it difficult to host families for sessions in the office.

Another challenge is supporting those who age out of the ECCT program. There have been significant challenges within the communities of Half Moon Bay and La Honda/Pescadero in

terms of programs available for continued mental health and case management support post ECCT. Assisting families in transferring to Coastside Mental Health, Puente and School based services has been challenging. ECCT has provided extended services for some families as necessary and the team is able, however this is not always possible. Prior to Shelter In Place ECCT had been working closely with another Star Vista Program, Child and Parent Services Program (CAPS), to support their expansion into Half Moon Bay for short-term mental health and case management services for families with children 0-18 years. ECCT staff are in ongoing conversations with other Community Providers to look at this gap and better understand services available and supporting referrals/linkages made.

The negative impacts of the COVID-19 pandemic remain ongoing. The ECCT staff shifted quickly and creatively to remain connected to families. Many families lost contact with the program or began to disengage. There has also been a significant shift in the program’s work during the pandemic, mainly to the team shifting to supporting families in meeting immediate needs. The Mental Health Consultation component of ECCT faced significant challenges prior to COVID-19 related to the limited time teachers had to meet for mental health meetings. In general, there is a teacher shortage in the area which impacts their ability to support and coordinate with students and the students’ care teams and often leads to burnout.

The global pandemic also had a huge impact on the way Consultation work occurred in the program. Because children were not in the classroom their behaviors were not observed and identified. This led to less case consultation work and less linkages to needed early intervention services. Consultants did take advantage of the extra time people had at home to providing 1:1 meetings to support teachers through the pandemic changes. With a new virtual mode of operations in place the team is working to establish how data will be collected.

DEMOGRAPHICS

Of the 106 children served at the 5 sites:

Age	FY19/20
0-3	7%
3-5	93%
Sex	
Male	57%
Female	43%
Race/Ethnicity	
Sex	FY19/20
Latino/Hispanic Male	55%
Latino/Hispanic Female	34%
Race/Ethnicity	
Pacific Islander	15%
Language	
Latino/Hispanic	80%
Caucasian	30%
Language	
English	40%
Spanish	60%

Of the 18 families (20 parents) who received ‘light touch’ services:

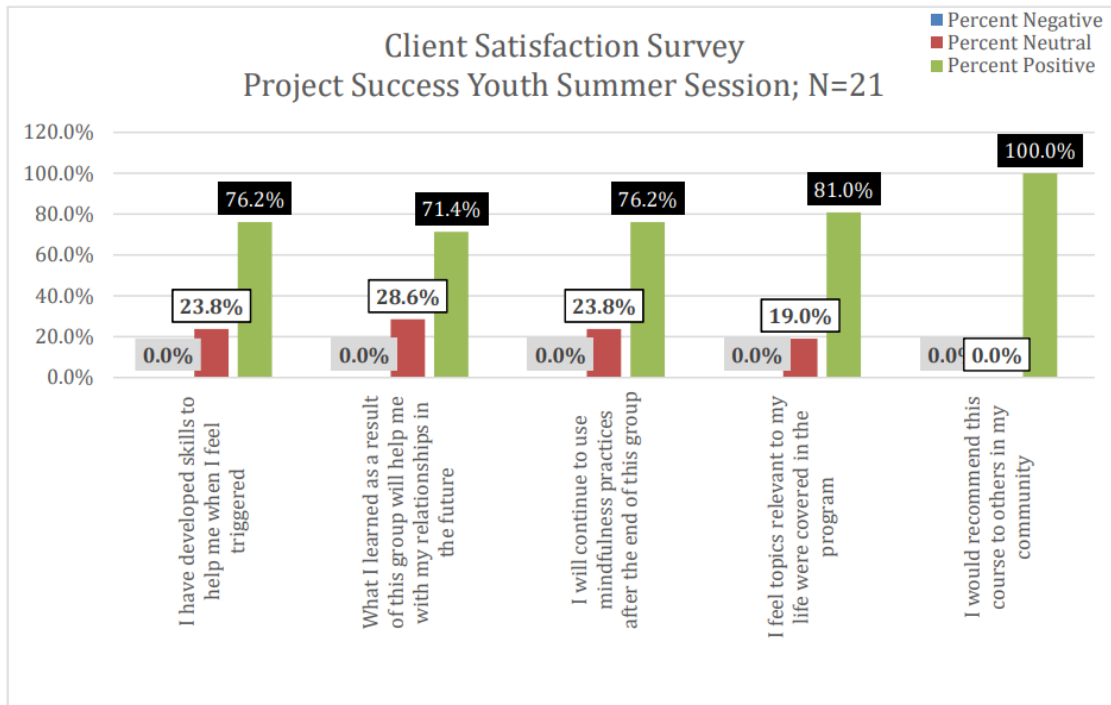
PROJECT SUCCESS

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

Project SUCCESS is designed for use with youth ages 9-18 and includes parents as collaborative partners in prevention through parent education programs. Clinical staff trained in culturally competent practices ran all the groups. All of Puente's Behavioral Health and Recovery Services (BHRS) staff are either licensed or pre-licensed by the Board of Behavioral Sciences (BBS). Project SUCCESS groups are offered on all three school campuses in the La Honda-Pescadero Unified School District (LHPUSD). The school district's small size provides an opportunity for every student in the district, ages 9 to 18, to participate in one or more Project SUCCESS activities. All groups were offered in English and in Spanish. Over fiscal year 2019- 2020, the program had 72 unique participants.

PROGRAM IMPACT

Results from the Project Success Youth 2020 Summer Session Satisfaction Surveys are below.



SUCCESSES

In December 2019 and January 2020, a total of 32 women participated in a series of Spanish speaking workshops for women planned primarily to improve and reinforce relationships. The classes addressed such issues as the Five Love Languages (recognizing that we all feel love and appreciation in different ways), trauma, alcohol and drugs (focusing on vaping) and self - care. Those women who attended two or more of the workshops were able to attend an evening of art and novelty. A bus full of women congratulated each other on finding other arrangements for their children and for getting out of work early on a Friday evening. The women repeatedly chorused that they rarely have self-care time on their own as they all have day jobs, children at home, and all kinds of commitments and responsibilities. Those who have been able to attend Puente events shared that they last time they were able to break free from their pressures of daily life, was when Puente has done other workshops and field trips for over extended moms in the past.

The bus pulled up to a ceramics studio in San Carlos where the women sat in a large circle sharing about their past and their present, while reinforcing the creative neuro-connections of their brain to design and paint. Many chose designs to honor their families, partners and children. After 2 hours in the studio, the group walked down urban streets lined with trees adorned with white lights. They expressed joy as they

promenaded the small downtown. The group then entered a new Vietnamese restaurant and for the first time in their entire lives, tried Vietnamese soups, rolls, rice-plates and vermicelli bowls. Many said that due to the easy to order from menus and the reasonable prices, apart from the delicious fare, they would be able to come back on their own. On the bus ride back home, the women requested this program continue as it helps them to have improved connections with their peers and relieves a lot of stress that can lead to depressive periods and anxiety. One woman called the series a self-improvement series, as she reported making an effort towards positive change in different relationships she has. The women chimed in that it has been so great that Puente recognizes the need for programs that bring women together, support them, informs them, and exposes them to difference experiences, encouraging them to be a bit adventurous.

Project SUCCESS	FY 19/20
Total clients served	267
Total cost per client	\$1,145

**Clients served includes Project SUCCESS and MBSAT clients*

CHALLENGES

In 22 years of service, the COVID-19 pandemic has been the biggest challenge for Puente. As a result of the shelter-in-place order, most staff have worked remotely since March. Puente teams were able to adapt, provide support for participants, and continued to provide as many services as possible including behavioral health programs. Puente saw a 20 percent increase in the number of participants during this time as there was a greater need - including mental health needs. It has been a challenge to provide more services with less direct in-person contact put in place to protect staff and participants. There has been an increase in the need for mental health services because of the COVID-19 pandemic. BHRS clinicians continue to provide services to clients and facilitate support groups via Zoom, Facetime, and by phone. Remote telehealth has long been suggested as a strategy to provide greater access to mental health care. Although there are challenges to providing remote therapy, it allowed the BHRS staff to continue to provide critical mental health care during this time while keeping participants safe.

In August 2020, the South Coast communities were evacuated because of the CZU wildfire. With the trauma of the wildfire and the evacuation, there is an even greater need for mental health services. Ten to 30 percent of wildfire survivors develop diagnosable mental-health conditions including Post-Traumatic Stress Disorder (PTSD), depression, and anxiety (National Center on PTSD). Feelings such as overwhelming anxiety, constant worrying, trouble sleeping, the desire to self-medicate with drugs and alcohol, and other depression-like symptoms are common responses after experiencing the trauma of a wildfire (SAMSA 2020). These symptoms are a natural response to dealing with an emergency situation such as fleeing a wildfire. However, if an individual continues to experience these types of symptoms when there is no immediate danger, it can lead to

PTSD. Having access to mental health care is one strategy to help alleviate mental-health conditions that develop after natural disasters (Hrabok et. al, 2020).

DEMOGRAPHICS

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

	FY 19/20
Total Clients Served	
Unduplicated clients served	267
Unduplicated families served	46
Age	
0-15	28%
16-25	30%
Adult	30%
60+	5%
Decline to state	4%
Primary Language	
English	78%
Spanish	22%
Race/Ethnicity	
White/Caucasian	40%
Mexican/Chicano	56%%
Other/data not available	3%
Gender Identity	
Male/Man/Cisgender	37%
Female/Woman/Cisgender Woman	60%
Decline to state	3%

TEACHING PRO-SOCIAL SKILLS (TPS)

Teaching Pro-Social Skills (TPS) is a ten-week program that uses “Skillstreaming”, an evidence-based, social skills training program designed to improve students’ behaviors, replacing less productive ones. The purpose of TPS is to help elementary school children learn pro-social skills in order to improve their social and behavioral functioning in school. During the 2019-20 academic school year, weekly TPS groups were held in seven different San Mateo County, Human Services Agency (HSA), Family Resource Centers (FRC) locations. The locations included the following schools: Taft (Redwood City), Hoover (Redwood City), Belle Haven (Menlo Park), Woodrow Wilson (Daly City), Bayshore (Daly City), Martin (South San Francisco), and the Puente de la Costa Sur resource center on the coast.

PROGRAM IMPACT

During fiscal year 2019-2020, from September 2019 to December 2019, a total of nine TPS groups were provided to a total of 43 students. Due to the COVID-19 pandemic and schools site closures, HSA was only able to conduct the fall cohort sessions (TPS is designed to be in-person, with challenges to program fidelity if delivered virtually). The following is a breakdown of the group and sites for the fall 2019 cohorts:

- One (1) groups consisting of a total of 5 students at Bayshore Family Resource Center
- One (1) groups consisting of a total of 4 students at Martin Family Resource Center
- One (1) groups consisting of a total of 6 students at Belle Haven Family Resource Center
- Two (2) groups consisting of a total of 7 students at Hoover Family Resource Center
- Two (2) groups consisting of a total of 12 students at Puente de la Costa Resource Center
- One (1) groups consisting of a total of 5 students at Taft Family Resource Center
- One (1) groups consisting of a total of 4 students at Woodrow Family Resource Center

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

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

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

1. Positive behavior changes were demonstrated in 90% of skills taught.
2. Overall, there was a 13% increase in scores across the 31 skills from pre-assessment to post-assessment, indicating improved behavioral skills.

Teaching Pro-Social Skills	FY 19/20
Total clients served	43
Total cost per client	\$4,651

SUCCESSSES

TPS was well received by the school teachers and administrators; the following message was sent to a PSW from school personnel: “[Student] has been showing lots of improvements at school and with other students. He was in a situation where he implemented the skill ‘How to Stay out of Fights’ to settle the issue and refrain from engaging.”

As a result of the positive outcomes from TPS participation reported by the school administrators, other schools have requested the service. For example, one of the administrators at Hoover school, who helped the PSW coordinate the TPS groups, transferred to Roosevelt school in Redwood City and requested TPS groups at Roosevelt because she saw how it benefitted students at Hoover.

CHALLENGES

The greatest challenge for the 2019-20 was the COVID-19 pandemic including school closures, shelter-in-place, and social distancing. One additional challenge was the redesign of the Family Resource Centers, which included bringing the Psychiatric Social Workers internally and realigning their job duties with State child welfare mandates.

DEMOGRAPHICS

	FY 19/20
Age	
0-15	100%
Primary Language	
English	81%
Spanish	19%
Sex Assigned at birth	
Male	62%
Female	38%
Race/Ethnicity	
Asian	2%
Latino/ Hispanic	65%
Black/African/-American	9%
White/Caucasian	12%
Asian Indian/South Asian	2%
Filipino	7%%
Samoan	2%

TRAUMA-INFORMED CO-OCCURRING SERVICES FOR YOUTH

Trauma-Informed Co-occurring Prevention Services for Youth target youth and transitional age youth (TAY) ages 15-25 who are at greatest risk for adverse childhood experiences; children of color and children who grow up in poverty show the greatest risk for ACEs. Other groups can include juvenile justice involved, immigrant youth, homeless youth, youth in foster care, etc. In San Mateo County, African American, American Indian, Latinx, and Native Hawaiian and Pacific Islanders, are more likely to live in high poverty areas (15.2%, 24.2%, 12.7%, and 10.9% respectively).

Trauma-Informed Co-occurring Prevention Services for Youth consists of three required components: Group-Based Intervention; Community Engagement; and Social Determinants of Health (SDOH) Screening and Referrals.

1. The Group-Based Intervention component utilizes evidence-based or promising practice intervention or curriculum to address trauma and co-occurring substance use issues with youth. Agencies can opt to provide the Mindfulness-Based Substance Abuse Treatment (MBSAT), which was piloted with youth throughout San Mateo County or an

alternate culturally-relevant intervention/curriculum. Examples of alternate interventions/curricula include, but are not limited to, the National Compadres Network curricula; Keepin' it R.E.A.L.; Teaching Transformative Life Skills to Students: A Comprehensive Dynamic Mindfulness Curriculum; and Mission Possible 360. Agencies providing Trauma-Informed Co-occurring Prevention Services for Youth target at least 8 youth per cohort and each cohort consists of at least eight sessions for the intervention and one session for BHRS staff to present on youth engagement opportunities.

2. The Community Engagement component address systemic and community-level challenges that are necessary for positive youth development and behavioral health outcomes. Agencies provide at least two foundational trauma-informed 101 training for adults and other members of the community that interact with their youth cohort participants (parents, teachers, probation officers, service providers, community, etc.) to create trauma-informed supports for youth. This component also encourages agencies to connect the cohort youth to leadership engagement opportunities such as the BHRS Office of Diversity and Equity (ODE) Health Ambassador Program for Youth and the Alcohol and Other Drug (AOD) youth prevention programs.
3. The SDOH Screening and Referrals component acknowledges that social determinants of health (e.g., food insecurity, housing, transportation, medical treatment, etc.) can account for up to 40 percent of individual health outcomes, particularly among low-income populations. Agencies screen youth participants at intake for social determinants of health impacts to support appropriate referrals and identifying community-based social service resources and social needs and/or gaps. A screening tool will be developed by BHRS and made available to the selected provider.

Four agencies will provide Trauma-Informed Co-occurring Prevention Services for Youth interventions as follows:

Beginning FY 2019-20:

- Mindfulness-Based Substance Abuse Treatment (MBSAT)
 - StarVista provides 6 cohorts per year in North County and South County
 - Puente de la Costa Sur provides 2 cohorts per year in the South Coast region

Beginning FY 2020-21 (program outcomes will be reported in the next Annual Update):

- Mindfulness-Based Substance Abuse Treatment (MBSAT)
 - YMCA Bureau of San Mateo County provides 2 cohorts per year in South San Francisco
- Panche be Youth program
 - The Latino Commission provides 2 cohorts per year; 1 cohort of the indigenous and culturally-based Xinachtli for girls and 1 cohort of El Joven Noble curriculum for boys in Half Moon Bay.

MINDFULNESS-BASED SUBSTANCE ABUSE TREATMENT (MBSAT)

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

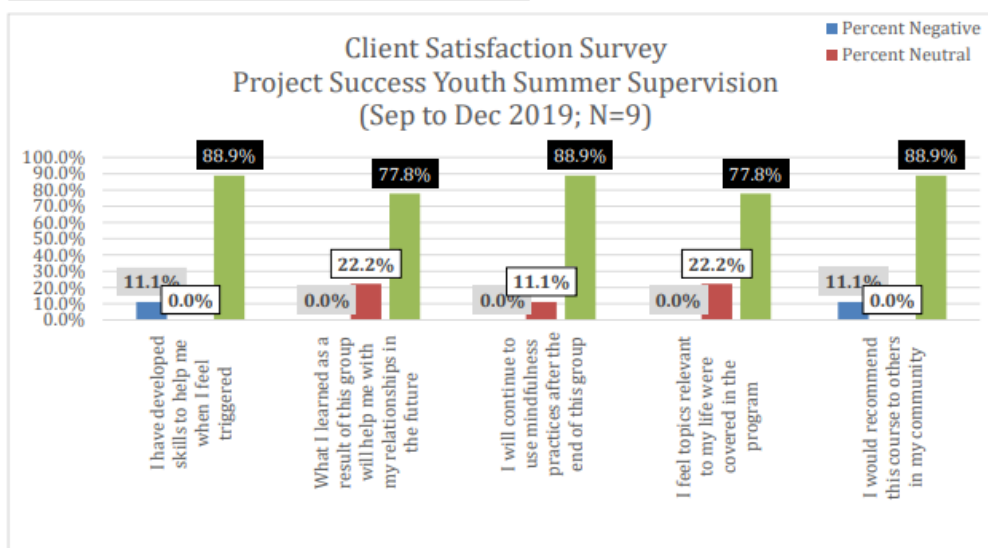
MBSAT – PUENTE DE LA COST SUR (PUENTE)

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

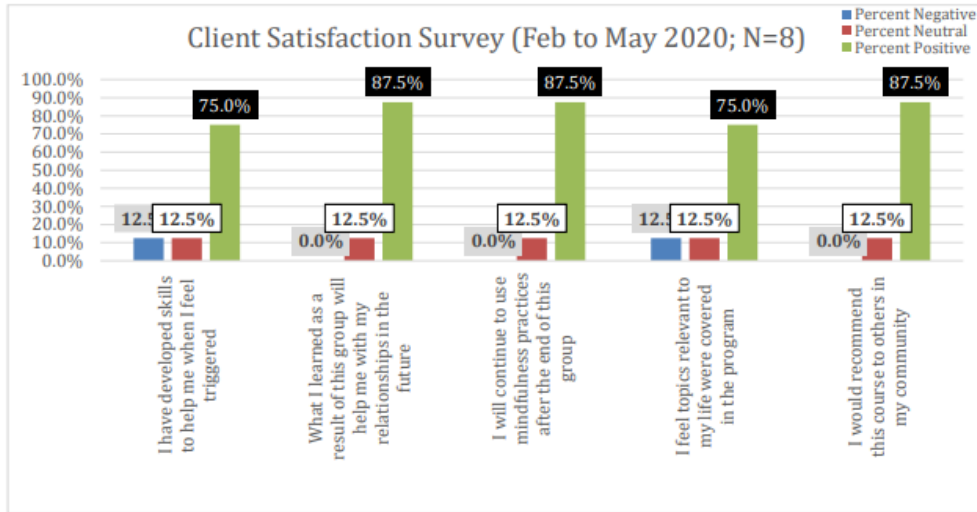
PROGRAM IMPACT

During the school year (2019-2020), Puente provided two 12 week group format sessions of MBSAT to Pescadero High School students (ages 14-18) for one hour each week. The first group ran in the fall, 2019 and served 10 youth. The second group ran in the spring, 2020 and served 14 youth. Both groups were scheduled during after school hours. This groups were formed by Puente clinicians through collaboration with Pescadero High School administration to identify those students deemed to be at a mid to high risk for substance use/abuse.

FALL MBSAT CLIENT SATISFACTION SCORES:



SPRING MBSAT CLIENT SATISFACTION SCORES:



MBSAT - Puente	FY 19/20
Total clients served	24
Total cost per client	\$1,250

SUCCESSSES

MBSAT participants reported overall positive experiences with the mindfulness group. One group member reported the group helped him “express [his] emotions more”. Another member reported that they were “exposed to things [they] wouldn’t normally do [their] self like mindfulness”. Group members report successfully learned the informal mindfulness technique of “riding the wave” (a process of noticing and paying attention to your cravings as they rise and fall) and practiced role playing scenarios in which they employed this method of responding to stressful situations/triggers. Puente believes that MBSAT’s model and values as a curriculum helped these youth to feel open to discussing substance use in an environment that fostered independent thinking, mindful responses to stress, and an increased sense of self-awareness.

Perhaps the greatest success was the unexpected transition Puente had to make from meeting in-person, at school, to existing solely online through Zoom each week during the second cohort (Feb.-June 2020). Nine out of thirteen original group members successfully made the transition to the online group and found it a great way to stay in touch with peers during a time of great change and stress. One member reported, “It was a peaceful group where I got to be free from my anxiety...I feel like the group helped me reconnect with my friends better too.” While both the facilitators and youth would have preferred the group to finish in person, this Zoom group was a place of connection that we all looked forward to each week.

CHALLENGES

A major challenge faced during this past year's cohort of MBSAT was navigating the transition from in-person group meetings to video call-based groups. This hurdle involved increasing communication between facilitators, students, and administrators, as well as coming up with new ways to lead group activities online while still fostering active participation from youth. The relationship formed in the beginning of the group (in-person) with the youth most definitely helped the facilitators to better transition and engage students online. However, some youth continued to struggle with engagement and understanding of topics once the online switch was made. In order to accommodate students in future online MBSAT groups, the facilitators plan to include cater more to the group's learning style, providing more interactive Zoom activities each session and reducing the amount of didactic/lecturing material as much as possible.

MBSAT - STARVISTA

StarVista offered MBSAT groups to various community-based organizations in San Mateo County. These organizations offer programming and work with the aforementioned age groups at their facilities. StarVista attends the various sites and aligns to be fitting in with their programming schedules. Flexibility and convenience are significant components of this program in order to make it as accessible as possible to the population. When shelter in place order began, the program adapted to fit an online virtual method of service delivery. This allowed groups to continue to adhere to regulations associated with COVID-19 protocols. Groups are split up based on age if necessary (15-17 and 18-25).

PROGRAM IMPACT

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

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

Increases number of individuals receiving public health services: Under pre-COVID-19 circumstances, providers would travel to the underserved youth. The program reached participants through programs where they are already receiving services (both literally and virtually). Since having established an online platform due to COVID-19, MBSAT was able to cast their net even farther, reaching homes with already limited accessibility due to schedules and timing of personal lives and/or travel limitations due to financial constraints. If there appear to be any unmet needs, reported or perceived by the clinician, in an effort to ensure the youth’s health needs are being met, StarVista collaborates with the partner sites to coordinate the appropriate level of care for all participants that engage in the program.

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

Implements recovery principles: By emphasizing increased awareness and acceptance as core element of mindfulness, individuals can implement the principles that are critical to their recovery. Teaching mindfulness encourages implementation of self-actualized, self-directed factors that are identified by the individual in recovery. Mindfulness is rooted in holistic, strength-based, person-centered, and self-directed elements – all key principles of recovery. Due to COVID-19 related challenges this year, most group cycles were interrupted due to shelter-in-place orders. Thus, the data collected is insignificant for analysis as it is all consisting of “pre” surveys with only a handful of “post” surveys. The resounding self-report from participants was very positive and StarVista looks forward to having the data tell the same story after implementing changes to their data collection methods.

MBSAT – StarVista	FY 19/20
Total clients served	43
Total cost per client	\$2,093

SUCCESSSES

One of the most notable shifts reported from clients was in their willingness to enjoy and engage in “therapy”, they would say. They reported that they thought it would be boring and a poor use of their time, but by the end of the 8-week cycle, they reported having enjoyed learning and would ask how they could continue. Another notable success of this program has been seeing a shift in desire to change by the participants. So often, youth participants are barely “contemplative” in regard to the “stages of change”. Most youth, after participating in the full workshop are much closer to an “action” stage of change. This is where they have identified what they want to work on and are actively working towards goals. This is an enormous step in improving their journey and creating an internal process of awareness and action. Multiple youth reported using the tools learned in group during their daily lives. This further showcased that when provided the encouragement and the space, they would thrive. Youth left the group self-reporting a generally greater ability to express their emotions in a way

that was receivable and positive to those around them. It appears groups that holding more open groups with flexible times and online formats has led to higher levels of interaction and participation. One major difference between the online and in-person group setting is that youth have seemed to appreciate being in their own spaces as opposed to sitting in the group circle. In addition, youth have exhibited very positive bonds with group facilitators.

CHALLENGES

The most significant challenge was adaptation to new guidelines due to COVID-19 in conjunction with lack of participant consistency. At first, youth are often hesitant to embrace the workshop, but slowly warm up to the process. With online groups requiring participants to “log in” on their own without partner-program oversight has shown a need for increased reminders through texts/emails. With that in mind, if TAY do not warm up to the group concept and the online platform quickly, this has shown to harm future attendance, engagement and potential growth. When the youth are present, they are very engaged. Incentives, such as gift cards, would likely increase participation and fidelity. StarVista intends to add this as motivation for participation in the new Fiscal Year. An additional challenge pertains to in-home resources. Sometimes youth do not have the privacy or the internet connectivity to participate in the group to their fullest. Further encouraging the move to online only surveys is that most youth do not have the desire or patience to fill out the survey in-person or have a printer at home to print and fill out. This made tracking outcomes during this year extremely difficult. Further emphasis will be placed on reliable completion and tracking of surveys by diversifying how the survey can be taken and increasing simplicity.

DEMOGRAPHICS

	FY 19/20
Age	
0-15	7%
16-25	93%
Primary Language	
English	100%
Sex Assigned at birth	
Male	40%
Female	60%
Race/Ethnicity	
Mexican/Chicano	19%
Black/African/-American	19%
White/Caucasian	30%
Asian	9%
Asian Indian/South Asian	2%
Tongan	21%
Another race/ethnicity	8%

PEI AGES 0-25: EARLY CRISIS INTERVENTIONS

YOUTH CRISIS RESPONSE & PREVENTION

The Crisis Intervention & Suicide Prevention Center (CISPC) has multiple components with the sole purpose of providing crisis and suicide support to all ages of the San Mateo County community including a 24/7 Crisis Hotline, outreach and training, and mental health services.

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

PROGRAM IMPACT

The program served 73 youths with initial intervention in school settings as a response to crisis intervention. Additionally, 100% of the clients receive referrals for crisis counseling, and 100% receiving crisis counseling through the youth intervention program.

Case Management/Follow-Up Phone Consultation (youth and adults)	
	FY 19/20
# of new cases	62
Total # of sessions provided	76
Youth Outreach Interventions (evaluations at school sites)	
# of initial interventions (new youth served)	73
# of follow up sessions with youth	226
# of follow up contacts w/ collateral contacts	132
Clinical Training/Supervision (youth and adults)	
hours provided (including prep. time)	85
number of trainings attended	24
Crisis Hotline & Chat Room	
Number of calls	13,515
Teen Chat Room # of Private Chats this month	280
Outreach Presentations	

# of people served	2679
School-Community Training in Suicide Prevention (# of presentations)	62
Program Outcomes	
% of youth seen by Crisis Staff who are diverted from suicide	100%
% of youth seeking crisis counseling that receive it	100%

FY 19/20	Youth Interventions	Crisis Hotline
Total youth served	73	13,515
Total cost per client*	\$4,686	\$25,308

**Cost of services include youth interventions, crisis hotline response and outreach*

SUCCESSSES

A success for the Youth Intervention team includes an encounter described below.

The principal was asking to consult with the Youth Intervention Team clinician. The clinician spoke with the Principal and learned the student was a previous client. The clinician met with the student at his school and was able to assess him for safety. After their conversation, it was clear the student was presenting a risk to himself. The clinician, having already had a relationship with the student and family, collaborated with school personnel, the student, and student's mother about the importance of maintaining safety and mental health support. The mother agreed to take the student to the hospital, where he was held on a 5150 hold. During his hold, this clinician worked with the mother in setting up mental health services for herself, to have continued support. Once the student was released from the hospital, this clinician co-facilitated a re-entry meeting with the student, his mother, the Principal, and school Psychologist. The purpose was to find and maintain academic and mental health support and to ensure that all supporting members (school personnel and community agencies) were consistent in their support. In addition, this clinician provided short term therapy with the student for the interim period until he was successfully connected to county mental health services for long-term support.

CHALLENGES

Due to the pandemic and shelter-in-place regulations, crisis clinicians have faced some challenges with referring and connecting youths to on-going services. As a result, many youths served through the YIT have stayed enrolled in these services. Additionally, and due to the impact of this pandemic, crisis clinicians are providing significantly higher level of case management services. The families, previously just facing one crisis, now face a mirage of crisis- including job loss, housing instability, and change in income.

EARLY INTERVENTION: EARLY CRISIS INTERVENTIONS

SAN MATEO MENTAL HEALTH AND REFERRAL TEAM (SMART)

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

PROGRAM IMPACT

The highest volume of calls for SMART response is Thursday through Saturdays.

- SMART’s first goal is to divert 10 % of calls where a 5150 was not already placed.
 - In FY 19-20 AMR diverted 39.1% in the first quarter, 30.9% in the second quarter, 34.9% in the third quarter, 39.4% in the fourth quarter.
- SMART’s second goal is to respond to 75% of appropriate calls for service.
 - In FY 19-20 AMR responded to 71.4% in the first quarter and 68.4% in the second quarter, 75.7% in the third quarter, 68.0% in the fourth quarter.
- SMART evaluates people in the field and able to connect people to behavioral health services that would otherwise not have occurred. Being able to transport people right on the spot to the appropriate services has increased connectivity and treatment for many people. Many people are more likely to be forthcoming with a psychologically trained medic about what is going on than law enforcement.
- SMART Medics are able to evaluate both physical and mental health issues including suicidal ideation and direct people to the appropriate resources. SMART responds to many people under 18 who are in crisis. By addressing the youth’s concerns and getting supportive and protective factors in place the youth is much more likely to remain in school. Getting supportive services to the youth’s family helps the family unit to stay intact. SMART refers parents to services, so they can provide for their children.
- SMART responds to many homeless severely mentally ill adults. By getting them evaluated and getting the right level of medications and placements this assist in reducing homelessness.

SMART	FY 19/20
Total calls received	2615
Total cost per client	\$56

EARLY INTERVENTION: EARLY ONSET OF PSYCHOTIC DISORDERS

EARLY PSYCHOSIS PROGRAM- (RE)MIND

The (re)MIND® (formerly PREP) Program is a coordinated specialty care model for prevention and early intervention of severe mental illness that specializes in early intervention for

schizophrenia spectrum disorders. The BEAM Program is an expansion on the (re)MIND® model and specializes in the early intervention of bipolar and affective psychoses. (re)MIND® and BEAM delivers comprehensive treatment grounded in wellness, recovery and resilience to youth and young adults experiencing early symptoms of psychosis. By intervening early with evidence-based, culturally responsive, and comprehensive assessment and treatment the (re)MIND®/BEAM Programs are transforming the perception and impact of psychosis so that most cases of schizophrenia spectrum, bipolar, and affective psychosis disorders detected in the earliest stages are treated to remission. The (re)MIND/BEAM Aftercare Services were developed from the need to provide program graduates (Alumni) and caregivers with a specialized safety net to sustain gains achieved through engagement in psychosis early intervention. Individuals served regardless of insurance status include:

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

The Felton (re)MIND™ Program provides a wide array of services designed to wrap around the individual, and their family members involved in treatment. Services begin with an outreach and education campaign to help community members and providers to detect early warning signs. Once an individual has been identified and referred to the program, they receive a comprehensive, diagnostic assessment to determine their diagnosis to identify early intervention services. Following assessment, individuals participate in assessment feedback session(s) where they receive psychoeducation on diagnosis and treatment options.

Besides early diagnosis, program services include:

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

PROGRAM IMPACT

The (re)MIND® and BEAM Programs served 76 youth and young adults during FY 19/20 achieving the following outcomes:

- Exceeded their goal of reducing the number of inpatient hospitalizations episodes by at least 50%. There were 39 participants enrolled for at least 12 months in FY 19/20. Out of 24 participants with prior hospitalizations within 12 months of enrollment, 22 (92%) experienced a reduction in acute hospitalization episodes. In addition, out of 15

participants with no prior hospitalization history, 14 (93%) continued to have no hospitalizations. This highlights the importance of early intervention for psychosis in preventing mental illness from becoming severe and disabling.

- Exceeded goal of a least 75% of participants engaged in meaningful employment and/or education: There were 60 participants enrolled into full program services. Out of the 60 participants enrolled, 51 (85%) were engaged in personally meaningful part-time or full-time school or work as a result of their engagement into early psychosis services.
- Exceeded goal of 40% of participants engaged in new levels of employment or educations: There were 39 participants enrolled for at least 12 months in FY 19/20. Of these 39 participants, 20 (51%) achieved new levels of employment or education.
- Exceeded goal of 70% of Aftercare participants will sustain improvements on CANS/ANSA domains of psychosis, education and/or employment: Initial and most recent annual CANS/ANSAs were used to evaluate maintenance of improvements on the domains of symptoms, education, and employment for 8 Aftercare participants. Out of 8 Aftercare participants, 7 (88%) demonstrated maintenance of improvements.
- Exceeded goal of 80% maintained placement in lower level of care: Of the 76 participants served during FY 19/20, 71 (93%) maintained their placement at home or in a lower level of care as a result of their engagement in early psychosis services.
- Met goal of 90% service satisfaction: The results of the November 2019 semi-annual California Department of Health Care Services Consumer Perception Survey were used to evaluate service satisfaction. During the survey period, 30 participants received direct services of which 25 participants completed and returned their surveys for a return rate of 83%. Of the 25 participants surveyed, 23 (92%) indicated that they agreed/strongly agreed to feeling satisfied with services.
- Nearly met goal of 75% of participants will report they can handle daily life: During the survey period, 30 participants received direct services of which 25 participants completed and returned their surveys for a return rate of 83%. Of the 25 participants surveyed, 17 (68%) indicated that they agreed/strongly agreed to feeling as though they could handle daily stressors/problems.
- Met goal of holding 12 Peer and Family Alumni Groups: During FY 19/20, 8 individuals were served through the Alumni Care expansion, the program held 16 Peer and Family Support Groups that included alumni in attendance throughout the year.

RE (MIND)	FY 19/20
Total clients served	76
Total cost per client	\$11,038

SUCSESSES

Success Story #1: The individual was the recipient of both early intervention services as well as one of the first to benefit from alumni care. One of the factors that makes this individual’s success so profound is the absence of natural supports that are typically present with those who tend to make the biggest gains. It should be noted that a core aspect of early psychosis intervention is the engagement of an individual’s family in their treatment, utilizing services such as Multi-Family Group and Family Support Services. This individual came to the program as

an emerging adult, having just been hospitalized, and was struggling to function (academically, at work, and socially) due to their symptoms. They had experienced significant trauma within their home growing up and their family was not supportive of treatment. Several times during treatment, the family changed residences which caused academic and treatment disruptions. Nevertheless, the participant remained engaged with their treatment team (therapist, supported employment and education specialist, peer support specialist, and psychiatric nurse practitioner). As a result of their engagement in services and continuity of care post-graduation made available through Alumni Care, this individual was able to achieve remission of symptoms, safely discontinue psychotropic medications with professional guidance, complete their AA degree, and transfer to a 4-year university. This participant continues to receive supportive services through Alumni Care and continues to thrive.

Success Story #2: On March 16, 2020, six local counties declared a Shelter-in-Place Order, to be effective on March 17 due to the COVID-19 Pandemic. One of the key features of effective early psychosis programs is assertive engagement protocols and services provided in the community where participants live. However, these engagement strategies were not available to staff as of March 17. Immediately upon hearing the order, program staff prepared to transition to working from home. During the first week of the Shelter-in-Place Order, staff was able to engage 100% of program participants and families via phone contacts, assessing their needs, and providing support. Over the course of the months that followed, staff continued to provide services by phone and eventually through telehealth platforms. These services were adapted to meet the needs of participants, including increasing the frequency of contacts in shorter treatment sessions, as necessary, for contacts to be experienced as meaningful and effective by participants and families. Staff also provided an additional 44 in-person visits as indicated by clinical needs, following strict safety measures. As a result of program staff's efforts during this period, participants were able to maintain stability in the community during times of elevated stress for themselves and their natural support system, with none needing to access ER, crisis stabilization or psychiatric inpatient services.

CHALLENGES

The biggest challenge experienced by (re)MIND® in FY 19/20 were the same challenges experienced systemically, responding to the complexities of operating in the context of a pandemic. COVID-19 and the resulting Shelter-in-Place Order had potential to create a serious negative impact on service accessibility and engagement, participant's well-being and outcomes, and staff's health and wellness among other impacts. Program staff had the challenge of integrating frequent updates, new policies, and changing recommendations into their own lives and clinical care. Program leadership had to work to redefine and reconstruct the program infrastructure to move away from an office-based setting to working out of staff's homes successfully.

As was reported in Success Story #2, the program's response and effort was effective and the participants responded well to the support. However, there were aspects to the program that suffered as a result of COVID-19; community outreach efforts were put on hold to allow greater time for availability to participants, hiring for vacant positions was temporarily halted while

program leadership worked to support existing staff and participants, and the program census growth slowed significantly.

1. Disruption to community outreach: Spring is a natural time for a big push in terms of community outreach, hosting events (open house, mental health awareness month), and receiving a healthy flow of referrals from schools that are preparing to enter summer break. As a result of the changing community landscape in response to COVID-19, the program saw a decrease in the number of referrals generated during this time. (re)MIND® did grow by enrolling 11 new participants during the final quarter of FY 19/20, but this is at least half of what new enrollments would look like in a typical year.
2. Staff Transitions: During the latter part of 2019 and early 2020 a total of three staff transitioned into other roles outside of the agency, leaving an impact on capacity to process new referrals. Hiring was a priority until it was put on hold temporarily at the onset of the Shelter-in-Place Order.
3. Limited program growth: A large cohort of program participants graduated from services (27 during FY 19/20, preceded by another 21 individuals during FY 18/19). What often happens with graduating cohorts is that several participants leave the program in a short time and it takes longer to enroll new participants.

The program is actively addressing the factors that have resulted from the challenge brought on by COVID-19.

1. Outreach plan and impact: Program staff are now engaged in virtual outreach to promote access to the program and educate the community on serious mental illness while simultaneously reducing stigma. Since the first virtual presentation, one month ago, the program has received 10 inquiries and referrals, matching the growth in one month that was achieved in the entire last quarter of FY19/20.
2. Filled vacancies: Once program leadership had equipped staff with effective strategies for working remotely, the focus returned to hiring. The three vacant positions are now filled, and the program can once again operate at full capacity to respond to community needs.
3. Engaging graduates: In addition to maintaining an active referral network, the addition of Alumni Care is helping to maintain engagement with graduates for longer periods of time. During FY19/20, program staff provided ongoing support to 8 Alumni and are already providing support to 10 Alumni as of August of FY20/21. The inclusion of graduates into services, particularly group activities, is instrumental at instilling hope for those who are in an earlier stage of recovery.

DEMOGRAPHICS

	FY 19/20
Age	
0-15	10%
16-25	78%
26-59	12%
Primary Language	

	FY 19/20
Race/Ethnicity	
Asian	4%
Mexican/Chicano	29%
Eastern European	7%
European	11%

English	100%
Sex Assigned at birth	
Male	53%
Female	47%
Sexual Orientation	
Straight or heterosexual	51%
Gay, lesbian, homosexual	1%
Bisexual	5%
Questioning or unsure	5%
Another sexual orientation	8%
Decline to state	29%
Gender Identity	
Male/Man/Cisgender	54%
Female/Woman/Cisgender woman	43%
Questioning/unsure	1%
Another gender identity	1%

Arab/Middle Eastern	1%
Black/African/-American	7%
White/Caucasian	11%
Asian Indian/South Asian	3%
Central American	4%
Chinese	9%
Native Hawaiian	1%
Filipino	12%
South American	1%
Disability/Learning difficulty	
Developmental disability	1%
Chronic health condition	1%
Learning disability	3%
I do not have a disability	91%
Another disability	4%
Veteran	
No	100%

EARLY INTERVENTION: PRIMARY CARE AND BEHAVIORAL HEALTH INTEGRATION

PRIMARY CARE INTERFACE

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

Primary Care Interface	FY 19/20
Total clients served	802
Total cost per client	\$1,333

PREVENTION: COMMUNITY OUTREACH, ENGAGEMENT AND CAPACITY BUILDING

OFFICE OF DIVERSITY AND EQUITY (ODE)

The Mental Health Services Act provided dedicated funding to address cultural competence and access to mental health services for underserved communities; in San Mateo County this led to the formal establishment of the Office of Diversity and Equity (ODE) in 2009. ODE advances

health equity in behavioral health outcomes of marginalized communities. Demonstrating a commitment to understanding and addressing how health disparities, health inequities, and stigma impact an individual’s ability to access and receive behavioral health and recovery services, ODE works to promote cultural humility and inclusion within the County’s behavioral health service system and in partnerships with communities through the following programs:

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

PROGRAM IMPACT

The Office of Diversity and Equity (ODE) measures progress along 5 indicators, defined below. A goal for next year will be to identify at minimum one question per indicator to begin collecting standardized data across ODE programs. This will allow for aggregate data on the impact of ODE as a unit. The following definitions are influenced by (1) public health frameworks and (3) ODE’s mission, values and strategy.

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

DEMOGRAPHICS

143 demographic surveys were collected from individual served across ODE programs.

	FY 19/20
Age	%
Age 0-15	2%
Age 16-25	9%
26-59	81%
60+	6%

	FY 19/20
Sex assigned at birth	%
Male	24%
Female	76%
Decline to state	1%
Intersex	%

decline to state	2%
Primary language	%
English	68%
Spanish	27%
Mandarin	1%
Tongan	2%
Another language	2%
Bilingual	2%
Race/Ethnicity	%
American Indian/ Alaska Native/	1%
Asian	10%
European	1%
Black/ African- American	6%
White/ Caucasian	21%
Asian Indian/ South Asian	3.5%
Hispanic/ Latinx	3%
Central American	6%
Chinese	2%
Mexican/ Chicano	17%
Native Hawaiian	7%
Filipino	1%
South American	4%
Another race/ ethnicity	1%
Multiracial	4%
Decline to state	3.5%
Gender Identity	
Male/Man/ Cisgender	24%
Female/ Woman/ Cisgender Woman	74%
Transgender Male	0%
Transgender Woman	1%
Questioning/ unsure	0%
Genderqueer/ Nonconforming	1%
Indigenous gender identity	0%
Another gender identity	0%
Decline to state	1%

Yes	
No	89%
Decline to state	
Veteran	
Yes	1%
No	98%
Decline to state	1%
Disability/ Learning	
Difficulty seeing	4%
Difficulty hearing or	1%
Dementia	1%
Developmental	1%
Physical/ mobility	3%
Chronic health	2%
Learning disability	1%
I do not have a	79%
Another disability	1%
Decline to state	7%

HEALTH EQUITY INITIATIVES (HEIS)

The Health Equity Initiative (HEI) strategy addresses access and quality of care issues among underserved, unserved, and inappropriately served communities. ODE provides oversight to nine Health Equity Initiatives (HEIs) representing specific ethnic and cultural communities that have been historically marginalized: African American Community Initiative, Chinese Health Initiative, Filipino Mental Health Initiative, Latino Collaborative, Native and Indigenous Peoples Initiative, Pacific Islander Initiative, PRIDE Initiative, Spirituality Initiative, and the Diversity and Equity Council. HEIs are comprised of San Mateo Behavioral Health and Recovery Services staff, community-based health and social service agencies, partners from other County agencies,

clients and their family members, and community members. HEIs are typically managed by two co-chairs, including BHRS staff and/or a community agency or leader. HEIs implement activities throughout San Mateo County that are intended to:

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

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

Health Equity Initiatives	FY 19/20
Total clients served	2500
Total cost per client	\$51

DIVERSITY AND EQUITY COUNCIL (DEC)

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

Mission, Vision, & Objectives

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

Highlights & Accomplishments

During Town Hall meeting in May, DEC created a space where community members were able to hear from county leadership, what is being done to address the impacts of Covid 19. Mid fiscal year, DEC’s co-chairs both transition out of their roles. DEC was able to achieve the goals and agenda set out for the year with the help and support of multiple staff-members of ODE. Additionally, DEC worked closely with BACHAC, County Health Public Policy and Planning, Catholic Charities, and StarVista to plan Town Hall Community Meeting in May. This event helped build the relationships amongst the agencies and it also created a partnership for supporting and advocating for vulnerable communities.

DEC members contributed to the accomplishments of DEC by resource sharing. Committee members often share upcoming events/webinars in topics of interest to the group. Also, their participation in the strategic planning of the fiscal year was a huge contribution from members. Community input for last years strategic planning was used to plan out the schedule for FY19-20 meetings. Based on that feedback, DEC hosted presentations on Human Trafficking, AOD Fellowship, and at least two of the meetings were a focused on HEI collaboration.

AFRICAN-AMERICAN COMMUNITY INITIATIVE (AACI)

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

Mission, Vision, and Objectives

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

- **Awareness:** Increase overall community awareness and involvement of community members in African American Community Initiative
- **Utilization/Access:** Increase knowledge and utilization of mental health services of BHRS among African American community members in San Mateo County.
- **Education/Training:** Act as liaison between African American community and BHRS, assisting in linkage to services such as Black Infant Health and community trainings such as Mental Health First Aid, Photo Voice, and Applied Suicide Prevention.
- **Employment:** To advocate for the staffing of at least one African American clinician or peer-support provider (MFT, LCSW, and other providers) in each Community Service Areas of San Mateo County's Behavioral Health and Recovery Services.
- **Research:** To provide feedback and inform San Mateo County BHRS regarding African American community as result of surveying through the Office of Consumer Affairs, focus groups, and community-based research.
- **Outreach:** Conduct at least one annual community-based event, such as in celebration of Black History Month, Juneteenth, or Kwanzaa to build support of AACI and to reach out to the African American community.
- **Partnership:** Partner with other organizations and health equity initiatives from the Office of Diversity and Equity to support AACI and AA clients and professionals as well as other diverse groups; link and collaborate with other entities that work in various capacities with African American community members.

Highlights & Accomplishments

One of the goals of The African American Community Initiative is to increase collaborative efforts with other HEI's in order to identify the health needs of communities of color and ultimately decrease disparities for communities of color.

Black History Month events in 2019 & 2020 focused on the mental wellness of African Americans of all ages. It acknowledged the chronic stress of racism and that everyday family challenges (such as securing resources, family stability) can add even more stress. The Initiative offered workshops and activities that provided coping strategies for the whole family to mitigate stress. Participants remarked that the workshops and speakers were very helpful and meaningful. The event planning began in the annual AACI strategic planning facilitated by

Leanna Lewis. In FY 19-20 community members participated in and/or hosted the following AACI events:

- Black History Month Celebration
- Black Pride SOGI Workshop
- Intergeneration Dinner: Black Queer Pride (collaboration with Pride Center)
- Hosted Multigenerational Trauma
- Participated in Drumming & Spirituality for Healing
- Tabling Opportunities

CHINESE HEALTH INITIATIVE (CHI)

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

Mission, Vision, and Objectives

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

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

- Referring behavioral services to unique 60 Chinese speakers in 2019
- Piloting a youth empowerment program by the end of FY 19-20
- Recruiting 5 new community members to volunteer/attend at CHI events/meetings

Highlights & Accomplishments

During FY 19-20 Chinese Health Initiative (CHI) created public spaces where members of the community, BHRS staff and other residents could feel comfortable openly talking about issues they would normally prefer to talk about in a private setting, namely immigration and suicide. With the opportunity to elevate these voices, community members feel more confident and less anxious about these issues. CHI hosted a 6-series Coping with Xenophobia webinars that had over 100 people sign up. The social media campaign on xenophobia reached over 13, 000 people on Facebook. CHI also, proud of created a PSA Video sharing the importance of talking about mental health in the AANHPI community.

CHI collaborated more with various presenters from different organizations (Office of Consumer Affairs – Census 2020 team, Census; Texas; Mind & Body Psychology; Office of Sustainability). Additionally, CHI improved partnership with NCOC via ODE’s support, especially with our CHI member and NCOC-linked Chinese Outreach contactor, Peter, at Chinese Hospital. CHI also built a stronger support network to increase efforts to promote the Census, Hep B Awareness, and Mental Health in the Chinese Community.

Members aimed to jumpstart the Family Support Group in Jan, with 1st group session in Feb 2020, but due to COVID in March 2020, it didn’t get to expand attendance; hopefully that’ll change once we transition over to Zoom trainings.

In FY 19-20 CHI members completed the following activities:

- Mental Health Awareness Video - approximately 19 attendees
- Coping with Xenophobia Webinars - approximately 70 attendees
- Xenophobia Social Media - approximately 13,000 views

FILIPINO MENTAL HEALTH INITIATIVE (FMHI)

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

Mission, Vision, & Objectives

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

Highlights & Accomplishments

In FY 19-20 the FMHI was able to engage the community with a focus on the culturally-responsive approaches to stresses tied to collectivist values. As a result, growth was experienced in membership and a positive response to the work from community partners. To give concrete examples, in January, FMHI collaborated with Westmoor High School to put together a culturally-responsive parent education night geared towards Filipinx families. At the “How to Succeed in High School and Beyond” event, the FMHI received a positive response from parents, students and our co-organizers, the Westmoor Counseling Department; this came in the form of verbal comments made during the event and in the evaluation forms. The Westmoor staff asked that FMHI make this an annual workshop.

In addition, FHMI experienced an increase engagement through conducting focus groups, which followed the needs assessment completed the previous fiscal year (18-19). FHMI held five focus groups (2 adults, 1 senior and 1 youth group). Collectively, this allowed FMHI to determine the needs and preferences of community members in the plan to create a Filipinx Cultural Arts & Wellness Center/Social Enterprise (with potential funding from the MHSA Innovations fund). Because of these activities, 3 new members committed to being a part of our Tribe Advisory, which is tasked with planning and co-creating programs for the center/social enterprise. In Due to the COVID-19 pandemic, FHMI quickly put together a needs assessment, an online resource page, community calendar and a bi-weekly support group (Kapwa Soul Sessions). These efforts aimed to address community needs brought on by the pandemic, but also focused on pointing them to the resources and support in the community. Another part of our COVID response included banding together with Filipinx organizations to create spaces for community, in the form of an open mic, to address both the pandemic and racial injustices that erupted after the death of George Floyd.

These activities underscore the shift in FMHI's approach, which is to create activities that engage community members in a culturally-responsive manner with the goal of building a consistent network of members, partners and collaborators -- especially partnering with those who have been working on the ground with deep ties to the community. Lastly, FHMI is grateful to be connected to Filipinx organizations that have been successfully engaging community, this has allowed FMHI to work collaboratively with these orgs and to further inform their networks about the work done, while promoting mental health awareness and resources. More importantly, this brings FMHI closer to the community and embodies the values inherent to our culture, including kapwa (togetherness).

In FY19-20, FMHI participated and/or hosted the following events and activities:

- Interfaith Day of Prayer Tabling – 10 attendees
- Serramonte Health Fair Tabling- 15 attendees
- 2nd Parol Lantern Workshop- 40 attendees
- Kusina Talks – 28 attendees
- District 5 Fair- 10 attendees
- Kapwa Soul Sessions between March 2020 to June 2020- 10-12 attendees per session
- Daly City Bayanihan Showcase: Open Mic for Black Lives- 24 attendees
- 4 Focus groups for various ages- 44 attendees
- Digital Storytelling Workshop- 4 attendees
- How to Succeed in High School and Beyond- 21 attendees
- Kalusugan: A Webinar on Mental Health & the Filipino Diaspora- 100 attendees

LATINO COLLABORATIVE

While the Latino Collaborative (LC) efforts began in 2008, its founding members have been committed to giving voice to the Latino community since the late 1980s. During these initial meetings, a small group of Latino providers met informally to address issues pertaining to health disparities and access within the Latino community and mental health services. These

meetings continued and in 2004, a core group of Latino providers requested a Latino-specific training for providers. At the time the County did not have the funds to provide the requested training. As a result, Latino providers organized regular meetings for San Mateo BHRS providers to come together to discuss client cases and strategies for serving the Latino population.

Mission, Vision, & Objectives

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

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

Highlights & Accomplishments

In FY 19-20 the Latino Collaborative welcomed several presenters sharing local resources into its meetings. Because the majority of members have direct contact with the community via direct services or outreach and prevention, these informational presentations can impact services. Presentations included:

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

In response to the high stress level being experienced by Latinx communities during this health crisis, the Latino Collaborative provided a 1-hour presentation on what is mental health. During an extended meeting time on May 26th, LC facilitated a discussion on what are common signs and symptoms of mental health conditions, how to support ourselves, families/community members that may be experiencing these symptoms and BHRS resources/services. The presentation was provided in Spanish (with interpretation in English).

This event was provided in collaboration and alignment with the Health Ambassador Program's presentation in May 2020, to create a week long focus the experience of Latinx communities in San Mateo County. The goal was to promote both events together to encourage participation and create equal spaces for information and community input.

In addition to resource sharing and promotion, LC members participated in the MHS Community Program Planning Process. During the input session members provided specific suggestions (prevention, direct services, workforce education and training) to support complex cases in San Mateo County. The feedback and input collected was presented and considered for the MHS budget. The LC was able to switch all interactions, activities, and documents to a virtual platform, in response to the shelter in place mandate due to the COVID-

19 pandemic. As a result the LC began working directly with Health Administration to support outreach/response to rise in Latinx cases of COVID-19.

In FY 19-20, the LC participated and/or hosted the following events and activities:

- Salud Mental y COVID-19 – 18 attendees
- AOD Presentation to collaborative
- MHSA input session for collaborative

NATIVE AND INDIGENOUS INITIATIVE (NIPI)

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

Mission, Vision, & Objective

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

The NIPI has further developed and articulated the following objectives:

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

Highlights & Accomplishments

The NIPI has not only provided mental health resources to San Mateo County residents but has also contributed to the professional development of San Mateo BHRS providers through trainings and workshops Initiative members have organized. In the 19-20 FY, NIPI successfully transitioned to virtual meetings, and participated in virtual events.

In collaboration with the Spirituality Initiative, NIPI hosted a Drumming Circle training facilitated by Dr. Nunez, a leading proponent of using drumming to help those with behavioral health issues. Many different segments of the community participated in this event. Several participants said that it had a “calming” effect upon them and that they had not realized how

drumming speaks to all human beings. Again, it is a tool for recovery and was a portent for trying different ways of treating those with mental illness. It was also a way that two of the HEIs collaborated to bring a significant event to San Mateo County and to BHRS.

In FY19-20, NIPI participated and/or hosted the following events and activities:

- Provider training - Native American Mental Health: Historical trauma and healing practices
- Provider training - Overcoming Trauma Through Digital Story
- Annual Indigenous Peoples Day in East Palo Alto
- HOSTED Virtual Drumming and Spirituality as a Method of Healing and Recovery (collaboration with Spirituality)
- Collaborated with community to get the Phoenix Garden up and running
- Participated in Virtual PRIDE Week

PACIFIC ISLANDER INITIATIVE (PII)

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

Mission, Vision, & Objectives

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

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

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

Highlights & Accomplishments

PII was successful in transitioning all work virtual upon the commencement of the community shut down due to COVID-19. Fresh and staid partners alike gathered to discuss their hopes and goals for the Pacific Islander Initiative. Several partners who had purposefully disengaged from the group after losing trust in its leadership were able to return, speak about their experiences, and commit to re-engaging. With this tone shift, PII embarked on the second year of long-term planning, building a comprehensive five-year plan that includes a youth leadership and mental health career pipeline program (PIONEER). PII also changed its meeting time from 6pm to 11am and began using a rotational schedule that brings the meeting to each region with many PIs

(North, Central, and EPA) once per quarter. Each regional meeting is hosted by one of the three large organizations serving Pacific Islanders in that area (Asian American Recovery Services, Peninsula Conflict Resolution Center, and One East Palo Alto). The group gained 10 new members. Trust, engagement, and collaboration has greatly increased.

PII engaged with community members directly through events and community trainings throughout the year. PII tabled at events, and hosted Heal & Paint sessions in collaboration with community organizations. PII has continued to focus on reducing stigma and increasing awareness about suicide in Pacific Islander communities. As follow-up actions to the event, the Initiative created a suicide prevention communication campaign specific to Pacific Islanders. In FY 19-20 PII participated and/or hosted the following activities and events:

- Hosted Series of Heal and Paint- Journey to Empowerment
- Leadership Workshop
- Created Photo Series: Suicide Prevention Cards
- National Day of Prayer
- Provided COVID-19 support for PII community

PRIDE INITIATIVE

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

Mission, Vision, & Objectives

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

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

Highlights & Accomplishments

FY 19-20 the LGBTQ of San Mateo County has been deeply impacted by COVID19 and the resulting Shelter in place that has limited service availability and increased disparities in a community that already faced isolation. Because of the Global Pandemic the PRIDE Initiative felt it was particularly important due to the impacts of COVID19 pandemic to creating a virtual PRIDE virtual event. With the assistance of the Pride Initiative members, all of the LGBTQ+ community partners, the initiative was able to shift the event from an in-person to a virtual one. 14 workshops and one Grand Finale were created, including 4 events from a Queer Authors series; a Census Outreach event; an event on health LGBTQ relationships; two Drag

Show one for Adults one for youth; a Health Equity Initiatives Outreach Event, a Virtual Dance Party and Zumba. PRIDE hosted a screening of a documentary called Me and My Boi's focused on Masculine and Masculine Centered LGBTQ People of color. As the Grand Finale a fun event was hosted by DJ King Kream which featured a diverse line up of entertainment. Overall, PRIDE week had 9,500 views on our PRIDE Initiative the week of the Virtual PRIDE Celebration. The day of the Grand Finale we had 6,115 views on Facebook. As well as 244 people attend our workshops during the week on Zoom.

During this difficult time the unwavering determination of the PRIDE initiative members, the community partners enabled them to reach our second strategic goal, "Create, support, partner on LGBTQ events, with the PRIDE Center, LGBTQ Commission, and ODE HEI's that builds community infuses cultural humility and addresses intersectionality." In the wake of a Global Pandemic it became possible to put together and host a Health Equity Initiative Outreach and Educational Event during the PRIDE celebration. During this difficult time of deep racial injustice and Global Pandemic PRIDE Initiative Co-Chairs have been more committed than ever to partnering with the other HEI's, increasing outreach and increased recruitment to LGBTQ+ from Communities of Color, working on intersectional issues around Social and Racial injustice, homophobia, transphobia, systemic racism and police brutality against People of color.

In FY19-20, PRIDE participated and/or hosted the following events and activities:

- SMC Virtual PRIDE Week - 9,944 attendees
- Census 2020 Training
- Office of Diversity & Equity MHSa training

SPIRITUALITY INITIATIVE (SI)

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

Mission, Vision, & Objectives

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

- Hope. The Spirituality Initiative recognizes that hope is the simplest yet most powerful tool in fostering healing.
- Inclusiveness. The Spirituality Initiative acknowledges that spirituality is a personal journey and that individuals should not be excluded from services based on their spiritual beliefs and practices.
- Cultural humility. The Spirituality Initiative encourages an attitude of respect and openness in order to create a welcoming and inclusive space for everyone.

Highlights & Accomplishments

In FY 19-20 the Spirituality initiative began developing a partnership with Mission Hospice and Home Care. They also continued to participate in two state wide phone-ins that occur monthly. The annual National Day of Prayer event gathers people of all faiths, religions, and understandings to celebrate the presence of all segments of the community and call their attention to those with behavioral health issues. The event increases awareness about mental health issues in faith communities and establishes the Spirituality Initiative as a willing collaborator and ready resource. It allows various faiths to express openly their particular faith in a focused manner on behalf of our clients. Mental Health and AOD issues cross over all faiths and religions and have a unifying effect.

SI adapted well to the Covid – 19 crisis which eliminated in person meetings and trainings. This allowed the initiative to continue their work by learning how to use the technology of zoom, helping to keep members focused and to stay in touch with our members. As a result SI experienced its attendance to increase by approximately 10 participants since using zoom for meetings. Follow up phone calls were conducted to members who were identified/thought to have needed special attention. This kept the caring aspect of the initiative intact. But despite the pandemic, a virtual Drumming Event in collaboration with NIPI was hosted in May. Out of the chaos of the pandemic the SI members kept their focus and continued to work with other HEI's. Finally, because of the racism towards the Chinese community a collaborative with CHI was created to present a virtual training on what they are facing as a community. The Initiative's monthly meetings have become a hub for faith leaders, community advocates, and BHRS staff interested in spirituality and mental health.

Presentations included:

- Assisted Out Patient Treatment (AOT) presentation by Nicholas Zwerdling and Sahara Lirene
- Senior Peer Counseling and Spiritual Care for our most vulnerable older adults:
Presented by Michelle Epstein and Angela Hay
- Mental Health Awareness week is Oct 4th through Oct 10th, sponsored by NAMI.
- Lived experiences presented by SI members
- Covid and Suicide Prevention" by Sylvia Tang, Co-Chair Suicide Prevention Committee, Office of Diversity and Equity.

HEALTH AMBASSADOR PROGRAM - ADULT

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

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

offered: The Parent Project, Mental Health First Aid (MHFA) and/or Youth Mental Health First Aid (YMHFA), Wellness Recovery Action Plan (WRAP), NAMI Family to Family, NAMI Basics, Applied Suicide Intervention Skills Training (ASIST), Photovoice Project, Digital Storytelling, Stigma Free San Mateo, and the Lived Experience Academy.

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

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

PROGRAM IMPACT & SUCCESSES

The BHRS Health Ambassador Program (HAP) advances the MHSA outcomes of reducing the duration of untreated mental illness, preventing mental illness from becoming severe and disabling and reducing school failure, suicide, prolonged suffering, removal of children from their homes, police involvement and supports mental wellness by introducing community members and families to information and research in the field of mental health.

This fiscal year, 24 new community members graduated from the Health Ambassador Program.

Courses Provided During FY 19-20 and Total Participants

- NAMI Basics July-August 2019: 19 participants
- Parent Project: 121 participants, 100 graduates.
- MHFA Adults: 129 participants
- ASIST August 2019: 9 participants
- Stigma-Free August 2019: 25 participants
- Lived Experience Academy May 11-June 22, 2020: 15 participants

NAMI Basics: 19 participants

This course was held from July 16 - August 20, 2019, at the Central County Clinic

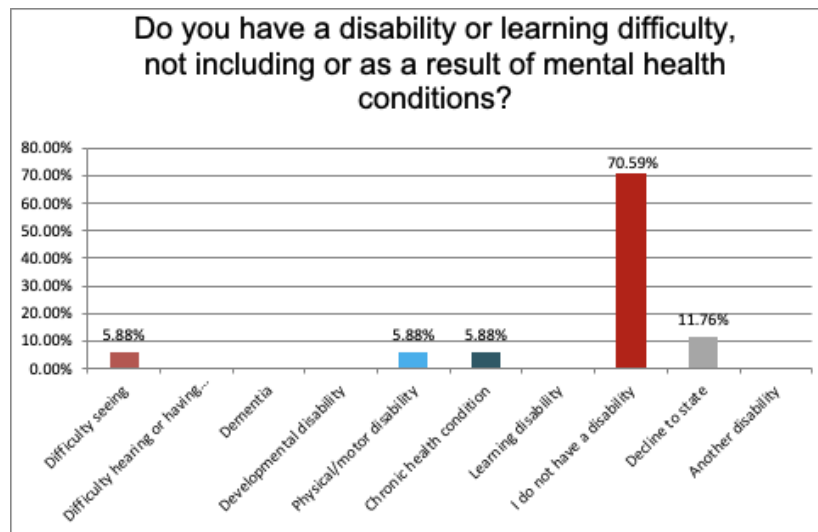
The goal of this course is to teach parents and caregivers of children struggling with mental health symptoms and how to address those symptoms. Participants are also educated on the mental health care system and how to navigate it if more help is needed. The course also teaches how participants can advocate for their child's rights and needs, and how to prepare for mental health-related crisis situations. However, the class also stresses the importance of practicing self-care while caring for a child with mental health conditions. This particular NAMI Basics class session was one of the largest that the county experienced and the demand was

higher than our capacity. We were intentional in bringing couples and families together to experience this training so that they can be united in their purpose of understanding and advocating for their children’s needs. There were four males who came with their partners and their children, as well, which was not seen before.

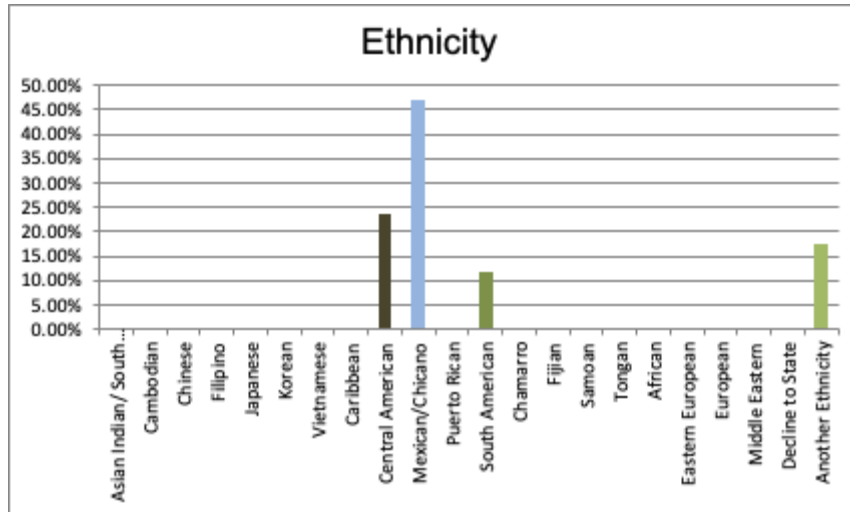
What city do you live in, work or represent in San Mateo County?

- East Palo Alto: 6.25%, Redwood City: 6.25%, San Carlos: 6.25%, San Mateo: 75%, South San Francisco: 6.25%

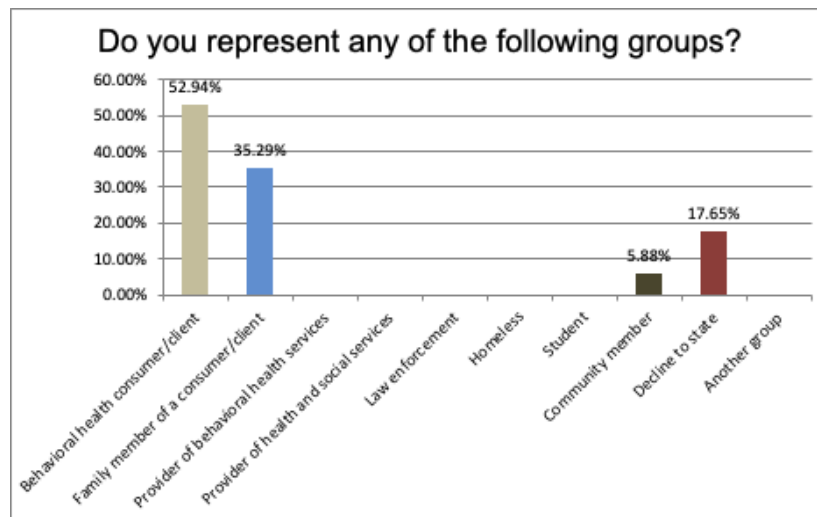
These results show the spread of residents in the county that are interested in related courses. Community members show resilience and eagerness by traveling from all around the county so that they can access these resources. Not only do they travel distances, but since the classes take place in the evenings, participants are likely to encounter the heavy traffic during commute hours and some participants expressed that they had to negotiate time off with their employer(s) so that they could make it to the class.



It should be noted that some participants also struggle with their own challenges, separate from their children, which only adds to the difficulty in raising, caring for, and being able to advocate for their children’s rights and needs. It could also be said that due to the participants’ own difficulties with mental health and physical challenges, the reasons for why they are taking this course could vary from person to person; It could be to learn how to better care for their children or to learn self-help skills in addressing their own mental health or any other reason and this possibility should not be ignored.



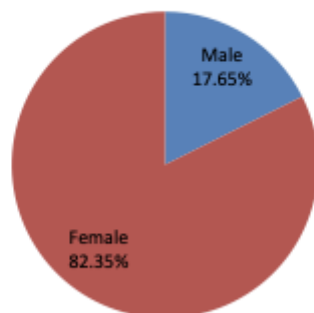
Central American: 23.53%, Mexican/Chicano: 47.06%, South American: 11.76%, Another Ethnicity: 17.65%. According to San Mateo County penetration rates, the Spanish-speaking community is the largest population of non-English speakers in the county, so offering this course in Spanish opens the county's reach to those many ethnicities and their communities. Although Mexican community members are the majority of Spanish-speakers, we acknowledge the Central and South American populations who attend our classes, as well, because of our inclusion values and goals.



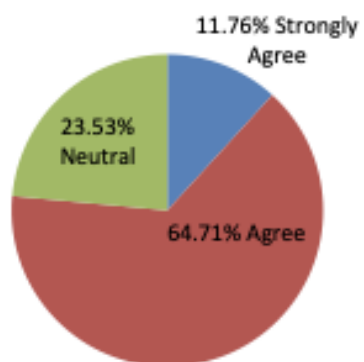
Most participants of this class were shown to already hold client status in San Mateo county, possibly due to their children's mental health conditions, while others are family members of mental health consumers or are community members.

The range of affected community members is vast and these groups should have access to proper resources. Although most participants are behavioral health clients, some may not be aware of all the services that are available. So, with taking NAMI Basics, they are educated on the different services that are available to them, learn to better advocate for their own or their child's needs, and evaluate the services that they are receiving.

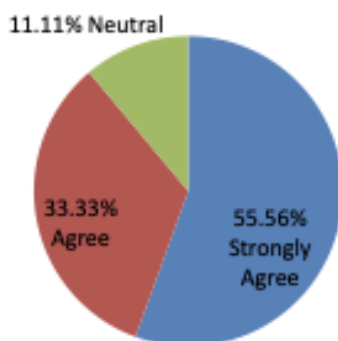
Sex assigned at birth



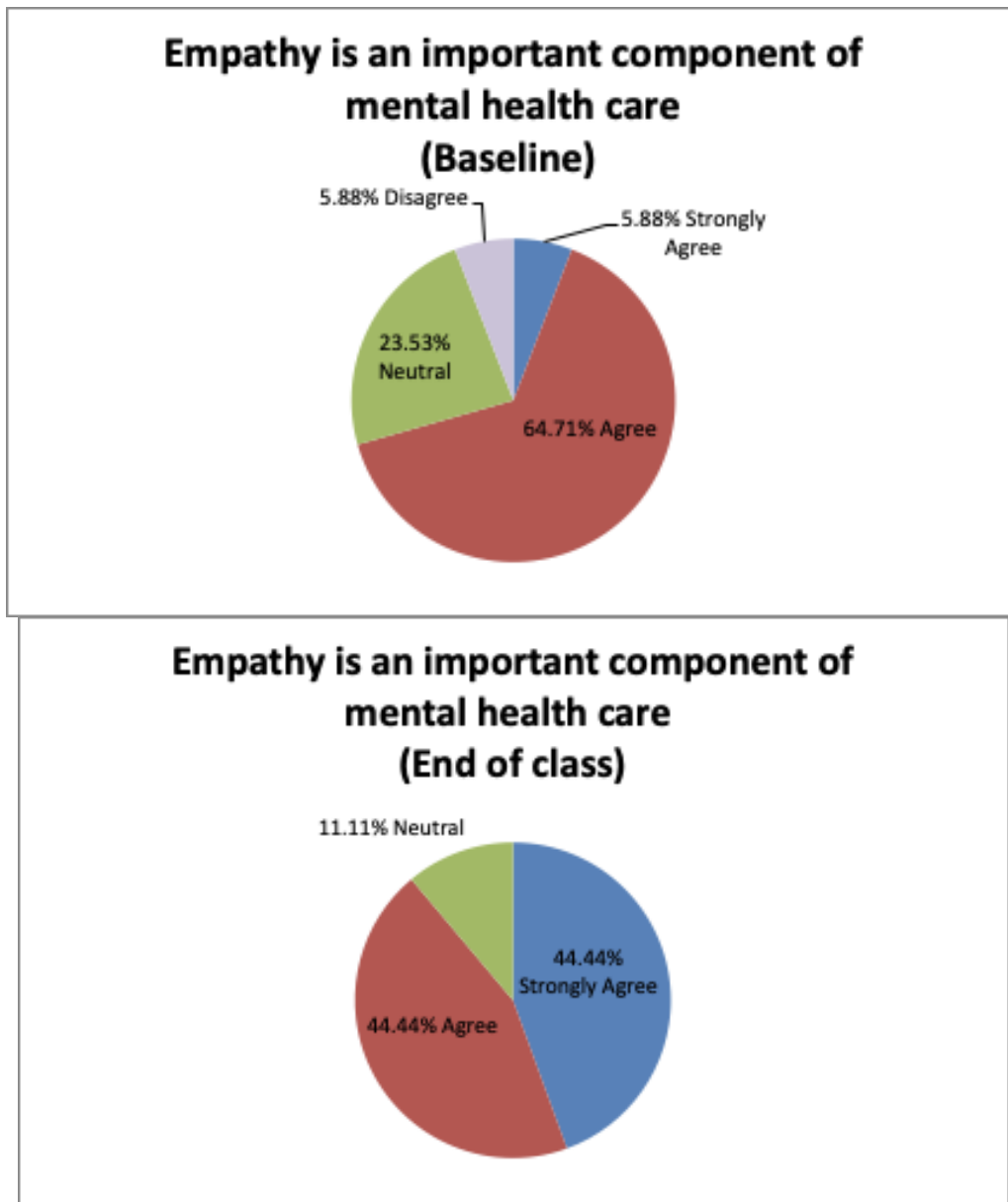
Stigma is a large barrier in mental health care (Baseline)



Stigma is a large barrier in mental health care (End of class)



This shows the necessary advancements made in stigma reduction among communities through the completion of this course. The attendees' acknowledgment and understanding of stigma, in all forms, being a large barrier is vital in advancing ODE's community empowerment goals and gives community members the willingness to access treatment. Stigma awareness reduces discrimination and increases empathy in communities when dealing with mental health conditions and substance use.



The increased understanding of the importance of empathy in mental health care contributes to the achievement of ODE's equity goals through tackling relevant cultural/social determinants and shows the effectiveness in offering this course and other related courses to underserved communities. Given the importance of families and their role(s) in treatment of

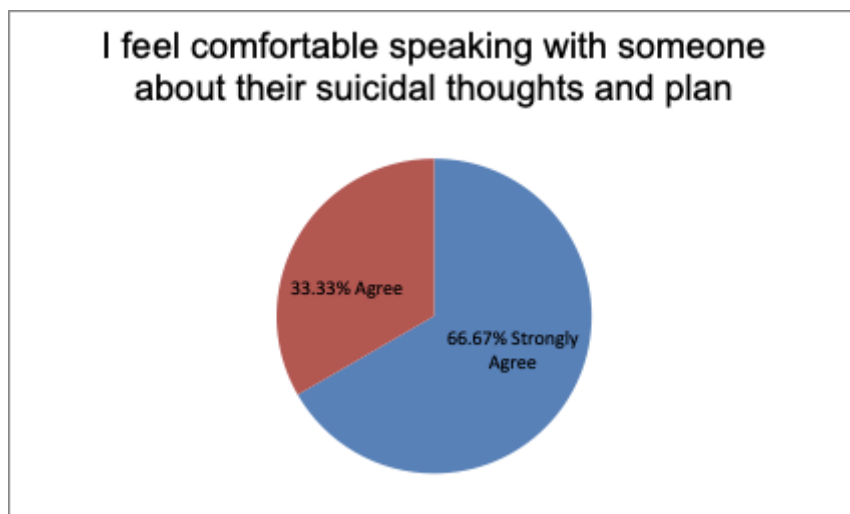
behavioral/mental health conditions/substance use, empathy is a necessary component in improving the family/household dynamics, relationships among community members and capability to advocate for the certain needs of those with mental health and substance use struggles.

ASIST (Applied Suicide Intervention Skills Training): 9 Participants

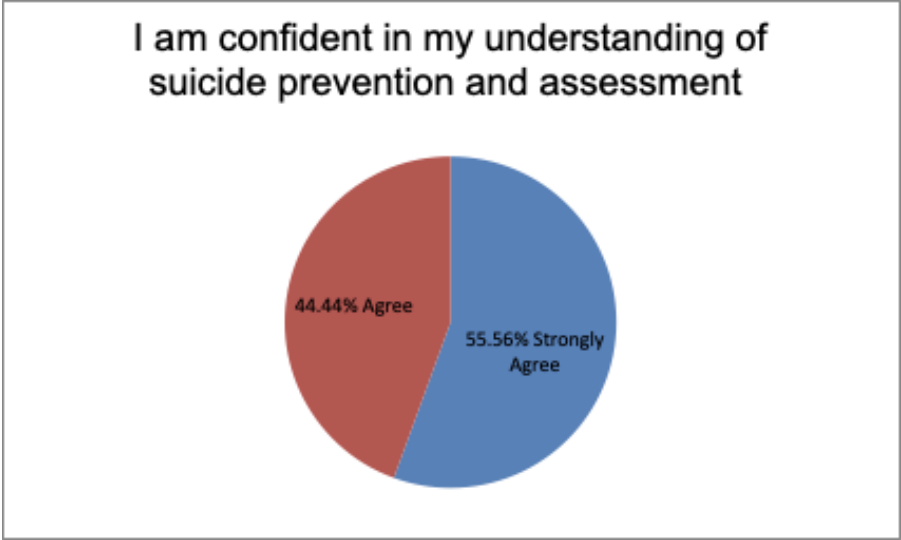
This course was offered, for the first time, with Spanish simultaneous interpretation because of the great need that was expressed by the community, for suicide awareness courses in the Spanish-speaking language. This training was held from August 15-16, 2019

This course is one that educates participants about suicide and how to recognize suicidal signs in self or others, as well as procedures in preventing immediate risks of suicide. The process of this course is to understand and recognize warning signs, properly intervening before an attempt, and to develop a safety plan to prevent future attempts.

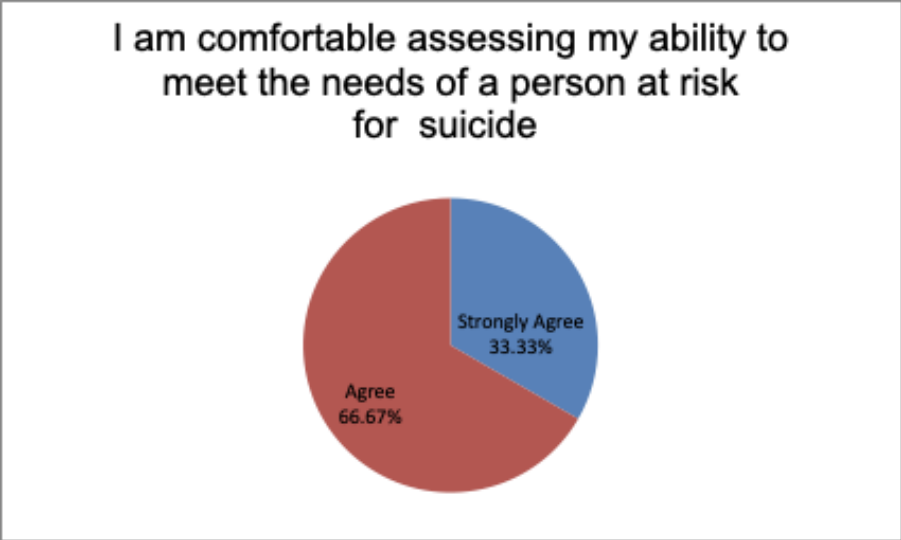
- Females: 8, Males: 1
- Ethnicity: Latino/Latina: 8, while the rest declined to state.
- Were you born in the United States? 6 responded, “No”, while the rest declined to state.



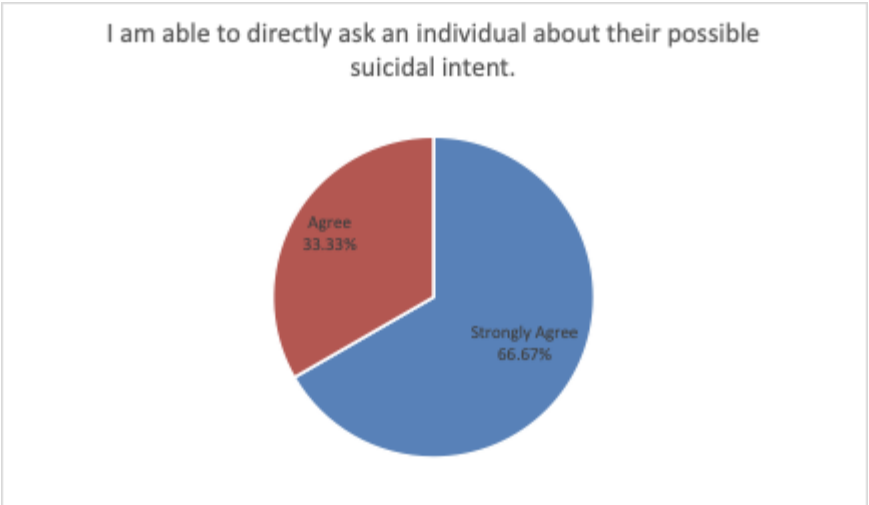
ASIST teaches cultural humility and helps to reduce stigma among community members and these results indicate that the course has taught the attendees how to conduct themselves around people who are having suicidal thoughts and to feel comfortable while speaking about the subject.



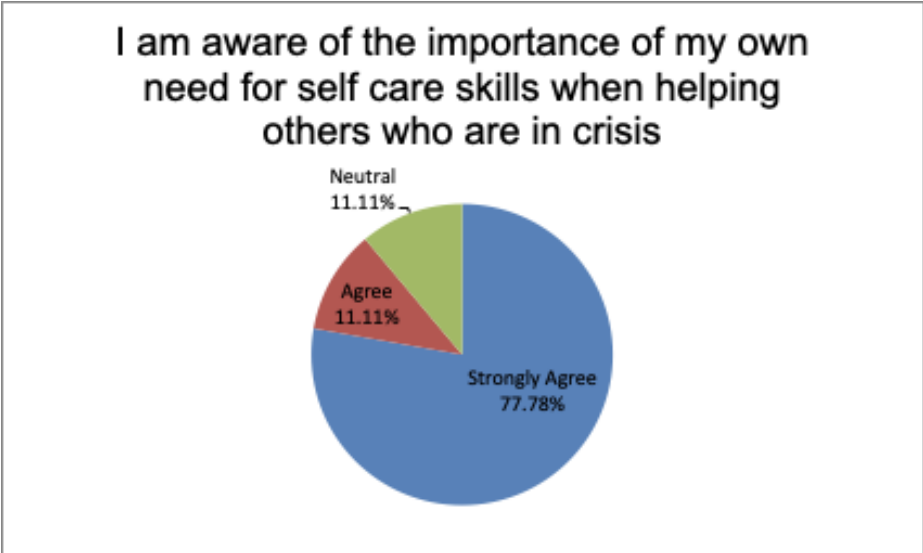
Increased knowledge of suicide and suicide prevention was achieved through ASIST which will help in working to reduce stigma and other barriers, as well as advancing ODE’s community empowerment goals.



The increased knowledge and ability to assist a person who is at risk for suicide is a very important skill for underserved community members to have because it helps reduce stigma and barriers, as well as allows community members to advocate for themselves and saves lives. This is also critical in our community knowing and understanding the resources that are in our county to support those who are in crisis.



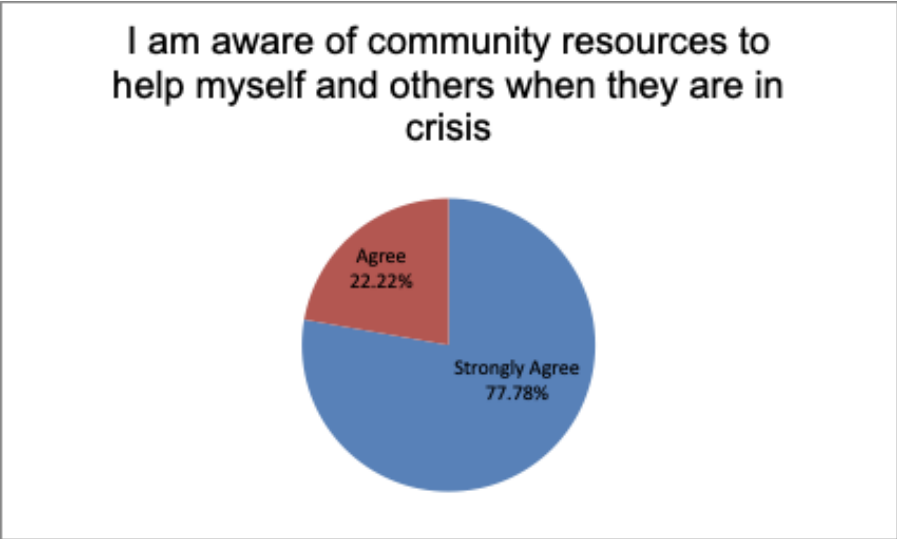
Through the ASIST training, participants not only began to feel comfortable saying the word, “suicide”, but also asking others about their suicidal intent through the roleplay exercises. Immense progress was shown by the participants in that regard, as it can be seen in the graph.



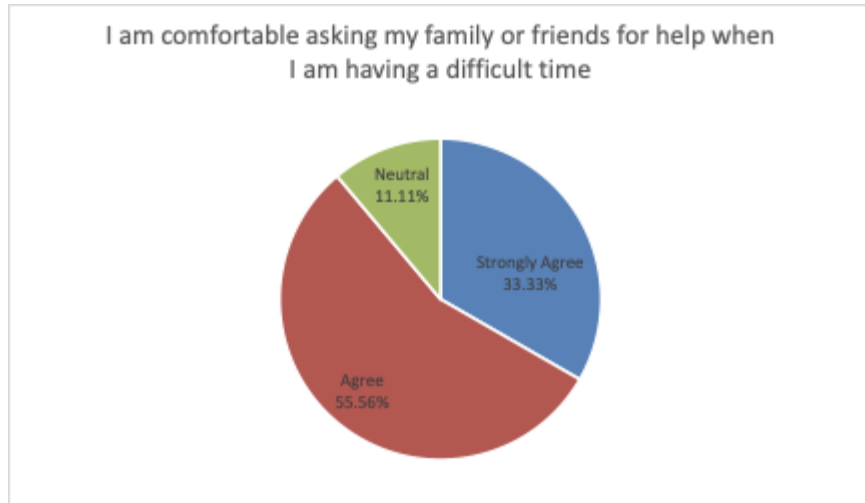
It came up during the discussion that parents or caregivers often put their own wellbeing to the side when dealing with their children and their mental health conditions and especially when their child is at risk for suicide; it is easy for them to put their own emotions and health on hold and focus on their children. So, it is important that they have learned the value of their own wellbeing and also learned to implement self-care routines to preserve their own mental and physical health.



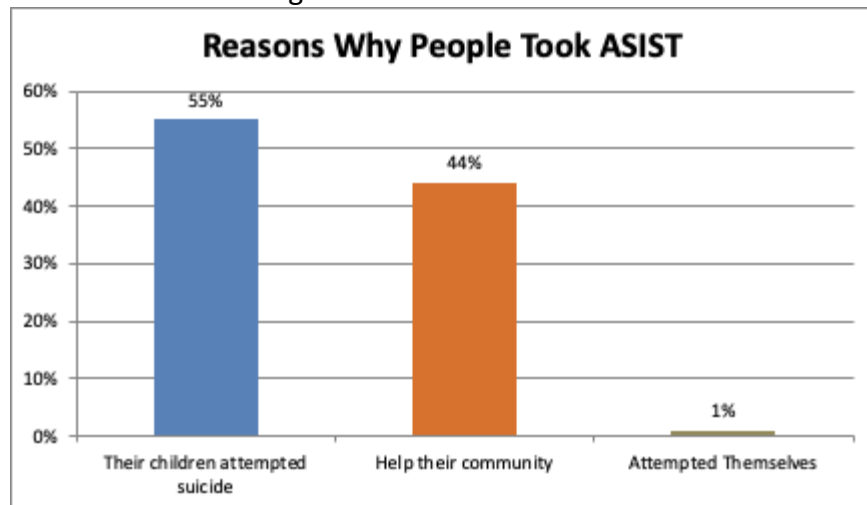
ASIST met its goal of promoting the understanding the ways that personal and societal attitudes affect views on suicide and interventions. Some people might be hesitant to get involved with someone’s suicide attempt or suicidal ideation, for whatever reason, but during this training, participants learned to interject to save lives. Participants were encouraged to reflect on their own attitudes and beliefs on suicide and suicide intervention in order to achieve personal development.



Increased awareness of the resources that are available to community members helps to reduce the barriers between treatment/prevention programs and affected community members.



It is important for people to feel comfortable in reaching out to those who are closest to them during times of crisis and ASIST emphasized that strategy. However, with the 11% still in the neutral response, it shows that more work needs to be done in promoting the ability of asking for support from others when feeling vulnerable.



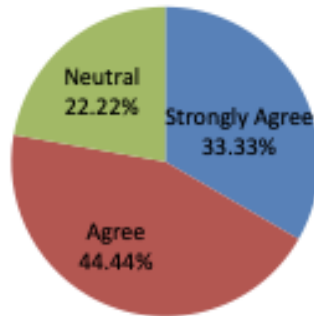
Stigma-Free/San Mateo Libre de Estigma: 25 Participants

This course was held in Spanish on August 27, 2019, at the Central County Clinic.

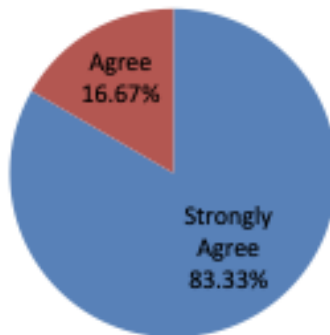
Stigma is a prominent issue and large barrier to mental health care and recovery, so this course works to tackle stigma head-on so that participants can learn to be free of stigma when they are facing mental health situations, either for themselves or for anyone else. Not only does this class tackle stigma, but it also promotes advocacy and inclusion for all, so that the wellness and health of fellow community members can also be recognized.

- Females: 17, Males: 5, while the rest declined to state.
- Ethnicity: Latino/Latina: 23, while the rest declined to state.
- Were you born in the United States? 22 answered, “No”, while the rest declined to state.

I am confident in my understanding of the impact of stigma in people living with mental health problems and/or substance abuse (Baseline)

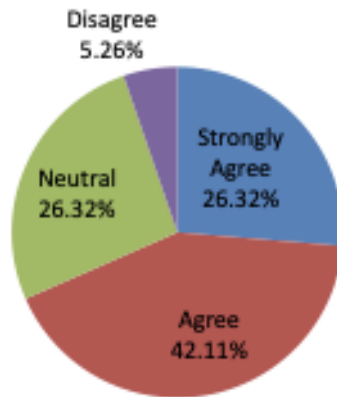


I am confident in my understanding of the impact of stigma of people living with mental health problems and/or substance abuse (End of class)

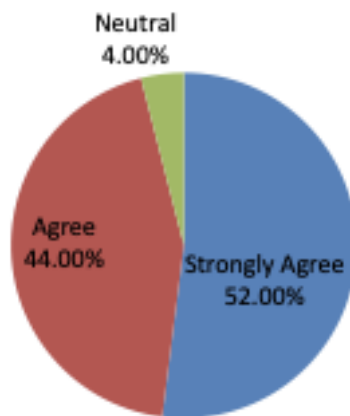


The understanding of the role that stigma plays in addressing mental health issues is important in the progressing of the county's equity goals and further assists in working towards identifying best practices for potential community shared decision making. These results also show that Stigma-Free is accomplishing its goal of stigma awareness and reduction among community members.

I am confident in my understanding of how to help people with mental health problems and/or substance abuse (Baseline)

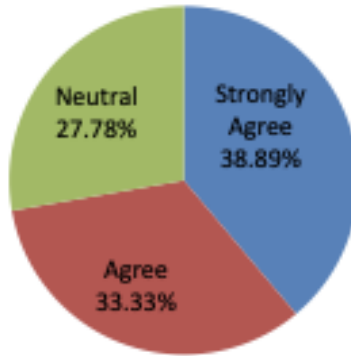


I am confident in my understanding of how to help people with mental health problems and/or substance abuse (End of class)

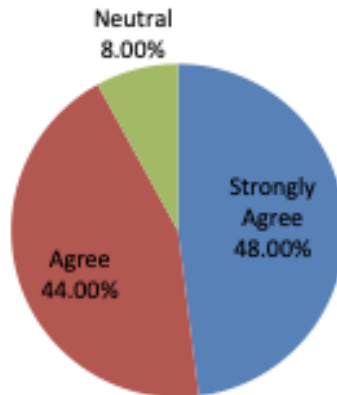


These results show that Stigma-Free was successful in teaching ways to help people with mental health and/or substance abuse challenges and further reducing the barriers between community members and their access to treatment and prevention programs that are offered by the county.

**I am confident in my ability to be inclusive
of people with mental health problems
and/or substance abuse
(Baseline)**



**I am confident in my ability to be inclusive
of people with mental health problems
and/or substance abuse
(End of class)**



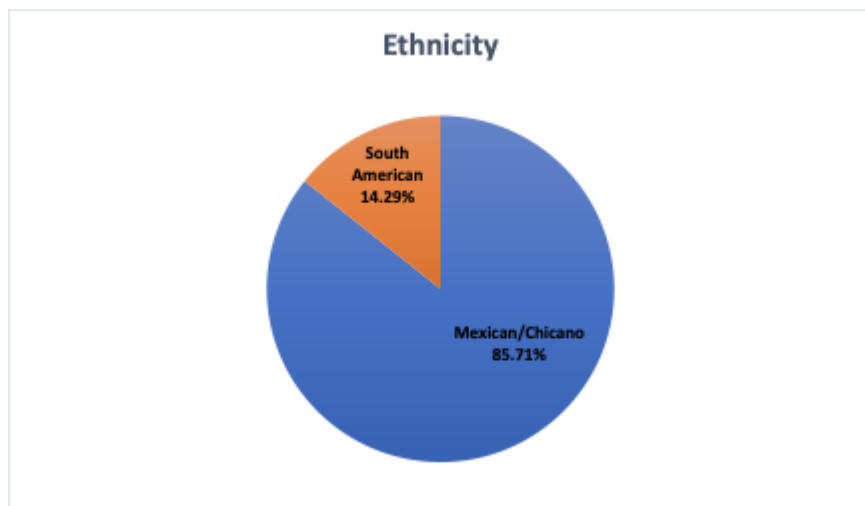
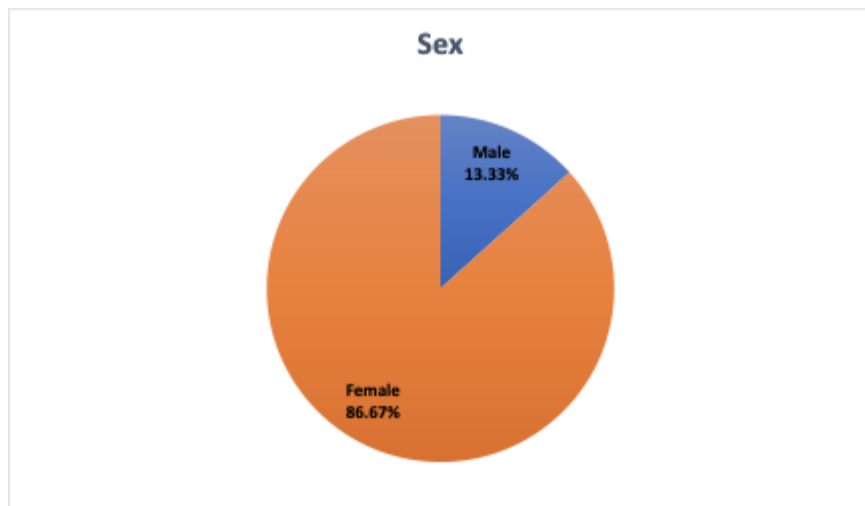
The increased ability of inclusiveness aligns with the county's community empowerment goals, as well as helps community members in achieving cultural humility and works towards the reduction of stigma within communities. In a paraphrased quote from a participant, he openly expressed to the whole Stigma-Free class that he was previously unable to accept that his child has mental health challenges but after attending various Health Ambassador Program trainings, he began to accept his family's circumstances and participate in actively seeking out effective treatment and services for his child.

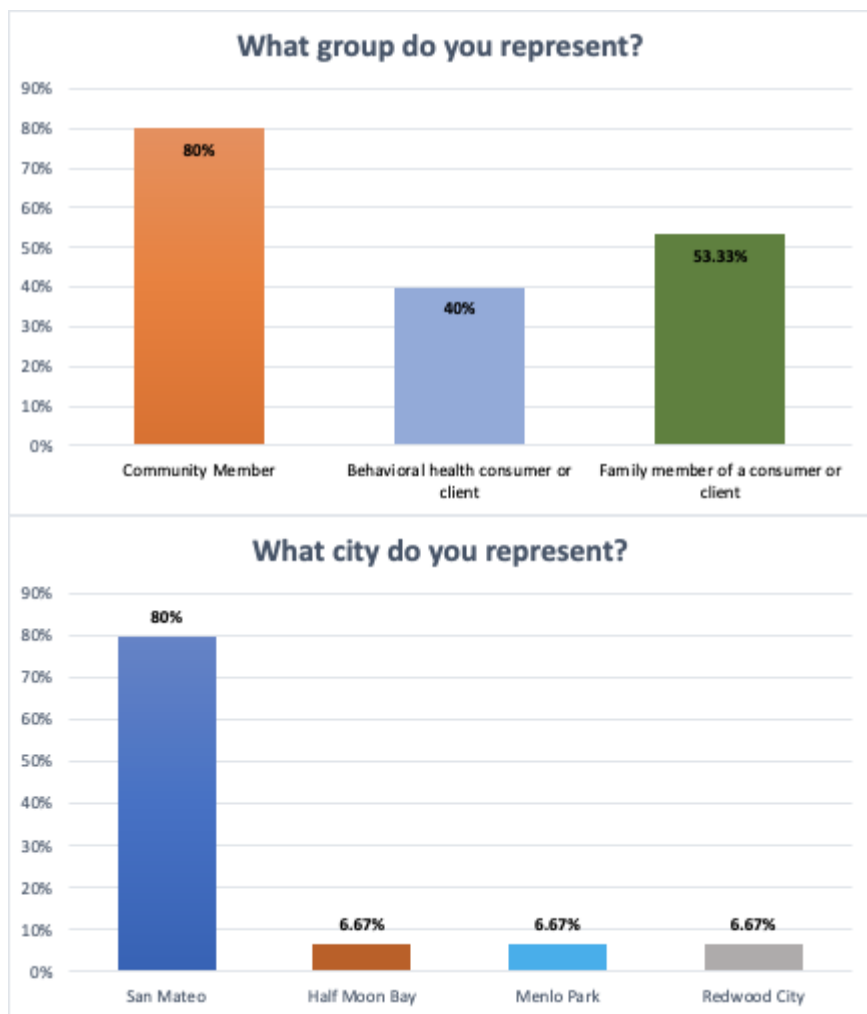
Lived Experience Academy (LEA): 15 Participants

This training was held in Spanish via Zoom meetings from May 15th to June 22, 2020.

The Lived Experience Academy is a series of six safe, supportive, weekly classes in which participants reflect on their lived experiences as consumers of mental health and/or substance use services, or as family members of consumers. Through this exploration, participants redefine their experiences living with a behavioral health condition, take control of the narrative of their lives, and learn to share with others their stories of hope, resiliency and recovery.

Participants learn about selecting stories to share, organizing the parts of a story, time management and public speaking skills. They also learned about the Recovery Model, the Consumer Movement, the BHRS system, and the opportunities BHRS offers them to share their stories and give their opinions about BHRS services. Very importantly, participants gain a renewed sense of who they are and of how the valuable lessons their recovery has taught them can be used to transform and improve the BHRS system.

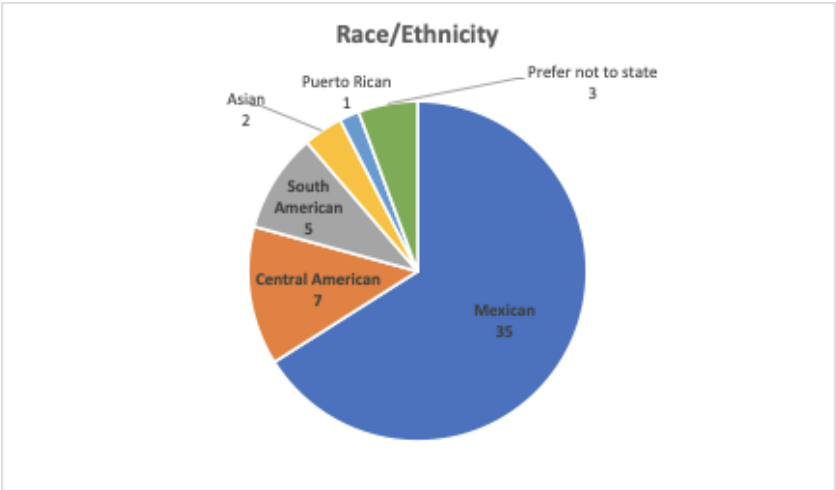




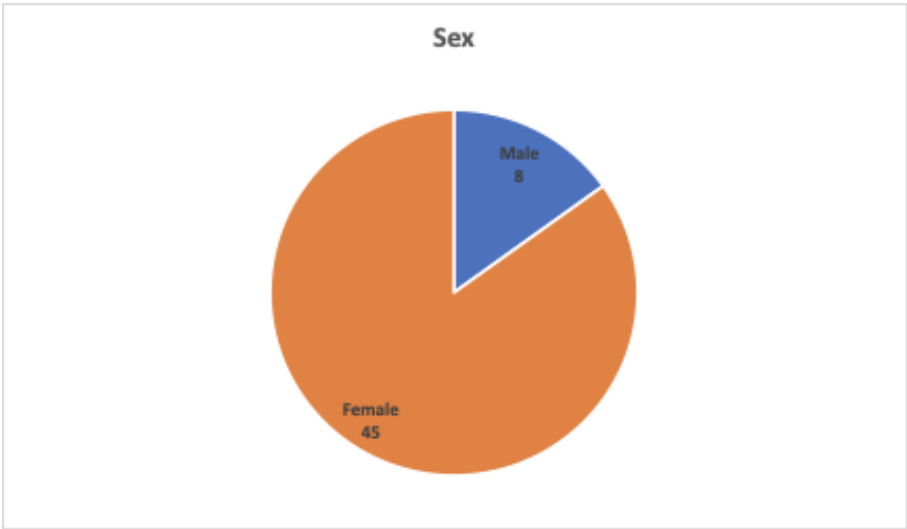
HAP Zoom Webinar 2020 “Familia y Bienestar Durante COVID-19” (Family & Wellness during COVID-19): 53 Participants

Health Ambassador Program community conversation about family and wellness during COVID-19 in celebration of Mental Health Awareness Month where BHRS panelists and Health Ambassadors shared information, experience, and tools to Spanish-speaking community members.

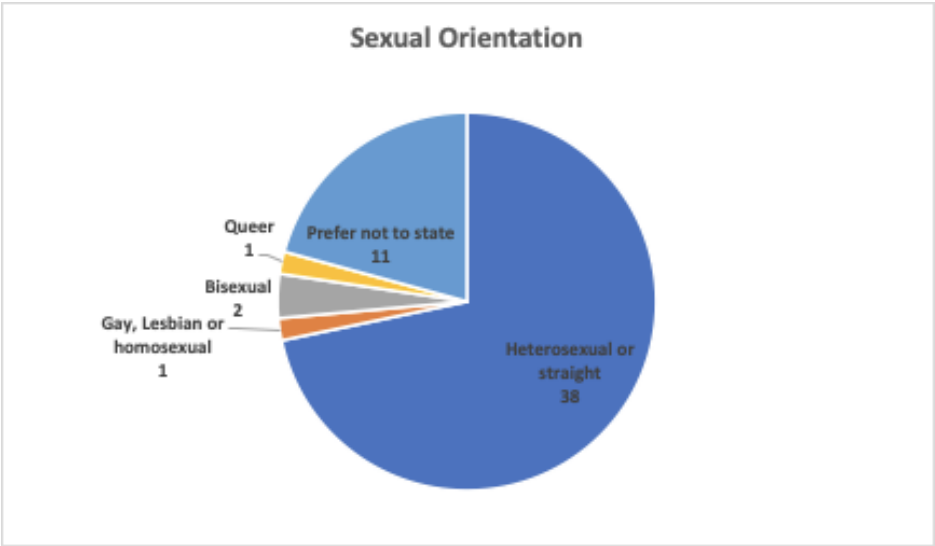
Due to the global pandemic that COVID-19 has left in its wake, we decided that it would be a perfect time for us to engage our Health Ambassadors and community members through a Zoom Webinar where topics like family, wellness, and behavioral health would be discussed. These discussions were led by panelists from BHRS as well as Health Ambassadors who shared their lived experience publicly with community members. This webinar was a huge success because we were able to reach over 2,000 people due to the fact that we also live-streamed the webinar on FaceBook Live, along with near 60 participants who attended through the Zoom webinar. This was also an event where we could promote the Health Ambassador Program and potentially gain new Ambassadors.



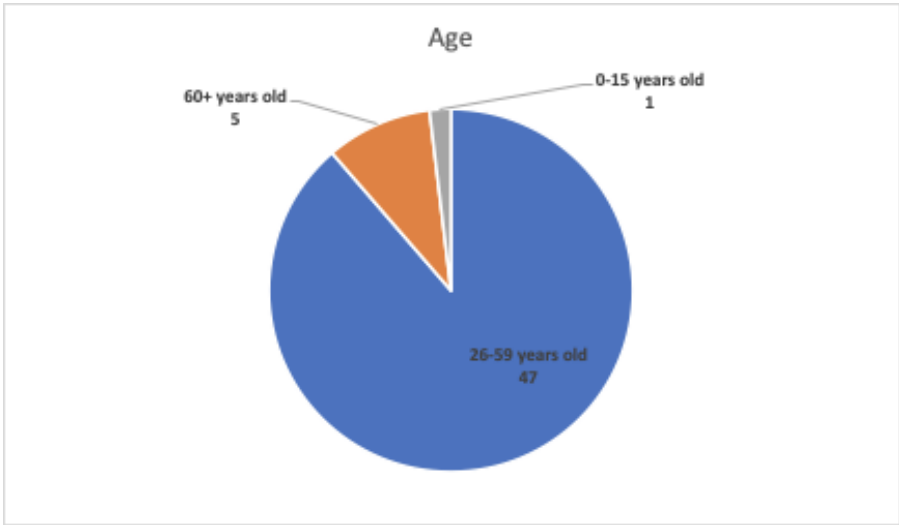
Out of our 53 unique attendees, 66% identified as Mexican, Central Americans being the 2nd largest group with 13% and South American registering 9% attendance. Although Mexicans are the largest represented group of attendees, we are intentionally reaching out to other Latinx communities to expand our reach.



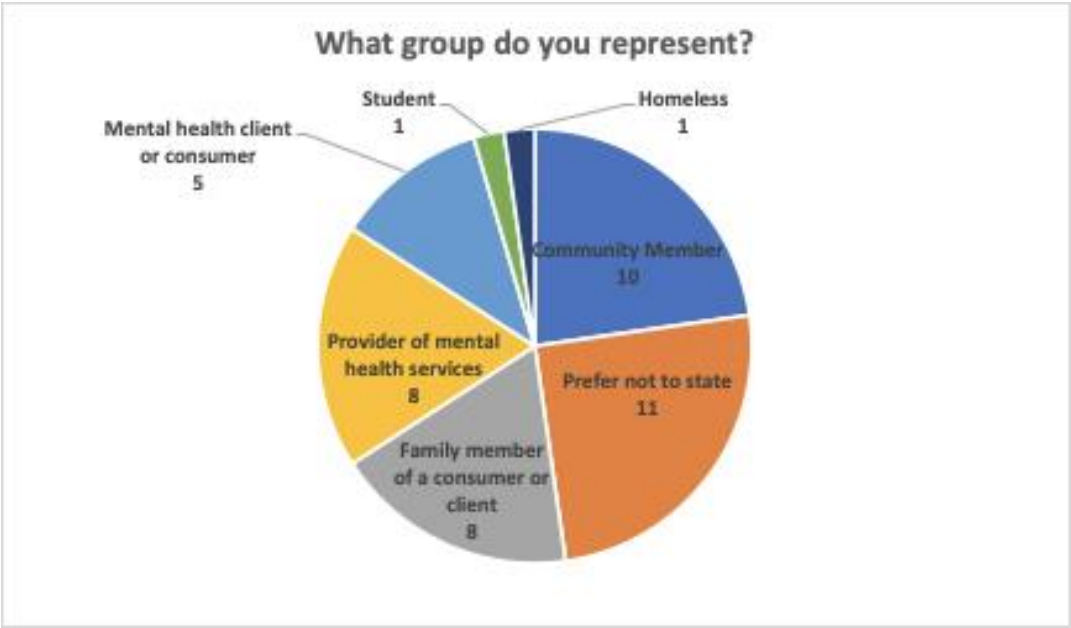
We are actively conducting more outreach to the men of Latinx communities because change can only occur if everyone is working together. It is also a priority for us to make men aware of mental health practices and knowledge because they are very important and influential figures in our society.



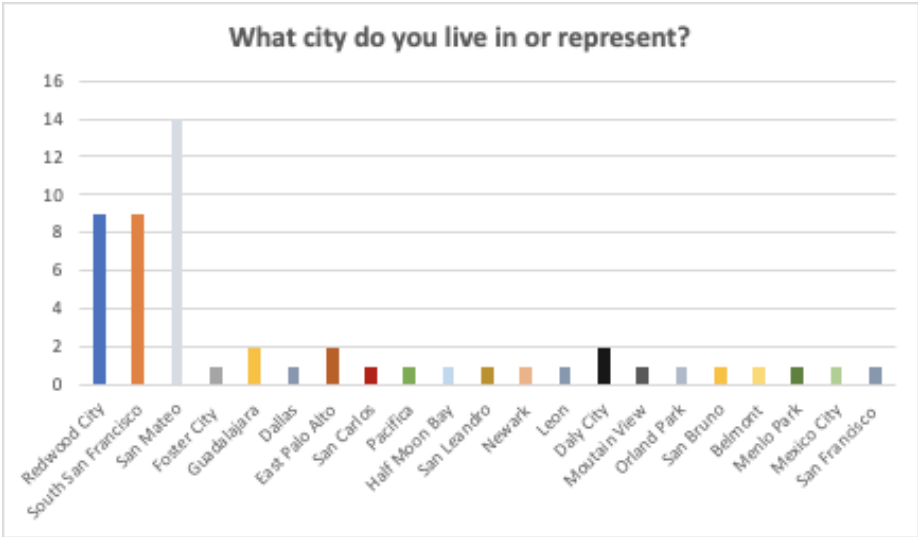
The fact that attendees, who are from Latinx communities, chose to state their sexual orientation is a step ahead in the right direction because topics like sexuality are not usually openly addressed in these communities.



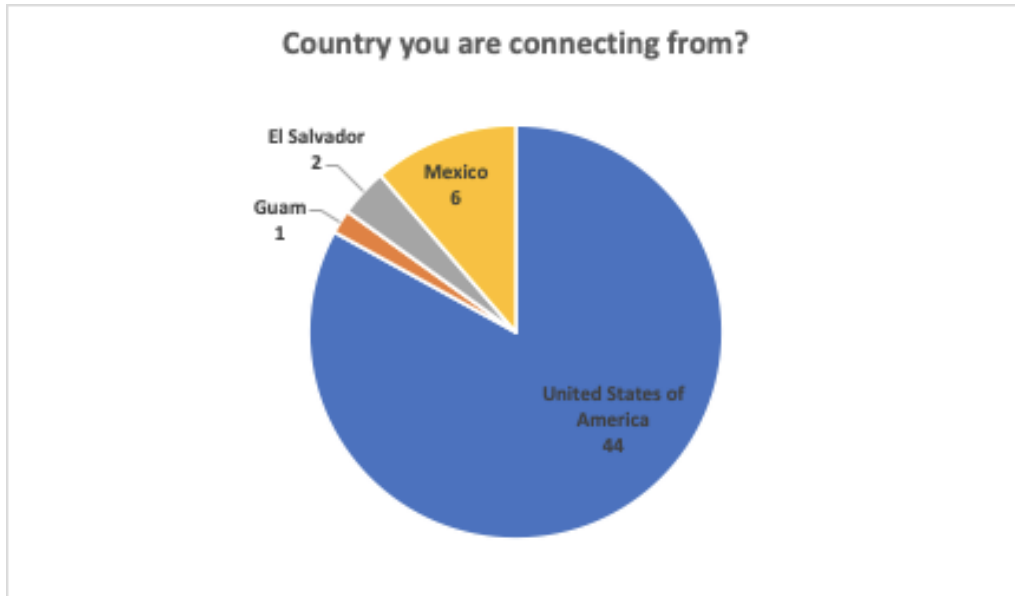
In the regular in-person HAP trainings we don't usually see 60+ years old attendees, however, we understand that mental health challenges occur at any age in our lives. Since the pandemic has put the elderly at a higher risk of the virus -they are also at risk of suffering abuse and mental health challenges due to isolation- it was important to bring to our webinar the whole family together, including the older adults, to bring awareness on these subjects.



39% of attendees seem to already have some knowledge of mental health, however with this webinar, we have reached out to 1 student, 1 homeless person, and 10 community members, which furthers the spread of knowledge and services to those who might be unaware.



Most of our attendees reported from 12 cities in San Mateo County and the use of social media allowed us to bring our webinar to the East Bay, Santa Clara County, San Francisco, 1 city from outside of California, and even 3 different cities from Mexico.



By bringing the HAP webinar to the general public throughout social media, we worked on reaching out to Spanish speaking communities anywhere we could. So the content we prepared with Professionals and Ambassadors about family and wellness reached people in 4 different countries.

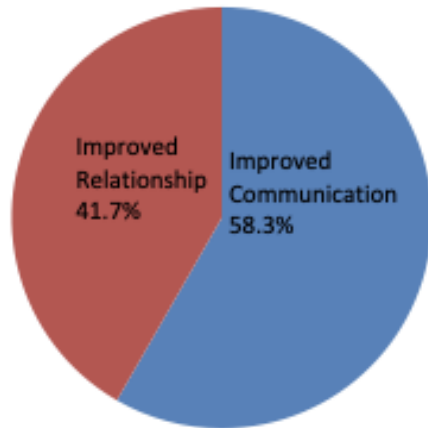
HAP Graduation Ceremony 2019: 19 Graduates

Due to the introduction of HAP courses offered in Spanish, a new group of potential Health Ambassadors was exposed to the Health Ambassador Program. With this exposure, participants quickly completed the 5 courses needed to become a Health Ambassador and by the end of 2019, there were 19 ambassadors ready to graduate. This cohort of graduates was predominantly Spanish speakers from Mexico and Central and South America. The graduates came from 8 different cities across the County. 15 are females and 4 are males and partners of other graduates. Some of them identified as alcohol and drug recovered individual, parents of children with developmental and learning challenges, caretakers of children with depression, anxiety, bipolar, ADHD, suicide alienation, and drug and alcohol use.

We held a graduation ceremony for the Health Ambassadors to congratulate them for their achievement and to show them that we care about their accomplishments and their continued growth and their road to recovery and improved daily lives. At the end of the ceremony, we distributed a survey that asked questions about how the Health Ambassador Program changed their lives and what they want out of being Health Ambassadors and what we can do to continue helping them while on their journey.

The following data was retrieved from the surveys that were distributed at the end of the ceremony:

How has your family dynamic changed since taking your first HAP training?



When asked this question, responses showed that with their new abilities to openly express their emotions and not to judge others, relationships within the family have improved immensely. Most other responses indicated that since taking their first HAP training, communication has also improved with the displaying of increased patience and increased calmness when speaking with family. These responses ultimately work towards our goal of stigma reduction within communities and empowering those communities.

What new skills have you learned?



Some responses show that attendees plan on using the knowledge that was gained to help and share knowledge with their community. They also mention many times how they gained empathetic qualities and practices when speaking with others which contribute to achieving our stigma reduction goals. They also show that they gained an essential understanding of self-advocacy or self-empowerment skills in that they are able to think positively about themselves and are able to thoroughly express themselves. However, it was also expressed that they do not feel that they have completely mastered those skills and are eager to learn how to accomplish that goal; Not only to advocate for themselves, but for those who are unable to raise their own voices. A quote that was taken from one of the surveys in response to the

above question: *“Be well with myself mentally and spiritually. Be well with my family. Be tolerant of insignificant things and be calm to avoid many problems”*

This response showed a complete achievement in the goals of the Health Ambassador Program. Learning and implementing wellness practices for self, family and community benefit in hopes of living a healthier and fulfilling life.



The successes that were mentioned in the responses showed progress in workforce development through the transitioning from Health Ambassador to the possibility of becoming Parent Project Facilitators, as well as working towards establishing a career with the skills learned in the Health Ambassador program.

Many responses also allude to their joy in the improvement of their relationships with family and others. There was an example in a couple in which one person was attending the Health Ambassador trainings while the other partner was not. After encouragement from the attending partner, the other partner decided to join in on the classes. That partner admitted during the graduation that he was overwhelmed with their three children who have mental health challenges and that was the reason that he dissociated from the Program. But after re-engaging in taking trainings and becoming a Health Ambassador, they both expressed that their relationship with each other has vastly improved as well as their understanding of their children and that they are now a stronger and united source of support for their children.

Some responses also show that they found success in their development of self-empowerment skills and empathetic practices. In terms of empathy, one of the Ambassadors expressed during the graduation that he has a relative in which he previously held stigmatized beliefs about his relative’s alcoholism. With the practices he developed during the Health Ambassador Program, he stated that he began to connect and resonate with his relative and even directed his relative to substance abuse services. And in terms of self-empowerment, In becoming Health

Ambassadors, they used the skills that they learned in the trainings to better advocate for their children in mental health care, academic and social settings.

Also, there were many responses that showed that Health Ambassadors not only spread their knowledge throughout their community, but they helped connect community members to services that are available to them, which contributes to the advancing of our community empowerment goals as well as assists in reducing barriers between community members and treatment/prevention programs. Health Ambassadors showed their willingness to be engaged within the county and governmental procedures by participating in an MHSa meeting. Also, an Ambassador participated in a panel to share her lived experience to the committee so that her experience and suggestions could be taken into consideration by BHRS to improve services. Also, by the end of this fiscal year, 5 more people have graduated and became Health Ambassadors, totalling 24 Health Ambassadors during the fiscal year of 2019-2020. Almost double the graduates from 2014 to 2018.

Public Speaking Opportunities

During this fiscal year, Health Ambassadors were given incredible opportunities to become involved in their communities, advocate for their rights, participate in activities that helped them in their wellness recovery process and to improve and influence change in BHRS access and services. They have done so by speaking to large bodies of people and to important government officials multiple times during the past year. For most of the Ambassadors, these were the first times where they spoke to large groups of people openly about their mental health and substance use challenges, and their lived experience throughout the Health Ambassador Program presentations in the Parent Project classes.

- Parent Project class presentations:
 - June 15, 2019: PRIDE Celebration
 - July 20, 2019: Parent Project Reunion
 - Sep 10, 2019: San Mateo High School and Carlmont High School (Belmont)
 - Sep 11, 2019: Bayside STEM Academy (San Mateo), Mills High School (Millbrae)
 - Sep 18, 2019: Mills High School (Millbrae)
 - October 29, 2019: Mental Health Presentation (San Mateo High School)
 - Nov 20, 2019: Mills High School (Millbrae)
 - December 18, 2019: HAP and Mental Health Presentation (Bayside STEM Academy)
 - February 26, 2020: East Palo Alto Academy,
 - March 4, 2020: South San Francisco High School
 - Vaping, other drugs and mental health San Mateo High School feb 19
 - HAP mental health presentation May 4 Daly city (virtual)

During these presentations, Health Ambassadors shared their recovery stories and lived experience to a group of Parent Project participants and also advocated for the Health Ambassador Program in hopes of recruiting some potential Ambassadors.

- Health Fairs
 - September 21, 2019: CARON Health Fair / 20th anniversary
 - Sep 27, 2019: Healthy Kids Wellness day

Our goals for the Health Fairs were to generate interest for the Health Ambassador Program by conducting outreach through various methods.

- MHSARC
 - December 4th @ the San Mateo Health Building

The MHSARC is committed to the involvement of diverse communities, key stakeholders, organizations, and individuals and family members with lived experience, especially those who rely on the mental health system and alcohol and other drugs services -- in the design of San Mateo County's Behavioral Health and Recovery Services.

This was an important meeting for Health Ambassadors because it was the first speaking opportunity that they had participated in, in a county and public environment. One of the Ambassadors shared her lived experience to the committee to advocate for the necessity to improve BHRS services so that it can subsequently improve the lives of her fellow and our community members.

- MHSA Three-Year Planning Meeting
 - April 29, 2020 via zoom

During this fiscal year, 5 Health Ambassadors participated in public comments during the MHSA 3-year planning committee meeting where topics like priorities for future funding and program expansions and/or improvements were discussed in collaboration with clients and families, community members, staff, community agencies and stakeholders. Health Ambassadors spoke to this committee by requesting expansions and improvements to certain programs that they felt are necessary for their wellness journey.

- HAP Webinar
 - May 28, 2020 via zoom

During our HAP webinar about family and wellness during COVID-19, Health Ambassadors spoke to a large group of community members about their wellness journey in the form of testimonials in hopes to inspire their fellow community members to go and seek out services that could help them if they also struggle with behavioral health challenges or other related struggles. Overall, we believe the Health Ambassador Program impacted over 5,000 consumers throughout San Mateo County/Behavioral Health and Recovery Services/Office of Diversity and Equity events, community events, and a variety of trainings.

- Suicide Prevention Month (SPM)

During the Suicide Prevention Month, the Health Ambassadors participated for the first time by learning about concept of suicide that was discussed through films and follow-up panels in hopes that parents and children can be more transparent with

each other about suicide, other aspects of mental health and stigma. Ambassadors also attended a Board of Supervisors meeting proclamation- for the first time which introduced them to governmental procedures. Lastly, Ambassadors were able to share their lived experience and life stories in public spaces.

- September 23 @ Menlo Park Main Library: The S-Word Film
 - September 5: Interfaith Day of Prayer for Faith, Hope & Life @ Redwood City
 - September 12: The Edge of Success: Film Screening & Panel @ Fox Theatre
 - September 17: Board of Supervisors Proclamation of September Suicide Prevention Month (Redwood City)
 - September 19: Mental Health Comic Book Presentation @ H.E.L.P. Mental Health Support Group (Menlo Park)
 - September 30: Bullying Prevention for Tweens and Teens @ Belmont Library
- ASIST (Applied Suicide Intervention Skills Training) in Spanish
 - August 15 and 16, 2019 @ San Mateo Community Collage

This course was offered, for the first time, with Spanish simultaneous interpretation because of the great need that was expressed by the community, for suicide awareness courses in the Spanish-speaking language.

The simultaneous Spanish interpretation was effective in engaging community members, however, having a bilingual facilitator who offered culturally relevant material showed great importance in getting the message across to the participants. It permitted for more openness and transparency among the group by allowing the facilitator to use examples in which the participants can relate to. It was seen during the class that participants were absorbing all of the information that was being presented to them because they were all affected by suicide in some ways in their lives. Their understanding of the course material was shown through their responses in the end of class survey. Not only did they understand the material, but they all expressed how they would implement the tools that they gained during the class into their lives. However, they also stated that this information related to suicide awareness should be spread to the rest of their community because of the stigma that is present as well as because of how often suicidal thoughts and self-harming occurs within their communities that goes unreported. It must be stated that after taking this training and going to the process meeting that follows, four participants immediately sought out mental health services for themselves and/or began to advocate for their children who were already receiving services. And in one case, a participant had previously stopped using her services for her children and after taking the ASIST training, she began using those mental health services again, with a better idea on how to advocate for her children and what she needs out of those services. However, it should also be noted that the ASIST training was not offered completely in the Spanish language and that further work needs to be done so that the training can be fully culturally and linguistically relevant for the Spanish-speaking community.

Redwood City Library TAKEOVER: “Walking in your Shoes: Education and Wellness for Success”

The Redwood City Library launched a contest for community members and community-based organizations to make a proposal for a library program or event that would bring more people into the Library, particularly those from underserved or under-represented populations, and to help them see the Library as a welcoming place and a valuable resource.

The Health Ambassador Program proposed a library takeover event in observance of the Mental Health Awareness Month in MAY at the Redwood City Public Main Library. We won a grant and approval to create an event intended for Spanish speaking community members. The event that we proposed was to bring in immigrant communities to the library to learn about communication techniques to talk to young people about their educational and emotional challenges. We made it a point to promote and include diverse and non-traditional families in the event so that they can also feel appreciated and welcome. Our purpose was to bring the family together as a whole by providing tools for immigrant parents to communicate and support their children when they are facing challenges while pursuing their academic goals. Also, we wanted the youth to hear about their parents' challenges so they, as a family, could work together to accomplish the same goals. We were intentional in bringing an Indigenous woman to further explore the concepts of indigeneity and gender equality. Our guest speaker will share her motivational story of how she accomplished her educational goal. The HAP event was supposed to happen on May 28th at the Redwood City Main Library, however, due to COVID-19, the event was indefinitely postponed.

Health Ambassador Program	FY 19/20
Total clients served	24
Total cost per client	\$508

CHALLENGES

The biggest challenge during this fiscal year was definitely the COVID-19 pandemic not only due to the fact that HAP is an organization that delivers services mostly through in-person meetings and events, but also due to the uncertainty that COVID has created for the community members because they need HAP's help now, more than ever. Attempting to navigate a world where it is suggested not to meet in-person has been the most difficult thing this year. However, the program has, nonetheless, prevailed and delivered the best services possible given the circumstances.

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

ADULT MENTAL HEALTH FIRST AID (MHFA)

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

PROGRAM IMPACT

- 1) Improves timely access & linkages for underserved populations
AMHFA training incorporates culturally humble questions, examples and resources to help participants to intervene with and refer behavioral health services to underserved populations in a more culturally responsive way.
- 2) Reduces stigma and discrimination
AMHFA shares mental health facts and stories of hope and recovery which both help reduce stigma of mental health issues and conditions.
- 3) Increases number of individuals receiving public health services
AMHFA training shares local resources participants can refer to for professional behavioral health support, including public health services.
- 4) Reduces disparities in access to care
AMHFA partners with agencies that connect marginalized communities to care, including those serving older adults and incarcerated youth.
- 5) Implements recovery principles
AMHFA implements the recovery principles of support from others and providing hope since participants become gatekeepers who provide hope and support to those facing mental health issues.

20 of the 69 graduates responded to the end of class evaluation due to COVID-19 county shut down. Of the 20 respondents:

- 100% feel confident to recognize the signs that someone may be dealing with a mental health problem, substance use challenge or crisis.
- 95% feel confident to reach out to someone who may be dealing with a mental health problem, substance use challenge or crisis.
- 50% feel confident to ask a person whether they're considering killing themselves.
- 95% feel confident to actively and compassionately listen to someone in distress.
- 95% feel confident to offer a distressed person basic "first aid" level information and reassurance about mental health and substance use challenges.
- 95% feel confident to assist a person who may be dealing with a mental health problem, substance use challenge or crisis in seeking professional help.

- 95% feel confident to assist a person who may be dealing with a mental health problem, substance use challenge or crisis to connect with appropriate community, peer, and personal supports.
- 100% feel confident to be aware of my own views and feelings about mental health problems, substance use challenges and disorders.
- 100% feel confident to recognize and correct misconceptions about mental health, substance use and mental illness as I encounter them.

ODE Indicators

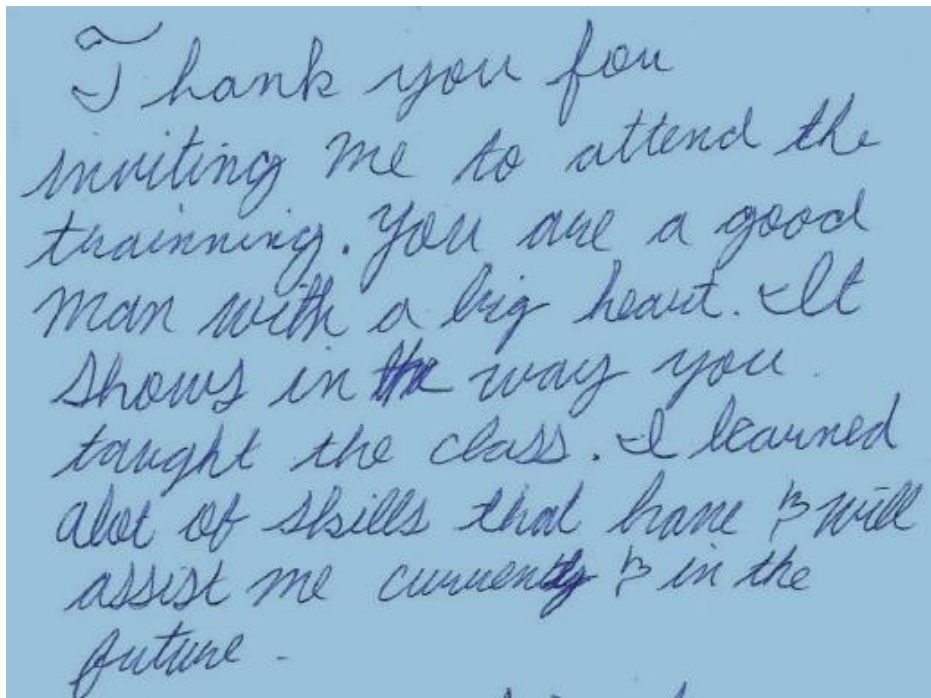
- Self Advocacy: 169 of the 179 graduates responded to the end of class evaluation. Of the 169 respondents:
 - 100% feel confident to recognize the signs that someone may be dealing with a mental health problem, substance use challenge or crisis.
 - 95% feel confident to reach out to someone who may be dealing with a mental health problem, substance use challenge or crisis.
 - 50% feel confident to ask a person whether they’re considering killing themselves.
 - 95% feel confident to actively and compassionately listen to someone in distress.
 - 95% feel confident to offer a distressed person basic “first aid” level information and reassurance about mental health and substance use challenges.
- Cultural Humility:
 - 85% (17/20) agreed that this training was relevant to them and their cultural background and experiences (race, ethnicity, gender, religion, etc.)
- Access: 20 of the 69 graduates responded to the end of class evaluation due to COVID-19 county shut down. Of the 20 respondents,
 - 95% feel confident to assist a person who may be dealing with a mental health problem, substance use challenge or crisis in seeking professional help.
 - 95% feel confident to assist a person who may be dealing with a mental health problem, substance use challenge or crisis to connect with appropriate community, peer, and personal supports.
- Stigma Reduction:
 - 100% (85/95) are MORE willing to take action to prevent discrimination against people with mental illness.

Adult Mental Health First Aid	FY 19/20
Total clients served	69
Total cost per client	\$1,019

SUCCESSES

AMHFA training program now contracts with 4 agencies (including 3 new contracted agencies) that can collectively offer Mental Health First Aid in the following languages: English, Spanish, Mandarin, Cantonese, Tagalog, Tongan and Samoan.

One of the AMHFA Contract Providers (One East Palo Alto) received the below card from a participant.



DEMOGRAPHICS

	FY 19/20		FY 19/20
Age	%	Gender Identity	%
0-15	0%	Male/Man/Cisgender	19%
16-25 (Age collected as 18-25)	9%	Female/Woman/Cisgender woman	76%
26-59	78%	Transgender woman	0%
60+	10%	Questioning/unsure	1%
Decline to state	2%	Genderqueer/nonconforming	0%
Primary Language	%	Another gender identity	3%
English	96%	Decline to state	0%
Spanish	2%		
Race/Ethnicity	%	Disability/Learning difficulty	%
American Indian/Alaska Native	1%	Difficulty seeing	4%
Asian	19%	Difficulty hearing or having speech understood	73%
Black/African/-American	12%	Developmental disability	4%
White/Caucasian	32%	Physical/mobility disability	16%
Hispanic/Latinx	6%	Chronic health condition	3%
Filipino	3%	Learning disability	0%
Puerto Rican	1%	I do not have a disability	0%
Pacific Islander	13%	Another disability	0%
Hawaiian	1%	Decline to state	0%
Multiracial	9%	Blank	0%
Decline to State	7%		

Sex Assigned at birth	%	Veteran	%
Male	20%	Yes	3%
Female	79%	No	1%
Decline to state	1%	Decline to state	0%
Sexual Orientation	%		
Gay, lesbian, homosexual	4%		
Straight or heterosexual	73%		
Bisexual	4%		
Queer	3%		
Pansexual	0%		
Another sexual orientation	0%		
Decline to state	16%		

ACCESS AND LINKAGE TO TREATMENT

Community outreach collaboratives funded by MHSa include the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) and the North County Outreach Collaborative (NCOC). The collaboratives provide advocacy, systems change, resident engagement, expansion of local resources, education and outreach to decrease stigma related to mental illness and substance abuse and increase awareness of and access and linkages to culturally and linguistically competent behavioral health, entitlement programs, and social services; a referral process to ensure those in need receive appropriate services; and promote and facilitate resident input into the development of MHSa funded services. See Appendix 11 for the full FY 2017-18 Outreach Collaborative Annual Report.

NORTH COUNTY OUTREACH COLLABORATIVE (NCOC)

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

PROGRAM IMPACT

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

In FY 2019-20, there were 12,506 attendees at individual and group outreach events across the five provider organizations in the NCOC.

Total clients served	12,506
Total cost per client	\$18

SUCSESSES

Client Statements:

“I finally realized that I am no longer a victim but am a survivor.”

“I realize that I am not alone”

“The world really scares me, but I am glad I have you to talk to”

“I don’t know where I would be without therapy each week”

CHALLENGES

The North County Outreach collaborative faced many similar challenges to other programs this year brought on by COVID-19. In the Pacifica Collaborative, losing a long-time outreach worker who had spent years building trust in the community was a huge setback to their work. Star Vista’s clients often face transportation challenges. Other program’s such as DCYHC rose to the challenge of moving their services to a virtual setting and meeting their clients’ complex needs as the pandemic worsened.

EAST PALO ALTO PARTNERSHIP FOR BEHAVIORAL HEALTH OUTREACH

The East Palo Alto Partnership for Behavioral Health Outreach (EPAPBHO) collaborative is comprised of community-based agencies from the East Palo Alto region of San Mateo County to provide culturally appropriate outreach, psycho-education, screening, referral and warm hand-off services to East Palo Alto region residents. One East Palo Alto (OEPA) served as the lead agency and work in collaboration with El Concilio of San Mateo County (ECSMC), Free at Last (FAL) and the Multicultural Counseling and Educational Services of the Bay Area (MCESBA). EPAPBHO is committed to bridging the mental health divide through advocacy, systems change, resident engagement and expansion of local resources leading to increased resident awareness and access to culturally and linguistically appropriate services. EPAPMHO provides the following services including:

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

PROGRAM IMPACT

EPAPBHO	FY 19/20
Total clients served	517

Total cost per client	\$394
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SUCSESSES

Success Story #1: A single mother of four (4) children came to the office for services. Staff noted she appeared overwhelmed and anxious. Staff listened as she shared some of her issues, which included her financial stresses and handling her four children in school with limited access to the internet for school. She was asked about talking with someone who she trusted or a counselor. She agreed to speak to a counselor for her bouts of depression. She was unable to go immediately but said she would make an appointment to the Ravenswood Clinic. She was provided a flier "Control Your Depression, What you can do to help yourself." A follow up call was made and she is feeling better as she was called back to work, we assisted her with her PG&E bill and she took heed to the suggestions made on the flier. She has walking more often and was very grateful for the call. Staff also assisted her with her Census.

Success Story #2 Sione came to APV for help with his court case in August. There were many issues surrounding his case, but one of the major factors he was reluctant to speak about was his depression and his need to smoke marijuana and drink in hopes for some relief. After supporting Sione with his court case and advocating for a lesser sentence by implementing an action plan, staff was able to link Sione to HealthRight 360 (HR360) and begin his journey towards recovery. Today, Sione is a lot more talkative and engaged with his family through the support from Anamatangi. Sione and his family have been receiving spiritual counseling with Mama Dee, Rev. Dan Taufalele and has been consistent in attending his meetings with HR360. The program looks forward to what the future holds for Sione Fehoko (JJ), and will continue to walk by faith and not by sight.

CHALLENGES

FAL describes their biggest challenge this year being COVID-19 and how it has caused them to continue pivoting and evolving their way of helping the community.

ECSMC's challenges are similar to years past – the diversity of each community in terms of culture, language, history, levels of acculturation and literacy are challenges that clients face when also dealing with poverty. Additionally, ECSMC could not make referrals for those who were seeing other providers outside of the County system. Furthermore, as with previous years, most of the cases were not severe mental illness. Finally, appointments for clients are not always available at the time needed though appointments could be made. However, ECSMC staff still take the time to establish some level of support and most of all, hope for all clients.

APV staff have definitely experienced the impact of COVID-19 on their families throughout their pandemic. In-person gatherings and face-to-face meetings are the methods of engaging Pacific Islanders (PI) and young people in the community. Over the years, raising awareness and reducing stigma around mental health have been conducted through creative PI gatherings such as music, song, dance and drumming as well as meals. Home visits have been the way to reach parents about their children, meeting face-to-face, explaining processes of school

systems, social service systems, behavioral health systems and supporting their navigation have been Mamadee and her team's success. However, COVID-19 exacerbated the barriers that families have dealt with, leading to clients and families suffering in silence from the pandemic, depression, unemployment, health issues, undocumented status, just to name a few. To mitigate the challenges, APV has pivoted their outreach and referral process to include wellness checks via phone and email, delivered wellness packages to homes, referrals and warm hand-offs to community resources and assistance programs. They will continue to develop and adapt programming as the pandemic continues in order to meet the growing need in the community.

OUTREACH WORKER PROGRAM

The purpose of the Lesbian, Gay, Bisexual, Transgender, Queer+ (LGBTQ+) Outreach program is to identify existing gaps in service provision that lead to underutilization of behavioral health and substance use recovery services by the LGBTQ+ community. Research has shown that LGBTQ+ folks experience disproportionately high rates of substance use as well as diagnoses of mental health conditions. While these heightened challenges are noted, LGBTQ+ community members are less likely to seek services and experience exacerbation of these challenges due to: 1) historical systemic identity-based discrimination of LGBTQ+ community members within health settings and society at large 2) lack of training of service providers to provide care that is culturally-responsive to the needs of LGBTQ+ folks, 3) lack of data collection on this communities' needs, which impairs our ability to see the scope of the challenges faced and disrupts potential funding allocation, among additional factors. The target population of this program is LGBTQ+ community members across all intersections of age, race, ethnicity and socioeconomic services, though priority is given to low-income folks, and folks with serious mental illness (SMI). Additionally, service providers and community-based organizations are the focus of much of this program in terms of training and consultation support. The primary program activities involve: providing trainings and consultation to service providers across BHRS, contract providers, SMC Health division partners and community organizations; connecting LGBTQ+ community members to services that are currently providing culturally responsive care to LGBTQ+ folks; and strengthening connections between and the capacity of existing LGBTQ+ entities in San Mateo County. Additionally, this program collaborates with partners to create community events to increase opportunities for connection, as well as bring awareness to LGBTQ+ community issues and challenges.

PROGRAM IMPACT

The efforts of the outreach worker program focus on connecting clients to clinical services as well as training clinicians, service providers and staff in community-based organizations on ways to improve services provided to LGBTQ+ community members and giving focus to making these spaces more affirming and inclusive of LGBTQ+ folks. The details below speak to these efforts. In total, 15 trainings were provided within this fiscal year for the following groups:

- BHRS Central Clinic staff – 10 participants
- BHRS Interface staff- 10 participants
- BHRS South County Clinic staff -12 participants

- South San Francisco Library trainings (3 sessions) -34 participants
- Lived Experience Academy – 12 participants
- Spirituality Initiative – 25 participants
- SMC C.A.F.E. participants- 30 participants
- Carl B. Metoyer Center for Family Counseling training – 6 participants
- Pop Up Photovoice Facilitators (2 trainings) - 15 participants
- LGBTQ+ Photovoice participants (4 session workshop)– 5 participants
- San Mateo County Probation Department – 40 participants
- SFSU Counseling MS Cohort- 15 participants

As a result, approximately 214 individuals received training that could improve the mental health outcomes of the clients they serve, and create more opportunities for allyship, support and visibility that can be found across communities in San Mateo County.

Within this fiscal year, the outreach program manager attended and participated in 203 collaborative meetings including meetings with the following groups;

- Suicide Prevention Committee
- Northwest School-based Mental Health Collaborative
- Mental Health Awareness Month Planning Committee
- Domestic Violence Death Review Team (DVDRT)
- Prison Rape Elimination Act (PREA) Review Board
- Trauma Learning Collaborative
- Pride Center Staff meetings
- Gender & Sexualities Alliance (GSA) Coordinator Meetings
- Transgender Day of Remembrance (TDoR) Planning Committee
- Pride 2020 Planning Committee
- Consultation meetings
- ODE staff meetings

In terms of direct referrals the Program Manager:

- Assisted 3 community members who were previously homeless with connections to temporary housing and shelters.
- Referred 4 community members to receive gender affirming medical care at San Mateo Medical Center’s Gender Clinic
- Referred 9 people to the San Mateo County Pride Center for clinical services and peer support programs.

SUCSESSES

The annual Transgender Day of Remembrance (TDoR) gathering serves as a space of community healing as the community comes together to collectively mourn the loss of transgender and nonbinary siblings whose lives have been taken by hate-based violence. On this day,

participants also reaffirm their commitment as a community and with allies to fight against anti-transgender violence and discrimination. The gathering begins with a candlelight vigil and procession through the streets, holding signs with the name of each person remembered in order to bring greater visibility to the losses the community has suffered and for passerby's to become aware that the lives of these folks deserve to be recognized.

Once the procession is complete, the events program features trans and nonbinary speakers who speak about their own lived experiences. The part of the program is powerful and features trans and nonbinary folks of all ages, different races/ethnicities and their varied life experiences. By hearing these stories, a deeper understanding of their experiences is cultivated, not only in regard to the higher rates of violence and discrimination they may have faced, but also about the ways in which they have come to find confidence in their identities and what makes them feel seen and heard. Participants have said that hearing from speakers has given them hope they can overcome struggles around their identities and can thrive as a trans/nonbinary person. Another powerful part of this event is the Reading of Names. A slideshow is created with the photos and names of each person being memorialized. An altar is created with individual memorials for each person to allow participants to learn about the person who passed and what was important to them.

Overall the event honors folks as multi-dimensional human beings and encourages allies to move beyond acknowledgement of the issue toward action.



Transgender Day of Remembrance 2019 Speakers with Supervisor Dave Pine (third from left), and the Redwood City Library partner Derek (first from left side). Additionally, the annual San Mateo County Pride Celebration creates a space to celebrate all identities with fellow community members, feel visibility, connect with other LGBTQ+ folks and share community resources. Throughout the event, LGBTQ+ visibility is key as LGBTQ+ voices are highlighted all day through dance, entertainment, community flags and statements from prominent LGBTQ+ figures in the community.

Due to Covid-19, the typical in-person event was moved to a virtual event and was expanded to a whole week of festivities. The collaborative group that came together to create this virtual week of events was led by the PRIDE Initiative in partnership with the San Mateo County Pride Center, the San Mateo County LGBTQ+ Commission, the Office of Diversity & Equity, CORA and community members.

A total of 14 virtual events were held, including workshops, author readings, drag storytime hour, a drag show, focus groups, a documentary screening, wellness-based activities, and a grand celebration that was livestreamed and recorded with the help of PennTV! Per the PRIDE Initiatives' annual report, "Overall, there were 9,500 views on the PRIDE Initiative Facebook during the week of the Virtual PRIDE Celebration. The day of the Grand Finale there were 6,115 views on Facebook, as well as 244 people attended the workshops during the week on Zoom."

CHALLENGES

A challenge faced in implementing this program includes the need to devote much time to increasing awareness of LGBTQ+ needs and decreasing implicit bias of providers, while simultaneously trying to connect LGBTQ+ folks to county services. While the goal is to increase the number of LGBTQ+ folks receiving services through the health system, this cannot be actualized until the providers are ready and capable to provide culturally humble services. Lack of staffing makes scaling outreach difficult.

Furthermore, partners who do not work at LGBTQ-specific organizations such as PRIDE Initiative members and the LGBTQ+ Commission are also working fulltime jobs, and there is a limit to how much time and energy they can put into creating a more equitable, inclusive health care system.

Lastly, the challenge in finding "unduplicated clients" who identify as LGBTQ+ in San Mateo county is exacerbated by the fact that the county does not have many social outlets for LGBTQ+ folks to meet each other outside of the Pride Center which many seek out to find care and peer support. Many LGBTQ+ folks often seek community outside of San Mateo County.

SENIOR PEER COUNSELING

See program description in General System Development- Older Adult System of care section above.

STIGMA AND DISCRIMINATION REDUCTION

MENTAL HEALTH AWARENESS AND #BETHEONESMC CAMPAIGN

#BeTheOneSMC is San Mateo County's anti-stigma initiative and aims to eliminate stigma against mental health and/or substance use issues in our San Mateo County community.

#BeTheOneSMC can mean many things to different people. #BeTheOneSMC's main message is that you can be that ONE who can make a difference in reducing stigma and promoting wellness in our community.

Primary program activities and/or interventions provided include:

1. Annual May Mental Health Month (MHM) Observance: This is one of the biggest mental health observances of the year for San Mateo County. The 2020 MHM consisted of:
 - a. Planning Committee which planned and implemented the 2020 MHM countywide virtual events. Planning committee members included clients/consumers, family members, county staff and community-based organization staff. Planning committee meetings convened from December 2019 to June 2020.
 - b. Proclamation which is the opportunity for the Board of Supervisors to officially proclaim and recommit to May MHM. There was a 10-minute presentation followed by public comment.
 - c. Event Support & Mini-Grants which is an opportunity for County and community partners to apply for event support and funding for their MHM event.
 - i. Event support includes
 1. Input/ideas on event theme, programming, communication/outreach and logistics
 2. Speakers with lived mental health and/or substance use experience
 3. Digital stories for screening
 4. Photo voices for exhibits
 5. Event flyer template
 6. Event promotion on website and social media (Facebook, Twitter and blog)
 7. Evaluation template
 8. Volunteer to support with day-of event logistics
 - ii. Mini-Grants \$1,000 were distributed to 5 grantee recipients (\$200 per grantee).
 - d. Communication Campaign which involved Facebook, Twitter and blog posts throughout the month.
2. Community Stigma Baseline Survey: San Mateo County launched and completed a Community Stigma Baseline Survey around mental health and substance misuse knowledge, beliefs and behavior. The San Mateo County Behavioral Health & Recovery Services Office of Diversity and Equity commissioned an independent research firm, Strata Research Inc., to implement a baseline survey among San Mateo County residents who were at least 18 years of age. This 15-minute survey was completed by 450 residents in San Mateo County during March 2020. This survey built off of the statewide mental health stigma survey conducted by RAND Corporation.

PROGRAM IMPACT

There was a total of 23 MHM events with collectively about \$1,400 attendees. Of the collected responses:

- 89% are MORE willing to take action to prevent discrimination against people with mental illness.
- 30% are MORE likely to believe that people with mental illness are never going to contribute much to society.
- 83% are MORE likely to believe that people with mental illness can eventually recover.
- 80% are MORE willing to seek support from a mental health professional if I thought I needed it.
- 76% are MORE willing to talk to a friend or a family member if I thought I was experiencing emotional distress.
- 87% learned how to better care for my mental health and seek help if need it.
- 98% agree that this program was relevant to me and other people of similar cultural backgrounds and experiences (race, ethnicity, gender, religion, etc).

Mental Health Awareness	FY 19/20
Total clients served	2500
Total cost per client	\$45

SUCCESS

Within the #BeTheOneSMC (Stigma Discrimination Reduction), the program manager and supporting staff are especially proud of quickly transitioning MHM events from in-person to virtual events. Here are a few quotes from our MHAM Planning Committee:

- “I attended at least 15 of the MHAM events. We accidentally had some overlap of events (that's a stair). The two events discussing Esme Wang's book, then a 3rd event in conversation with her were incredible. The two Open Mic events were impactful, powerful, funny. What a great way to join together. The events that shared voices of real people with real recovery and real lives were so powerful. Any of the events could have impact on people who don't currently receive "services" but can gain from WRAP and others' experiences. There were almost no tech glitches, despite our collective inexperience. Kudos to everyone who tried and tried again and again, and finally got on. Kudos to everyone who hosted events for their very first time. Our shared experience and shared humanity were magnified by MHAM events.”
- “Amazing job! Event Diversity was great! I think there was definitely a great myriad of choices.”
- “Great communication and publication marketing tools and notifications.”
- “The diversity of the committee and the variety of agencies participating.”

Here are a few quotes from the May 26th Trauma to Triumph event:

The stories were very inspiring.

- “WOW! This is a brilliant panel and this should be repeated. I will push my reps for more mental health funds and continue to reach out for help.”
- “Thank you all for hosting this inspirational event - I hope we can continue this broader conversation around mental health, including trauma and healing, with our loved ones and our communities. Thanks to each of you for having the courage to share your stories!”

CHALLENGES

Within the #BeTheOneSMC (Stigma Discrimination Reduction), the program manager sees the main challenge is broader outreach. There are a few quotes below from the MHAM Planning Committee with feedback on the need or strategies for broader outreach.

- “Communicating with all stakeholders in community, not only those on Facebook, those with computers and tablets. We were all stretched to convert both the events and communication to online with little notice. We can fine tune grass roots methods, like carving up county into NextDoor neighborhoods and getting our message posted in each neighborhood. Efforts to elevate tech abilities of BHRS clients and less connected people will be supported by MHSA funding. We can consider being a part of teaching tech, whether it's Zoom, or downloading an app”
- “Communication of Events to MHA clients through case workers, posted flyers at Residential Cares as well as county housing. Case manager participation in getting word out to clients and assistance learning zoom in simple step by step, perhaps in pictures, to help clients. On site events and flyers announcing Mental Health Awareness Month and encouragement to participate.”
- “Continue broadening community engagement. Use of San Mateo County Nextdoor communication channel.”
- Solutions to mitigate the challenge of broader outreach include:
- Create a communication map and identify who can help reach the different stakeholders
 - Program manager doesn’t have capacity to reach a comprehensive set of stakeholders
 - Program manager can try to recruit help from planning committee and planning committee can try to recruit further help from other volunteers
- Media engagement (e.g. print, radio, television)
- Use a broader range of social media (e.g. NextDoor, WeChat)
- Training community members on how to use online platforms to participate in virtual events (program manager doesn’t have capacity to do this on a broad scale so additional support would be needed).

DEMOGRAPHICS

Age	%		
Age 16-25	14%		
26-59	58%		

60+	25%		
decline to state	3%		
Race/Ethnicity	%		
Asian	21%		
Black/ African- American	5%		
White/ Caucasian	54%		
Hispanic or Latino/a/x	8%		
Native Hawaiian or Pacific Islander	6%		
Declined to State	3%		
Another race/ ethnicity or Mixed Race	3%		
Gender Identity	%		
Male/Man/ Cisgender	21%		
Female/ Woman/ Cisgender Woman	72%		
Transgender Male	1%		
Genderqueer/ Nonconforming	3%		
Another gender identity	1%		
Decline to state	2%		
Sexual Orientation	%	Disability/ Learning difficulty	%
Gay, lesbian, homosexual	9%	Physical/ mobility disability	3%
Straight or heterosexual	60%	Chronic health condition	3%
Bisexual	10%	Cognitive Disability	11%
Queer	14%	I do not have a disability	65%
Pansexual	2%	Another disability	5%
Asexual	2%	Decline to state	13%
Questioning or unsure	2%		
Indigenous Sexual orientation	2%		

SUICIDE PREVENTION

SUICIDE PREVENTION COMMITTEE

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

- 1) Suicide Prevention Committee (SPC): The purpose of the SPC is to provide oversight and direction to suicide prevention efforts in San Mateo County. The SPC meets every month. The target population is a diversity of community partners, suicide survivors and the San Mateo County community at large. For 2019-2020, SPC focused on two projects (1) Suicide Prevention Roadmap and (2) Suicide Prevention Docuseries.

- 2) September Suicide Prevention Month (SPM): The purpose of SPM is to encourage all in the community to learn how we all have a role in preventing suicide. The 2019 SPM included a: (1) proclamation, (2) event support and mini-grants, (3) communication campaign, (4) film screening and panel event and (8) other 15 events hosted by community partners. For 2019, SPM focused on the theme #ImHereForYou and partnered with libraries countywide for the first time for SPM.
- 3) Suicide Prevention Roadmap: Starting in October 2019, SPC conducted the 2020-2025 San Mateo County Suicide Prevention Strategic Planning process. San Mateo County's suicide prevention strategic plan will build off of the 2017-2020 San Mateo County Suicide Prevention Roadmap and California Suicide Prevention Strategic Plan. This strategic plan will also be shaped by public health and health equity frameworks which aim to advance health of people, communities, environments and society. The Roadmap will aim to be completed in the 2020-2021 fiscal year.

PROGRAM IMPACT

1. Improves timely access & linkages for underserved populations
Promote the crisis hotlines and emergency contacts in public events, meetings and campaigns that target the general San Mateo County community, including those targeted specifically to certain underserved populations.
2. Reduces stigma and discrimination
 - Provide training/education and communication campaign around suicide and suicide prevention that (1) increase knowledge about suicide and (2) promote stories of hope and recovery.
3. Increases number of individuals receiving public health services
 - Promote the crisis hotlines and emergency contacts in public events, meetings and campaigns that target the general San Mateo County community.
4. Reduces disparities in access to care
 - Target some interventions on groups with high risk of suicide. In 2019, specific targeted groups included youth in Jefferson Union High School School District, those bereaved by suicide loss, adolescents, older adults, Chinese & Chinese Americans, Latino/a/x and Spanish speaking and LGBTQ+).
5. Implements recovery principles
Integrating key recovery principles (particularly individualized and person-centered, respect, and hope) in our communication messages and framing of events.

Suicide Prevention Committee	FY 19/20
Total clients served	1,580
Total cost per client	\$69

SUCSESSES

1. Suicide Prevention Month Mini-Grants: Suicide Prevention Month implemented mini-grants for the first time. This resulted more events (16 events) scheduled than previous years. These events included new partnerships with Mission Hospice, BraveMaker and

Jefferson Union High School District. The approximate reach of all 16 events (including in-person and online reach) is about 1,570 people.

- With the help of a mini-grant, Mission Hospice launched San Mateo County's first and only Suicide Loss Support Group which had 12 participants and one participant shared their experience saying, "Everyone is so nice. This makes me realize we didn't deserve to have gone through this loss. Bad things happen to good people." Another participant also shared the below inspirational rocks.

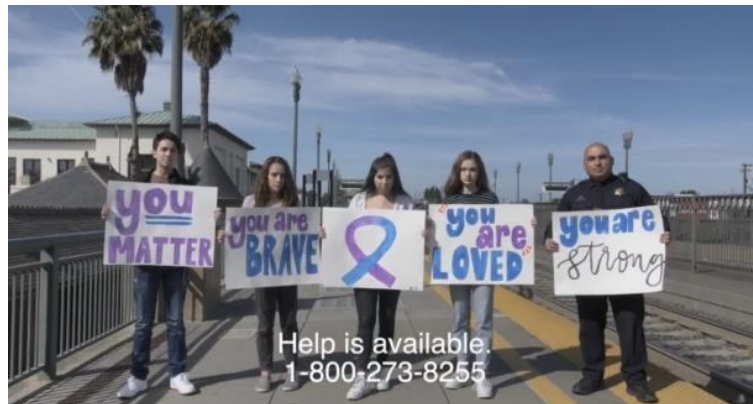


2. Directing Change Film: "The Tracks": The program manager served as a Directing Change Program & Film Contest mentor to a Notre Dame High School student. In October 2019, this student recently lost their friend to suicide by train and wanted to turn their school passion project into something meaningful to honor their friend's loss and to help prevent further suicides.
 - The program manager and student collaborated with Caltrain to create a 1-minute film called the tracks. Among Region 4 (Ventura, Santa Barbara, San Luis Obispo, Monterey, San Benito, Santa Clara, Alameda, Contra Costa, Santa Cruz, San Mateo, San Francisco, Kern, Kings, Tulare, Inyo, Mono, Fresno, Madera, Mariposa, Merced), this film was awarded honorary mention and is posted on the Directing Change website at <https://www.directingchange.org/films/>.
 - The program manager is also requesting Caltrain post the film on the Caltrain Twitter which has over 141,800 followers.
 - The filmmaker emailed the program manager the following email titled "Thank You" on 4/30/2020:

"Dear Sylvia,

I hope you are staying healthy and safe during this pandemic. I would just like to personally reach out and say thank you so much for all the hard work you put into my project. I could not have done this project without you. I appreciate how efficient you were with the mentor check in forms each month. I appreciate the countless resources you provided me with such as Dan Lieberman, Tony Gapistone, and many others at Directing for Change. I also appreciate your organizational skills and how you kept me organized and on a time line so that the project became manageable.

When I approached you with this project I knew the impact I wanted to make but I did not know how to play that out. You provided me with countless resources, structure, and many ideas to get my project rolling. You helped me make the impact I wanted to make with this project. I started this project with a lot of pain and grief in my life because of how suicide had personally rocked my world in October because of my friend Dustin. This project helped me channel that grief into something that will make an impact and bring a little bit of closure and healing to wound suicide had opened in me. I can not thank you enough for that. The work you do is amazing and we need more people like you in this world. I am excited to see how far this video will go and know it will have an impact. Again thank you so much so much for everything, Isabella Gaddini”



3. Suicide Prevention Committee Engagement: Another highlight is also that the Suicide Prevention Committee’s improved structure and engagement. For 2019-2020, SPC hosted 12 meetings with 65 unique attendees, including 10 client/consumer/family members. In addition to focusing on Roadmap and Docuseries as projects, the meetings focused on learning about suicide data, including death, attempt, ideation and help-seeking data. Guest speakers included the County health epidemiologists, 3 death review teams (child, elders and psychological autopsies) and County Office of Education.



CHALLENGES

Understaffed: The top challenge for suicide prevention program is that it is understaffed. About 25% of a full time position is dedicated to coordinating suicide prevention for the County. There are high expectations for this position to run a coalition and workgroups, facilitate strategic planning and action planning, monitor data and evaluations, coordinate community events (SPM), coordinate ongoing communications, and oversee contracts for Mental Health First Aid. This position gets some but not consistent/reliable support from (1) BHRs ODE Communications

staff, (2) SPC members (who usually volunteer small tasks that require more time for co-chair to train/orient) and (3) co-chair from Star Vista’s Crisis Intervention & Suicide Prevention Center (who has limited capacity with their role as a clinician and director of the crisis center). From November 2019 to March 2020 (5-Months), the program manager was chairing the SPC alone since there was a transition between the previous and new program manager of the Star Vista Crisis Intervention & Suicide Prevention Center.

Potential Solutions:

- Allocate more consistent staff time or hire contractor to support for Suicide Prevention Month event planning, event support and communications
- Allocate more consistent staff time or hire contractor to support for Suicide Prevention Month communications throughout the year
- Allocate additional staffing resources to oversee Mental Health First Aid Contracts – possibly Workforce Education and Training team which can oversee the suicide prevention training options (ASIST, MHFA, QPR)

DEMOGRAPHICS

Age		%	Sex assigned at birth		%
	Age 0-15	16.67%		Male	33%
	Age 16-25	16.67%		Female	50%
	26-59	41.67%		Decline to state	16.67%
	60+	0%			
	Decline to State	25%			
Primary language		%	Gender Identity		%
	English	50%		Male/Man/ Cisgender	41.67%
	Spanish	25%		Female/ Woman/ Cisgender	25%
	Decline to state	25%		Transgender Male	0%
				Transgender Woman	0%
				Questioning/ unsure	0%
Race/Ethnicity		%		Genderqueer/ Nonconforming	25%
	European	25%		Indigenous gender identity	0%
	White/ Caucasian	25%		Another gender identity	8.33%
	Central American	8.33%		Decline to state	16.67%
	Mexican/ Chicano	8.3%			
	Native Hawaiian	0%			
	Filipino	0%			
	Puerto Rican	0%			
	Samoan	0%			
	Japanese	8.33%			
	South American	16.67%			
	Another race	33.33%			
	Another ethnicity	25%			

Decline to state - race	41.67%		
Decline to state – ethnicity	16.67%		
Sexual Orientation	%	Disability/ Learning difficulty	%
Gay, lesbian, homosexual	16.67%	Difficulty seeing	0%
Straight or heterosexual	25%	Difficulty hearing or	8.33%
Bisexual	16.67%	Dementia	0%
Queer	8.33%	Developmental disability	0%
Pansexual	0%	Physical/ mobility disability	8.33%
Asexual	8.33%	Chronic health condition	8.33%
Questioning or unsure	8.33%	Learning disability	0%
Indigenous Sexual orientation	0%	I do not have a disability	50%
Another sexual orientation	0%	Another disability	16.67%
Decline to state	16.67%	Decline to state	25%
Veteran	%		
Yes	0%		
No	75%		
Decline to state	25%		

PEI STATEWIDE PROJECTS

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY (CALMHSA)

CalMHSA implements PEI Statewide Projects including Suicide Prevention, Stigma and Discrimination Reduction, and the Student Mental Health Initiative. CalMHSA is a Joint Powers Authority (JPA), formed July 2009 as solution to providing fiscal and administrative support in the delivery of mental health services.





INNOVATIONS (INN)

INNOVATIONS (INN)

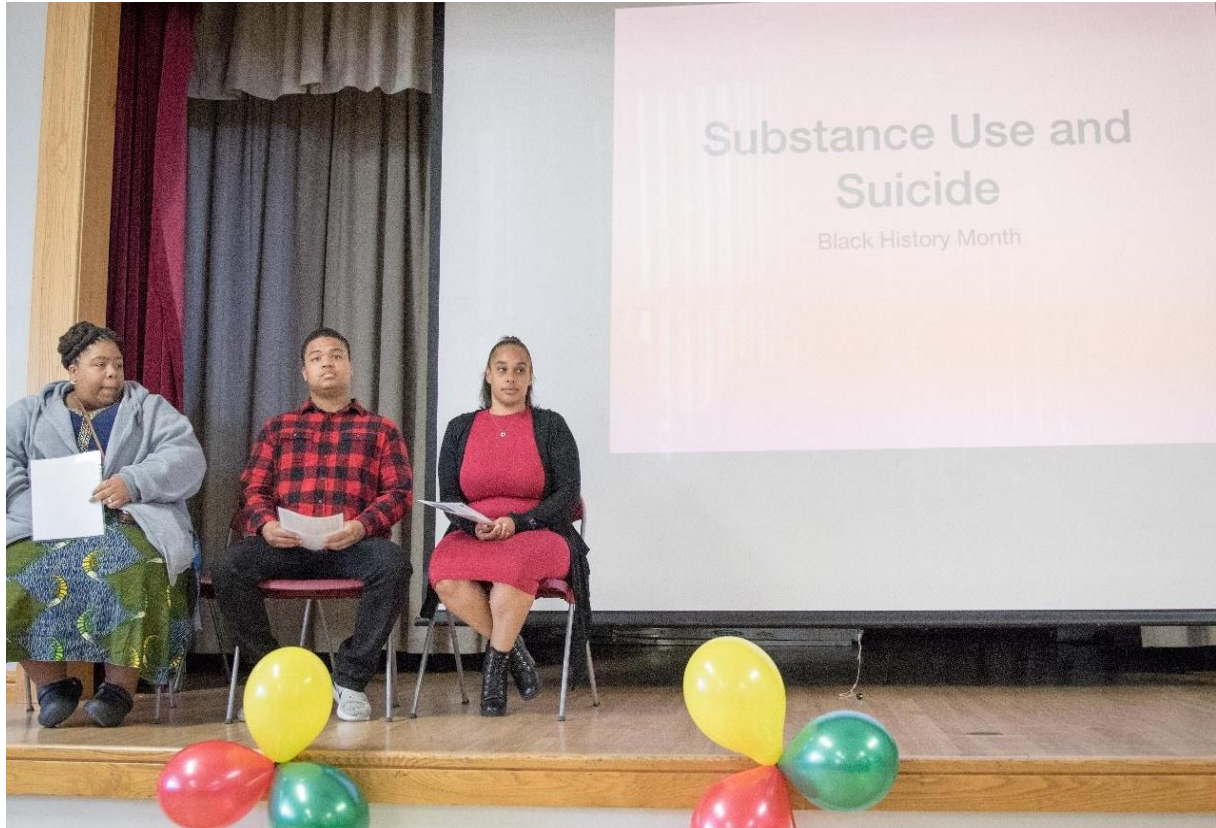
INN projects are designed and implemented for a defined time period (not more than 5 years) and evaluated to introduce a behavioral health practice or approach that is new; make a change to an existing practice, including application to a different population; apply a promising community-driven practice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

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

INN projects that continued in San Mateo County through FY 19-20 include:

- The San Mateo County Pride Center
- Neurosequential of Therapeutics (NMT) in an Adult System of Care
- Health Ambassador Program for Youth (HAP-Y).
- Help@Hand (Tech Suite)

Please see Appendix 12 for the INN Evaluation Reports.



WORKFORCE EDUCATION & TRAINING (WET)

WORKFORCE EDUCATION AND TRAINING (WET)

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

WET, informed by broader social justice and equity efforts, a wellness and recovery orientation and two advisory committees, strives to equip the workforce, consumers, and family members for system transformation by planning, coordinating, and implementing a range of initiatives, trainings, and program activities for the Behavioral Health and Recovery Services (BHRS) workforce, consumers/family members, and community partners. WET serves the BHRS Workforce, contractors providing behavioral health services, consumers and family members and subgroups of those populations. For example, WET program areas such as the BHRS Clinical Internship/ODE Internship programs are implemented for interns and other non-licensed/certified staff/community providers to gain knowledge and supervised professional experience in a local government setting. One of the broader objectives of the internship programs is to attract and retain a diverse workforce.

As a program area of the Office of Diversity and Equity (ODE), the WET Team also focuses on providing program activities that are in alignment with the best practices established by ODE and policies implemented by the County and this includes modeling the ODE Team values across the work. The WET Team program areas may be categorized into three broad areas. Training and Technical Assistance, Behavioral Health Career Pathways and WET Workplace Enhancement Projects. The annual training plan and education sessions to provide up-to-date information on practices, policies and interventions approved for use in BHRS is an integral component of the Training and Technical Assistance area. Interns who have obtained an internship in one of the more than 20 clinic and program training sites can collaborate with the County's Health Equity Initiatives in the Cultural Stipend Internship Program which is supported by the Behavior Health Career Pathways program area. As part of the BHRS Workforce Enhancement Projects, the WET team was actively involved in the successful, inaugural BHRS Mentorship Program.

PROGRAM IMPACT

The WET Team of the Office of Diversity & Equity provides programs that build the capacity of the workforce, community providers, and consumers and family members. Primarily providing training/education/development. It is imperative for underserved, marginalized community members and populations to have timely access and links to services, in their many forms

provided by the county. Those communities include ethnic/racial communities, communities' members with limited English proficiency and member of the LGBTQ communities. However, there are sometimes barriers which may hinder the timely access. Some of those barriers might include lack of language services, lack of cultural humility, lack of knowledge of trauma informed care practices and/or recovery as a lifestyle. WET activities help to reduce stigma and discrimination by training providers, community members. Most workforce education activities have an indirect impact however, without it, members of the community may suffer lack of access to services or insufficient services. By attending some events as a constant presence, trust is built and communities are more likely to reach out when they or someone they know may need of services. Equity is a core principle in WET trainings.

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

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

**Other trainings include: ABC's of Child Family Treatment(CFT), Crisis Response Team, (Clinical)Supervisors' Training, Internship orientation, Photovoice, BHRS New Hire Orientation, Prevention & Management of Assaultive Behavior, Child & Adolescent Needs & Strengths (CANS) Training, and Law & Ethics for Behavioral Health Providers.

SUCCESSSES

The WET team was able to successfully transition into virtual trainings as a response to the COVID-19 pandemic. One of the main initiatives for the 2019-2020 fiscal year was to implement the Relias Behavioral Health Library Solutions supplement to the San Mateo County LMS in order to extend and expand online courses/trainings for all BHRS staff and providers. Additionally the WET team successfully implemented the BHRS EMDR Training Program, Mindfulness Based (MBSAT), Eating Disorders Training and continued to virtually provide trainings in Prevention & Management of Assaultive Behaviors, Becoming Visible Using Cultural Humility in Asking SOGI Questions.

CHALLENGES

One of the greatest and most consistent challenges to implementing WET program activities was the trainers impacted by the COVID-19 pandemic along with the inability to provide ASSIST trainings due to lack of permission provided by contractor for virtual trainings. Additionally, the loss of staff contributed to hurdles faced during the 19-20 fiscal year.



HOUSING

HOUSING

MHSA Housing funds provide permanent supportive housing through a program administered by the California Housing Finance Agency (CalHFA) to individuals who are eligible for MHSA services and meet eligibility criteria as homeless or at-risk of being homeless. BHRS collaborated with the Department of Housing and the Human Services Agency's Shelter Services Division (HOPE Plan staff) to plan and implement the MHSA Housing program in the County. Since 2006, the MHSA Housing Program funded 62 housing units across housing developments in Redwood City, South San Francisco, San Mateo and North Fair Oaks community.

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



CAPITAL FACILITIES & INFORMATION TECHNOLOGY (CF/IT)

E-CLINICAL CARE

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

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

APPENDICES

**APPENDIX 1. MHSA STEERING COMMITTEE MEETING MATERIALS
& MHSARC AMENDED BY-LAWS**



Be the one to help



Mental Health Service Act (MHSA) Steering Committee Meeting

Open to the public! Join advocates, providers, clients and family members to provide input on MHSA program planning.

The MHSA Steering Committee meets throughout the year to provide input, recommendations and stay up-to-date on new MHSA developments and ongoing programming.

Meeting objectives include:

- Learn the latest MHSA updates including revenue projections, Innovation projects and ongoing program planning.
- Provide input on the MHSA Steering Committee structure moving forward.
- Get involved in new program and strategy planning.

- ✓ Stipends are available for clients/family members
- ✓ Language interpretation is provided if needed*

*Please contact Tania Perez at tsperez@smcgov.org by September 25th to reserve language services.

DATE & TIME

Wednesday, October 7, 2020

3:30 pm – 4:00 pm (MHSARC)

4:00 pm – 5:30 pm (MHSA)*

Zoom Meeting: <https://us02web.zoom.us/j/81395582235>

Dial in: +1 669 900 6833 / Webinar ID: 813 9558 2235

iPhone one-tap: +16699006833,,81395582235#

**The MHSA meeting is combined with the Mental Health Substance Abuse and Recovery Commission (MHSARC), both meetings are open to the public.*

Contact:

Doris Estremera, MHSA Manager
(650) 573-2889 ♦ mhsa@smcgov.org

www.smchealth.org/MHSA



SAN MATEO COUNTY HEALTH
**BEHAVIORAL HEALTH
& RECOVERY SERVICES**

The Mental Health Services Act (MHSA) provides a dedicated source of funding in California for mental health services by imposing a 1% tax on personal income over \$1 million.




Mental Health Services Act (MHSA) Steering Committee Meeting

October 7, 2020



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Before we begin...

- Stipends for clients and family members participating
- Demographics survey, link in chat box  PAUSE
- Meeting is being recorded
- Participants are muted and share screen are disabled
- Participation
 - "Raise Hand" button
 - Host will unmute one participant at a time
 - 1-2 minutes maximum




SAN MATEO COUNTY HEALTH
**BEHAVIORAL HEALTH
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Agenda

- MHSA Overview
- MHSA Updates
- MHSA Steering Committee Restructure
 - Motion to approve
- New planning




MHSA Overview

76%  **Community Services & Supports (CSS)**
Direct treatment and recovery services for serious mental illness or serious emotional disturbance

19%  **Prevention & Early Intervention (PEI)**
Interventions prior to the onset of mental illness and early onset of psychotic disorders

5%  **Innovation (INN)**
New approaches and community-driven best practices

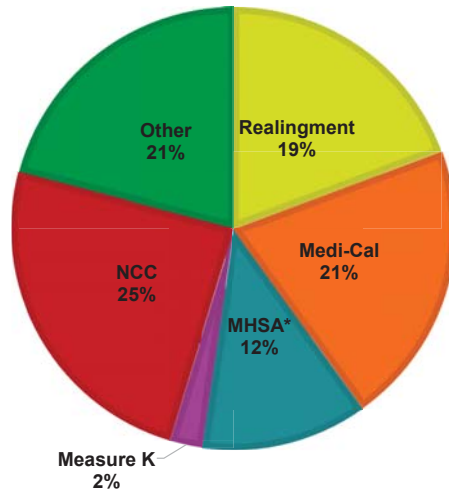
Workforce Education and Training (WET)
 Education, training and workforce development to increase capacity and diversity of the mental health workforce

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

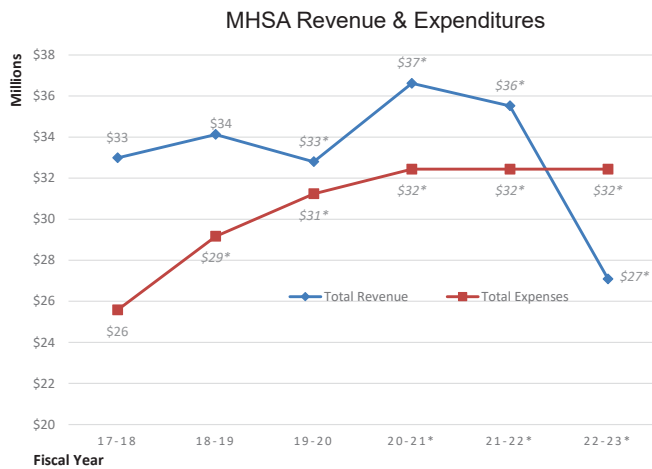
1% tax on personal income over \$1 million
San Mateo County: \$30.7M annual 5-year average through FY 19-20

BHRS Budget & MHSA

- BHRS Fiscal Year 2019-20 Revenue



MHSA Revenue Projections



MHSA Reserve & Unspent

Fiscal Year End	19/20
Trust Fund Balance	\$42,448,640
Target Reserve	\$17,065,120
5% INN	\$1,640,023
INN Ongoing	\$2,829,163
WET Ongoing	\$535,490
Housing Funds	\$105,039
One-Time Plans	\$17,500,000
TOTAL Obligated	\$39,674,835
Unspent	\$2,773,805

*estimates; ongoing expenditure projections do not include one-time





Questions?

Update - \$12.5M, 3-Year One-Time Spend Plan

Priority	Item	FY 19/20	FY 20/21	Status
System Improvements - Core MHSA Services	Full Service Partnership	\$500,000	\$250,000	In progress
	Stop gap and one-time system improvement		\$2,500,000	In progress
	MHSA PEI data-informed improvements	\$100,000	\$50,000	In progress
	Trauma-informed systems (BHRS, HSA, CJ, etc.)		\$100,000	Not started
Technology for System Improvement	Network Adequacy Compliance	\$100,000		In progress
	Improve productivity (documentation, EHR)	\$100,000	\$225,000	In progress
	Increase access-telepsychiatry/health	\$30,000	\$30,000	Completed
	Workforce Capacity Development		\$206,000	In progress
Workforce and Community Education and Training	Community Education (B&C, MH101)		\$180,000	In progress
	Crisis Coordination (on-going)		\$150,000	In progress
	Supported Employment		\$400,000	Not started
	Workforce pipeline and retention		\$124,000	In progress
	SSF Clinic		\$500,000	Delayed
Capital Facilities	EPA Clinic	\$700,000		Delayed
	Casita House Renovations	\$100,000		In progress
	Cordilleras		\$500,000	Delayed
Stop Gaps	HAP-Y		\$250,000	In progress
	NMT- Adults		\$200,000	In progress
	Tech Suite		\$300,000	In progress

Update - \$5M COVID One-Time Spend Plan

Priority	Item	FY 19/20	Status
Technology Supports	Phones + Data Plan for BHRS Clients	\$108,000	In progress – October
	Phones + Data Plan for Contractors	\$270,000	In progress – October
	Tablets + Data Plan	\$69,000	In progress – October
Workforce Needs	Workspace assessment and safety	\$200,000	In progress
	Client activities/needs	\$50,000	In progress
	Alternative Care Sites	\$100,000	Not started
Client Supports	Hotels for homeless	\$200,000	Not started
	Co-occurring detox facility	\$200,000	In progress
	COVID Testing Program for high risk clients	\$96,000	In progress
Stop Gaps	Primary Care Interface	\$1,337,972	In progress
	Resource Management	\$2,169,028	In progress



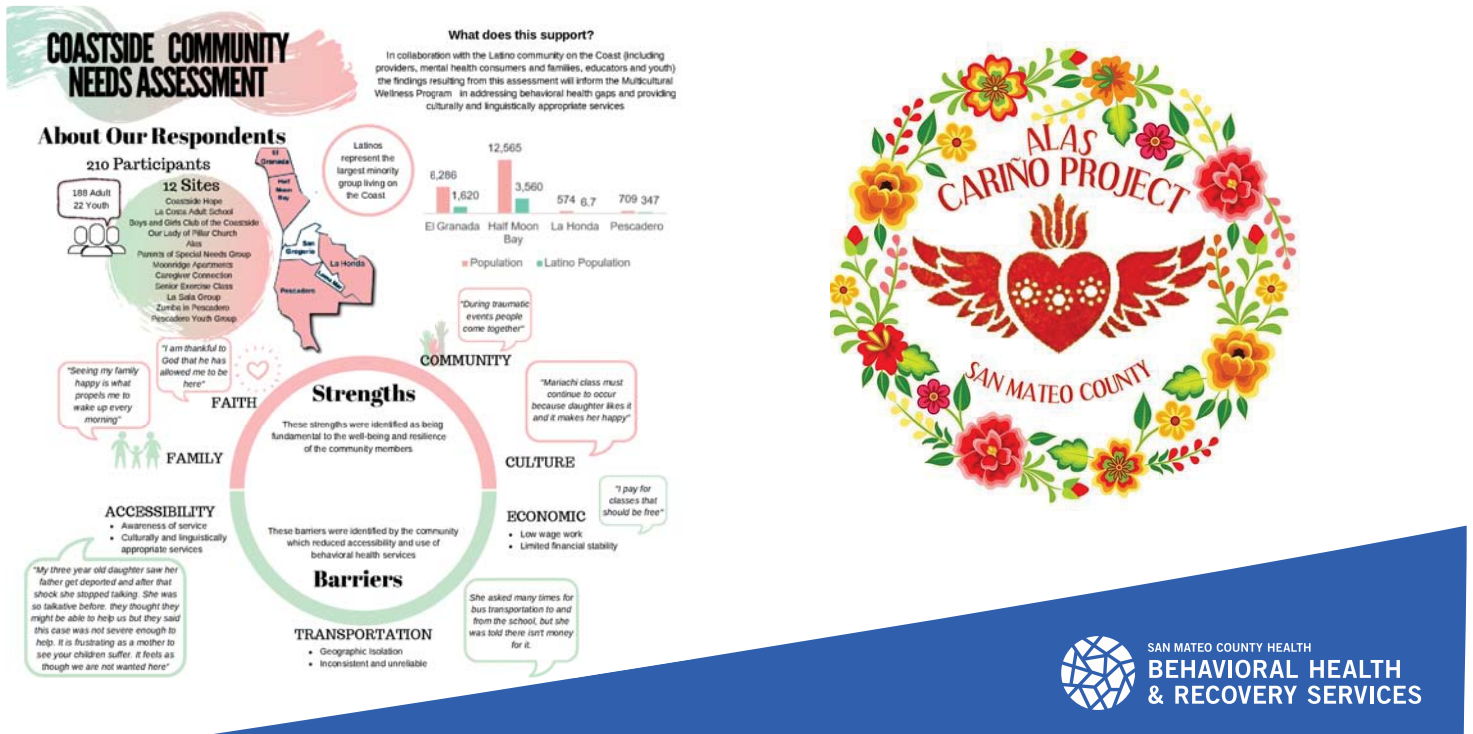
Update - Innovation Projects

Proposed Projects*	Status
Addiction Medicine Fellowship	Not approved – 9/24/20
Prevention and Early Intervention Services in Low-Income Housing	To be determined – 10/26/20
PIONEERS - Native Hawaiian and Pacific Islander (NHPI) youth mental health	To be determined – 10/26/20
Older Adult Homelessness Prevention and Economic Stress	Withdrawn – 7/8/20
Social Enterprise Cultural and Wellness Café for Filipino/a/x youth	APPROVED – 8/27/20 RFP to release soon

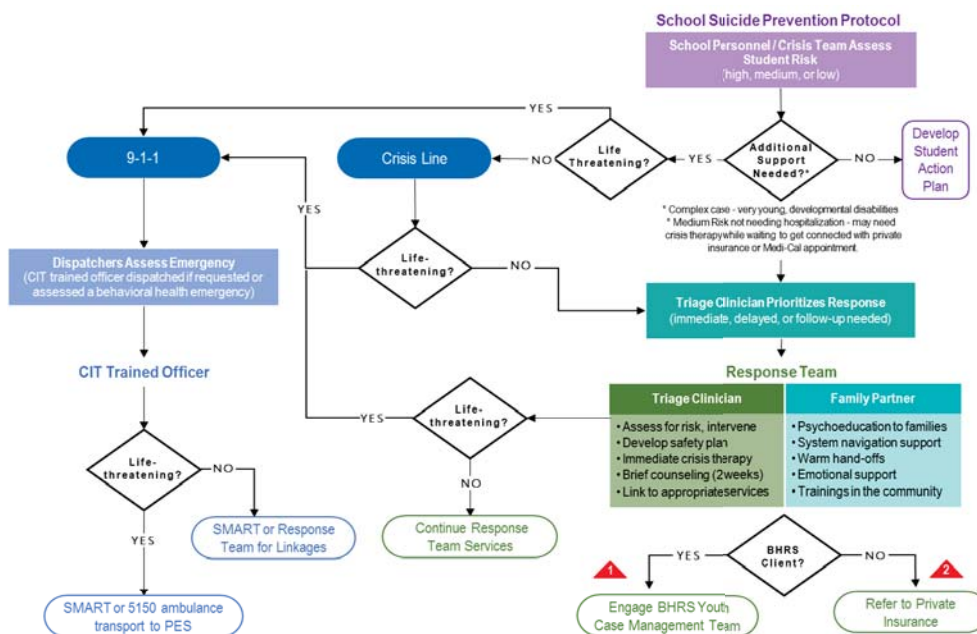
**all project proposals were submitted to the State Mental Health Services Oversight and Accountability Commission February 2020*



Update – Coastside Multicultural Wellness Program



Update - Youth Crisis Strategy Development

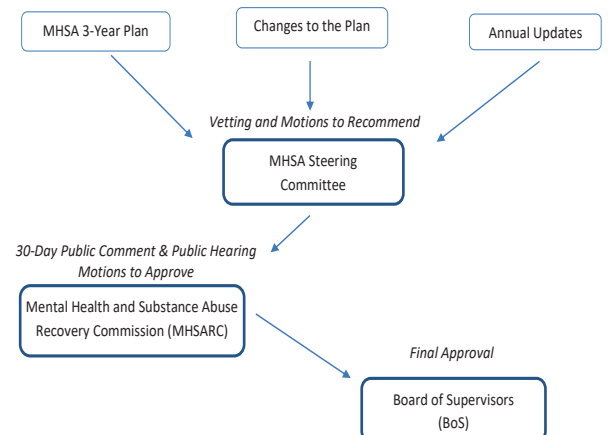


Questions?



MHSA Steering Committee Restructure

- MHSA legislation - role of local mental health boards
- Currently:
 - All MHSARC commissioners are MHSA Steering Committee members
 - Change to minimum 1 MHSARC commissioner to serve as liaison to the MHSARC
 - MHSA Steering Committee meets twice a year
 - Change to four times a year





Questions?



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Motions

- MHSARC Steering Committee:
 - “Motion to recommend the restructure of the MHSARC Steering Committee to include a minimum of 1 MHSARC commissioner (instead of all MHSARC commissioners) to serve on the MHSARC Steering Committee.”
- MHSARC commissioners:
 - “Motion to vote to approve the restructure of the MHSARC Steering Committee to include a minimum of 1 MHSARC commissioner (instead of all MHSARC commissioners) to serve on the MHSARC Steering Committee.”



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MHSA Planning: How to Get Involved

- **Subscribe at MHSA website**
www.smchealth.org/MHSA
- **Attend standing committees**
 - <https://www.smchealth.org/get-involved>
 - MHSARC Committees (Adult, Older Adult, Youth)
 - Housing Operations and Planning
 - Health Equity Initiatives & Diversity and Equity Council
 - Lived Experience Education Workgroup
 - Suicide Prevention Committee and more!



Thank you!

Doris Estremera, MHSA Manager

mhsa@smchealth.org

smchealth.org/MHSA

https://www.surveymonkey.com/r/MHSA_MtgFeedback



SAN MATEO COUNTY HEALTH
**BEHAVIORAL HEALTH
& RECOVERY SERVICES**



Mental Health Services Act (MHSA) Steering Committee Meeting Three-Year Plan Strategy Prioritization

<https://2020victory.zoom.us/j/99517137157?pwd=Vm4yUXVoMHlCNy9Zc24vSkNvSUR4dz09>
#success

Wednesday, October 7, 2020 / 4:00 – 5:30 PM
Zoom Meeting: <https://us02web.zoom.us/j/81395582235>
Dial in: +1 669 900 6833 / Webinar ID: 813 9558 2235
iPhone one-tap: +16699006833,,81395582235#

MINUTES

1. **Welcome, Logistics & Agenda Review** 10 min
 - Promoting steering committee members to panelists
 - Stipends for MHSA portion of the meeting, please stay after so we can collect your information
 - Distribution of demographic survey, link dropped in the chat
 - Meeting is being recorded, we will keep our eyes on the chat, write down questions so we can capture them

2. **MHSA Overview & Updates** 50 min
 - Mental health services act 1% tax on personal income over one million dollars and it is a dedicated revenue source to transform how we do our work in BHRS
 - \$30.7 million averaged in the last 5 years
 - Majority goes to direct treatment, also dedicate a portion of prevention of early intervention and innovation
 - Revenue projections and reserve
 - Scott Gruendl
 - Folks were confusing total BHRS budget with MHSA; MHSA is about 12% of our funding and it has been a consistent revenue source
 - MHSA is categorical and that acts as a protection and there are minimal limits and protect the revenue to protect funds to be spent in a way voters have agreed with
 - Tax revenues are volatile, and have a tendency to have variations
 - In the current year we are expecting a small drop in revenue in the Fiscal Year (FY) 22-23 we are expecting revenue to drop.



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- We have a spike in FY 20-21, because tax collection was pushed back to July, including for millionaires. It looks like there is a spike in revenues when it is money that would have been collected in FY 19-20.
 - FY 22-23 there is a projected \$5 million gap, the difference between projected \$27 million revenue and \$32 million in expenditures.
 - We have about a \$9 million increase in the reserve, because of the way revenue has been spent, even with the \$5 million expected gap.
 - We have not projected out past FY 22-23, more to come and hopefully things begin to recover, the tax is retrospective is back on the year that has occurred. We will live with the impacts of COVID 19 for a while, even as economy improves.
- Questions
- Stephanie: Is it such a dip because millionaires are making less or out of work, how are they affected by COVID.
 - Answer: We do not know the answer to that immediately. This is revenue on individual tax payers so, the current projection is that millionaires will be impacted.
 - Jean: I don't fully understand the dip in revenues for the FY 22-23, why isn't that in the FY 21-22 year with people being out of work. Why is the revenues almost sustained but then crashes?
 - Answer: Delay in the collection of taxes. There is this false spike then there looks like there is a decline in FY 21-22 which should have looked like a steady source. There are also adjustments made with a 2-year lag. In FY 19-20 there was better economic growth than projected, so the adjustment is seen in FY 21-22.
 - Randall: Mild to moderate will no longer be served, has that been integrated into these calculations and the lowering of cost of providing services. Has that been integrated in what we have looked at and use of prevention and early intervention?
 - Answer: Mild to moderate and de-delegation to the health plan would not affect MHSA revenues. Prevention and Early intervention occur on a community level and to community-based organizations serving mild to moderate patients. No direct line from mild to moderate and MHSA. In our budget, we were spending more on mild to moderate than we were earning, so that loss will no longer be on the books.
 - Questions from chat – for the increased revenue years, why we don't we carry over the surplus?
 - Answer: That is exactly what we are doing with the surplus.



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BEHAVIORAL HEALTH & RECOVERY SERVICES

- Lana: Pie chart in the initial slide, what is in the “other” category in the budget?
- Answer: It is a number of things, mostly grants like whole person care. Still funds a number positions today.
- Randall: Wanted to make a comment regarding the idea that was discussed in town meeting about the budget. Some confusion about the entire system and the MHSA. We see that MHSA is about 12%. One of the great things about that funding, not only can it be changed quickly, we have various categories that funding can be directed to and with more flexibility. That’s why participation is so important we have more say on how that money is spent as opposed to the entire budget.
- Answer: MHSA was set up to be stakeholder driven. It is intended to transform our mental health system. It is based on input from people and public and they have a lot of say in this part of this part of budget. The overall budget, there is a lot of say but, that primarily happens at the Board of Supervisor’s level. MHSA is a steady funding source even while volatile.
- We are one piece of the big picture, sometimes it seems that MHSA should be everything, but it is only a part of the big picture.
- Status on one-time spend plans
 - Doris Estremera
 - Update on the \$12.5 million three-year plan for one-time spending. We put it together with your input, we have marked items that are in progress. Some items have been delayed or not started such as capital facility projects due to COVID-19.
 - The other not started are programs that require a planning process and a bidding process, such as the trauma-informed systems and supported employment program.
 - For the \$5 million COVID-19 One-time Spend Plan...All in progress and we launched technology supports this month. We are training peer and family partners, so they feel equipped to support clients as distributing the devices, help them navigate through apps, doxy.me for appointments, etc. We hope devices start getting distributed by beginning of November.
 - Two projects have not started, alternative care sites, providing beds for individuals for those who test positive for COVID-19 and the hotel program. At that time unable to place clients in existing sites, for those with mental health conditions or substance use.
- Innovation projects
 - Submitted to the state in February. One approval and are moving forward with a Request for Proposal (RFP) on the social enterprise café, a



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BEHAVIORAL HEALTH & RECOVERY SERVICES

proposal for Filipinx community around culture and wellness as a protective factor for mental wellness.

- The Addiction Medicine Fellowship did not get approved, the reason cited was that it was not innovative enough. It's a tough one to take, and we are working to give feedback to State. It meets the legislation requirements as reviewed by the OAC staff but, not approved by the commissioners.
- Prevention early intervention services in low income housing and PIONEERS project we will find out soon if they are approved.
- Older adult prevention and economic stress project withdrew.
- Coastside Multi-Cultural Wellness Program
 - This project is from our last 3- year plan. It was delayed yet, a great example of a delay that led to something beautiful and amazing. We went back to the community and heard from folks themselves. Office of Diversity and Equity (ODE) staff, family partners and interns went into the community and asked what the need is, what are the barriers, the strengths. What would make this project meaningful?
 - ALAS is the organization that received the award and started the Cariño project providing mental health wellness and culture to the coastside region, you can see the ribbon cutting linked on the MHSA website.
- Youth Crisis Intervention Strategy
 - This project was also delayed, and it gave us time to integrate the project better and we brought it to the MHSARC Youth Committee to work through it.
 - It is about intervening before a crisis becomes life threatening and law enforcement is involved to minimize trauma. The response team involves a clinician and family partner (no law enforcement).
 - This flowchart shows all that we had to consider, County Office of Education participated and connected what happens at the schools
 - Ziomara Ochoa- Deputy Director: for the youth crisis response program another initiative that has come though the state is FURS, that was passed in July and it requires emergency response program for foster youth or former foster youth. It is a collaboration with child welfare, juvenile detention, and behavioral health. The State mandate is part of a continuum of care reform, looking to sustain foster care in placement. Help bring response and support to foster care families in that moment to prevent them from going to another foster home or residential program
 - We will merge these two efforts together the crisis response and FURS requirement
 - Questions:



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BEHAVIORAL HEALTH & RECOVERY SERVICES

- Do MHSA funds, pay for peer and family worker positions and salary? Will peer workers be provided tablets to use?
- Answer: MHSA funds 19-20 peer workers across the BHRS system. The tablets will be at sites if Peer Staff need tablets that's something that can go to IT. We can follow up on this, if its for the clients we will make it happen.
- How many tablets have been given to clients? How are they distributed?
- Answer: Will be distributing in November. Tablets are prioritized for onsite locations, they go to residential places like board and cares. The phones will go to clients so it's the clinicians and family partners that will let us know. If client cannot access a phone or data plan to participate in services, they qualify.
- What happens to the funds for the addiction medicine fellowship?
- Answer: It needs to be allocated or we will lose the funding in 3 years. The money will roll into the next project that gets approved. If we are at risk for reversion, we will plan again for new projects.
- Can you tell me how much focus was on young children in the youth crisis strategy development? For example 5-11?
- Answer: Cover all the age ranges 0-18. Whoever is in these rolls will have the knowledge to serve youth with the various age ranges. One of the goals is to respond to the school needs which include young children.
- Is there any movement in creating ER beds for children 12 years old?
- Answer: Not in the budget currently. If we had to, we would contract at that time
- When is the older adult project delayed until? Why are there no youth peer support workers in the youth crisis?
- Answer: There are youth peer support workers in the youth crisis strategy. Older adult services not ready to take on the project and will keep you all posted.
- With COVID increasing mild to moderate mental health in just about everybody, I wonder if not focusing on this population is a good idea? Where do they go now?
- Answer: Our prevention and early intervention is generally population focused, especially individuals that may not engage in mental health treatment. We rely on community-based organizations so you may be outreached to our services and not know it. Capture folks not identified as mild to moderate or SMI.



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- Randall: Could you go back to the flow chart slide? Having had some good experience with mental health, child protective services. I would like leadership and everyone else involved to look at the idea for the part of this chart that says life threatening? As far as children are concerned everything is life threatening. Please expand the definition of life threatening. Reduce symptomologies that will require an action.
- Answer: We appreciate that feedback. One thing to highlight, but part of the action is the response to the crisis line worker that would then escalate the situation. Every concern should be considered as urgent. There will be a flow chart of how it will be addressed. We will continue to work on it as far as what the flow would be.

3. MHSAs Steering Committee Restructure

15 min

- Motion to implement new structure
 - The MHSAs legislation requires that commissioners review the MHSAs three-year plan, annual update and any changes made to program and expenditures as part of the plan and provide input.
 - What is not in the legislation how we structure the community input, even this steering committee.
 - We need more time; MHSAs meetings feel very rushed and we've heard from stakeholders that things are going over their head and we cover too much information.
 - We would want to do a motion to not require all MHSARC commissioners to be on the steering committee.
 - Separate out the MHSAs steering committee from the commission, the commission would send liaisons to participate in the MHSAs steering committee. That commissioner will report on MHSAs to the rest of the Commission.
 - The MHSAs Steering Committee would vet and spend more time with issues/recommendations, make a motion to the commission then the liaison bring it to the commission for a vote
 - We could hold more than 2 meetings per year where we could do quarterly basis
 - Questions/comments:
 - Full support for meeting 4 times per year, 2 meetings per year is not enough
 - Increase minimum to 2 MHSARC liaisons instead of a minimum of 1
 - All commissioners need to be at the Steering Committee, having 2 or 3 commissioners is a disservice to the people of San Mateo County, minimally a quorum should be met at steering committee meetings



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BEHAVIORAL HEALTH & RECOVERY SERVICES

- As many commissioners can go if they wish
- We will not make a motion now; the commission will vote at the next meeting

4. MHSA Planning - How to Get Involved

10 min

- Moving forward when MHSA needs more of a planning process, we are going to leverage our planning committees
- Subscribe to the MHSA website
- Attend standing committees that take on a project
- MHSA steering committee feedback survey

5. Adjourn

*** Public Participation:** All members of the public can offer comment at this public meeting. During the meeting, participants will be muted and share screen and chat will be disabled to prevent background noise and disruptions. The host(s) will unmute one participant at a time during the Q&A and Public Comment portions of the meeting. If you would like to speak, please click on the icon labeled “Participants” at the bottom center of the Zoom screen then click on “Raise Hand.” The host(s) will unmute you in the order in which the hand raise notification is received. Please limit your question/comments to 1-2 minutes, the host(s) will be monitoring the time. The meeting will be recorded.

Questions and public comments can also be submitted via email to mhsa@smcgov.org.

***REMINDER – Please Complete the Steering Committee Feedback Survey**

https://www.surveymonkey.com/r/MHSA_MtgFeedback





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**BEHAVIORAL HEALTH
& RECOVERY SERVICES**

ATTENDANCE

There were up to 47 participants (at 5:38pm) logged in to the Zoom app; below is a list of attendee names as recorded from Zoom, some call-in numbers and names were unidentifiable.

MHSA Steering Committee

1. Adriana Furuzawa
2. Carolyn Herron
3. Cherry Leung (MHSARC)
4. Chris Rasmussen
5. Supervisor Dave Pine (MHSARC)/
Randy Torrijos (Staff to Dave Pine)
6. Don Mattei
7. Jean Perry (MHSARC)
8. Juliana Fuerbringer
9. Kava Tulua
10. Leti Bido (MHSARC)
11. Maria Lorente-Foresti
12. Mark Duri (MHSARC)
13. Michael Lim
14. Mike Krechevsky
15. Pat Way (MHSARC)
16. Sheila Brar (MHSARC)
17. Stephanie Morales
18. Michelle Platte
19. Yoko Ng

Community Participants

1. Greg Thompson
2. Vincent Osar
3. Bendan VORSM
4. Gina Beltramo
5. Tiana Wilson
6. #1 NAMI
7. Julie Marquez
8. Shannon Stockwell
9. Martin Fox
10. Evan Milburn
11. Lanajean Vecchione
12. Anna Marie VORSMC
13. Shaziana Ali

Staff & Supports

- Doris Estremera (MHSA Manager, Host)
Scott Gruendl, BHRS Director
Chantae Rochester, Executive Assistant
Tania Perez (MHSA Support, Co-Host)

Other BHRS Staff

1. Claudia Saggese
2. Ziomara Rodriguez

14. Ronald VORSMC
15. Veronica
16. Randall Fox
17. Carolyn Shepard
18. Voices of Recovery San Mateo County
19. Dominic DiMenna
20. Yraes VORSMC
21. Patricia Pepa
22. Chelsea Bonini
23. Jackie
24. John Butler



Be the one to help



Mental Health Service Act (MHSA) NEW MHSA Steering Committee Kick-Off

Open to the public! Join advocates, providers, clients and family members to provide input on MHSA planning.

The MHSA Steering Committee meets the first Thursday at 3pm in February, May, September and December to provide input, make recommendations and stay up-to-date on new MHSA developments and ongoing programming.

Meeting objectives include:

- Orientation to MHSA and goal setting for 2021 MHSA meetings.
- Provide input on the use of MHSA funds to support ongoing programs.
- Learn how to get involved in program planning.

- ✓ Stipends are available for clients/family members
- ✓ Language interpretation is provided if needed*

*Please contact Tania Perez at ts Perez@smc gov.org at least 2 week in advance to reserve language services.

DATE & TIME

Thursday, February 4, 2021

3:00 pm – 4:30 pm

Zoom Meeting:

<https://us02web.zoom.us/j/83216209789>

Dial in: +1 669 900 6833

Meeting ID: 832 1620 9789

iPhone one-tap: +16699006833,,83216209789#

Contact:

Doris Estremera, MHSA Manager

(650) 573-2889 ♦

mhsa@smc gov.org

www.smchealth.org/MHSA



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BEHAVIORAL HEALTH & RECOVERY SERVICES

The Mental Health Services Act (MHSA) provides a dedicated source of funding in California for mental health services by imposing a 1% tax on personal income over \$1 million.



Mental Health Services Act (MHSA)
Steering Committee Meeting

February 4, 2021



Before we begin...

- Stipends for clients and family members participating
 - Please remain online after the meeting ends
- Meeting is being recorded
- Participants are muted and share screen are disabled
- Participation
 - Please enter your questions in the chat box; I will address those first
 - “Raise Hand” button
 - Host will unmute one participant at a time
- Quick Poll

Agenda

1. MHSA Orientation
2. MHSA Fiscal Updates
3. Goal Setting
4. Announcements





1. MHSA Orientation




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MHSA Components

76%  **Community Services & Supports (CSS)**
Direct treatment and recovery services for serious mental illness or serious emotional disturbance

19%  **Prevention & Early Intervention (PEI)**
Interventions prior to the onset of mental illness and early onset of psychotic disorders

5%  **Innovation (INN)**
New approaches and community-driven best practices

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

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

1% tax on personal income over \$1 million
San Mateo County: \$30.7M annual 5-year average through FY 19-20

MHSA Planning

• Community Program Planning (CPP) Process

- Three-Year Plan
 - Existing program priorities
 - Priority Expansions
 - Expenditure Projections
- Annual Updates
 - Data and outcomes for each program
 - Adjustments to the Three-Year Plan

Example: FY 17/18 Priority Expansion

Component	Updated Priority Expansions **	Estimated Cost Per Fiscal Year
Prevention & Early Intervention	Expansion of Stigma Free San Mateo, Suicide Prevention and Student Mental Health efforts*	\$50,000
	Youth mental health crisis support and prevention**	\$600,000
	After-care services for early psychosis treatment for reengagement, maintenance and family navigator support	\$230,000
TOTAL PEI		\$650,000

• Current Timeline

- Three-Year Plan Implementation: July 1, 2020 – June 30, 2023
- Annual Updates Due: June 30th each year
- Next Three-Year Planning Phase: January 2023 – April 2023
- Next Three-Year MHSA Plan Due: June 2023

MHSA Funding Principles

- Developed with stakeholders to guide annual funding allocations and expansions
 1. Maintain required % allocations
 2. Sustain and strengthen existing priorities
 3. Maximize revenue sources
 4. Utilize MHSA reserves to strategically mitigate impact to services
 5. Prioritize direct services to clients
 6. Maintain prevention efforts
 7. Sustain geographic, cultural, ethnic and linguistic equity
 8. Evaluate potential reductions and allocations



Current Three-Year Plan Priorities

Required Components	Required Categories	Local Plan Priorities	Funding Allocation (% of total revenue)
Community Services & Supports (CSS)	Full Service Partnerships (FSP)	Children & Youth Transition Age Youth Adult & Older Adults Housing Supports	76% 51% of the CSS allocation must fund FSP services
	General Systems Development (GSD)	Co-Occurring Integration Older Adult System of Care Child Welfare Integration Intellectually Disabled Peer/Family Partners Supports Crisis Intervention/Stabilization Infrastructure Strategies	
	Outreach and Engagement (O&E)	N/A	
Prevention & Early Intervention (PEI)	Early Intervention	Early Psychosis Primary Care Interventions Crisis Response	19% 51% of the PEI allocation must fund services for ages 0-25
	Prevention	Trauma Informed Systems Community Interventions for School Community Capacity Building	
	Recognition of Signs of Mental Illness	N/A	
	Stigma and Discrimination Reduction	N/A	
	Access and Linkages	N/A	
Innovations (INN)	N/A; requires approval by the State	Priority needs identified by the 3-Year Plan	5%

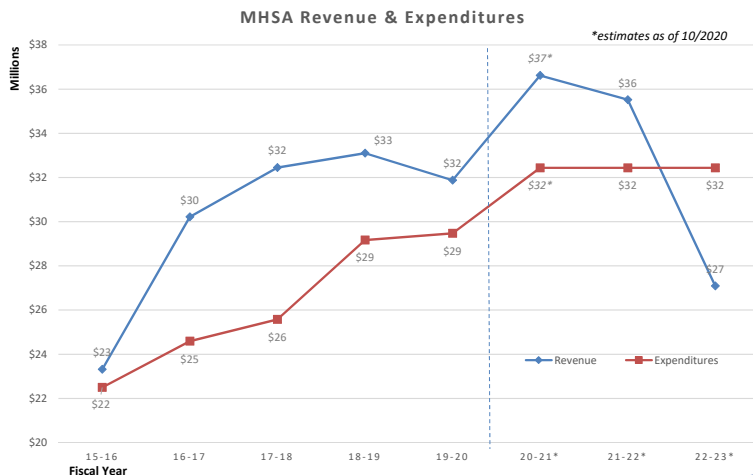


2. Fiscal Updates

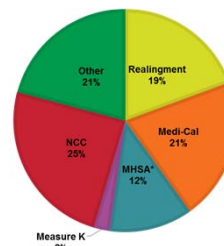


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MHSA Revenue Projections



BHRS FY 19-20 Revenue



3. Goal Setting



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MHSA Steering Committee Role

- The MHSA Steering Committee
 1. Makes recommendations to the planning and program development process
 2. Assures that MHSA CPP process reflects local diverse needs and priorities



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INPUT: How do we accomplish this role? What venues + topics?

1. Makes recommendations to the planning and services development process.

Currently:

- Planning committees/taskforce
 - Examples: PEI Taskforce, Youth S.O.S. Team, Housing Initiative Taskforce, INN selection committee
- Input via the MHSA Steering Committee meetings
 - Examples: Issue Resolution Process, Innovation Projects, Funding Principles, Program Presentations)



INPUT: How do we accomplish this role? What venues + topics?

2. Assures that MHSA CPP process reflects local diverse needs and priorities

Currently:

- Diverse membership requirements + selection committee
- Input on the Three-Year Planning Framework + input into all phases
- Prioritization vote on strategies for funding



Next Steps

- Synthesize all input and propose an MHSA Steering Committee Engagement Plan
- Next Meeting - May 6, 2021
 - Annual Update
 - Input on MHSA budget
 - Housing Initiative Outcomes



4. Announcements

- **New Innovation Projects**
- **Join the MHSA Steering Committee:**
www.smchealth.org/MHSA
- **Housing Initiative (March, April, May)**
 - 1st Wed of the month, 10:30am – 12:00pm
- **Subscribe at MHSA website to stay informed:**
www.smchealth.org/MHSA
- **Attend standing committees**
 - <https://www.smchealth.org/get-involved>



Thank you!

Doris Estremera, MHSA Manager

mhsa@smchealth.org

smchealth.org/MHSA

https://www.surveymonkey.com/r/MHSA_MtgFeedback



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Mental Health Services Act (MHSA) Steering Committee Meeting

Thursday, February 4, 2021 / 3:00 – 4:30 PM

MINUTES

1. Welcome, Logistics & Agenda Review

15 min

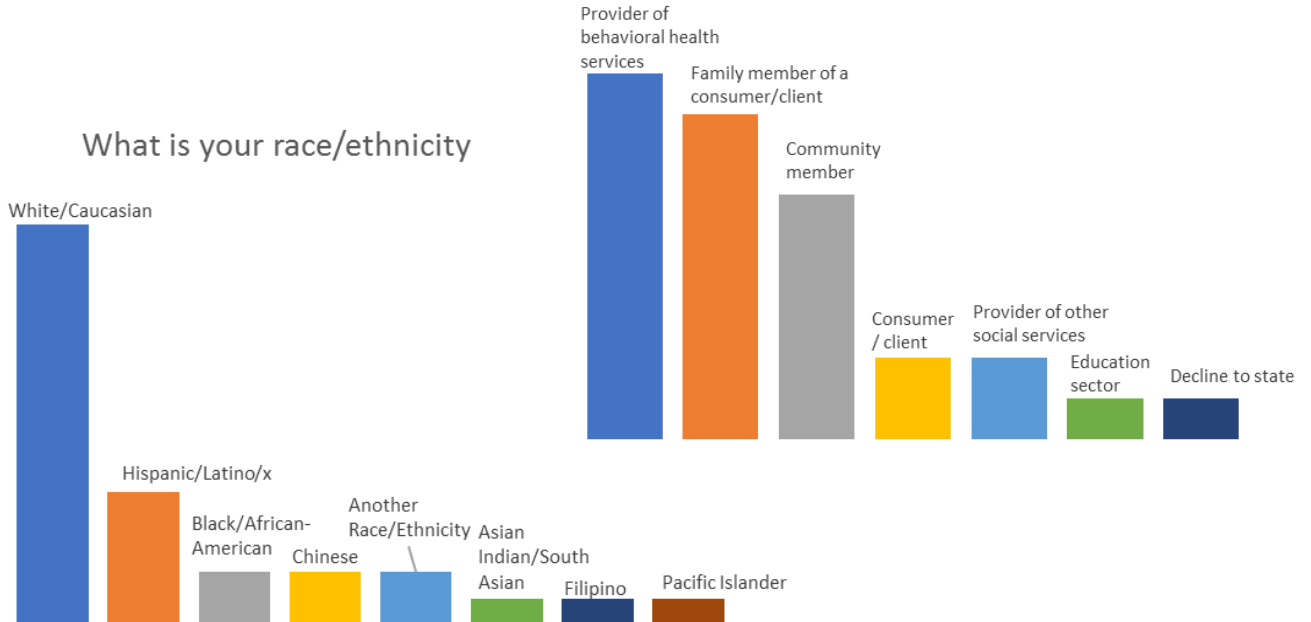
- Stipends for MHSA portion of the meeting, please stay after so we can collect your information
- Meeting is being recorded
- Participation: muted, share screen disabled, we will keep our eyes on the chat, send questions so we can capture them
- Polls: demographics and MHSA interests (attached)

What is your age range?	
26-59	55%
60+	45%

What part of the county do you live in OR work in?	
Central County	31%
County-wide	21%
East Palo Alto/Bell Haven	10%
North County	10%
South County	28%

What is your gender identity?	
Female/Woman	72%
Male/Man	24%
Gender Non-Conforming	0%

What stakeholder group do you represent?





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2. MHSA Orientation

- We will not spend as much time as I typically do on a new-member orientation but, we will do a high-level review of MHSA since this is our first meeting outside of the MHSARC commission.
- The full orientation packet is available on the MHSA website under materials for this meeting today.
- What is MHSA?
 - MHSA imposes a 1% tax on personal income over \$1M
 - Dedicated source of revenue to transform our system
 - Has averaged \$37M in the previous 5 years for SMC
 - Grew out of grassroots efforts to address a statewide issue from closing of state hospitals
 - CSS: 76% to direct treatment and services for SMI/SED (51% to FSP)
 - PEI: 19% for programs prior to the onset of MI, with the exception of early psychosis
 - INN: 5% is our opportunity to try things that we wouldn't otherwise because we don't know if it will work.
 - WET and CFTN do not get automatic allocation but, we can designate CSS monies (up to 20%) to these components. In SMC, we have an ongoing allocation to WET annually.
- MHSA Planning requirements
 - Community Program Planning Process to develop Three Year Plans and Annual Updates
 - Three-Year Plans build off of existing program priorities, set priorities for expansion, and provides revenue and expenditure projections
 - This past three-year plan we did not include any increased expenditures; we will be including new expenditures in the Annual Update now that we know COVID led to increased revenues due to millionaires increased income
- MHSA Funding Principles
 - Developed with stakeholders to guide annual funding allocations and expansions and will guide us moving forward with new COVID-related increased revenues
- Current Three-Year Plan Priorities
 - Each component (CSS, PEI and INN) have required categories per the MHSA legislation and under each category we have local priorities.
 - For example, CSS has required categories of Full Service Partnerships (FSP), General Systems Development (GSD) and Outreach and Engagement (O&E). Our local priorities under GSD include Co-Occurring Integration, Older Adult System of Care, Peer/Family Partners Supports, Crisis Intervention among others.



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- And, under each local priority we have the programs we are funding. In San Mateo County we fund well over 60 programs.
- **Questions/Public Comment**
 - Is supportive housing considered a direct services? Yes, it is under the CSS component.
 - With respect to allocation of funds, does steering committee have a voice in not only directing funds to FSP, but to acting on determinations that there are more people needing FSP than can receive FSP, due to budget? Yes, the MHSA Steering Committee votes across various priorities brought forward by stakeholders (including increasing FSP supports). Now, having said that... FSP is required to have at least 51% of the CSS funding so, as we increase housing supports (for example, which is our current priority in the Three-Year Plan) we will have to increase FSP. And of course, PEI.
 - Where is the Steering Committee's role in saying, this core service is an important priority AND also having input into moving money? Programs have ongoing reporting, evaluation and annual outcome data, a BHRS manager monitors these programs throughout the year. At times there are requests to reduce or increase funds to a program based on this ongoing process... we bring those requests to the MHSA planning process. For example, the Seeking Safety program (an evidence-based program) ...we were receiving feedback from providers and the youth that this no longer was a good match, based on the strictness of the implementation and the fact that our population wanted something more flexible, based on their current needs. We were able to pilot the Mindfulness-based Substance Abuse Treatment (MBSAT) program with youth and conducted focus groups, which led to the Trauma-Informed Co-Occurring Services for Youth RFP and allowed for more flexibility in proposing other culturally responsive curriculums for youth. It would be great to get to the place where you can hear about the programs because decisions to move monies from one program to another should be more than just a Steering Committee deciding we should do it. It would require looking at the data, outcomes, target community feedback and evaluation.
 - What is defined as "prevention"? Is this about having clients get to where they no longer need to have sessions with a mental health specialist/psychiatrist/psychologist? What is it that we are preventing? Prevention and Early Intervention is prior to onset of mental illness, with the exception of early psychosis. It requires we understand what leads to mental illness or where there are disparities among communities. One key expectations is that prevention leads to linkages for individuals that may need mental health supports.



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Prevention also uses a public health model in looking at the social determinants of bad health outcomes (the root causes of bad health outcomes) and focuses on skills building and connecting individuals to resources.

- Do you know when an RFP for Supported Employment will open up? At any point we are moving forward three to four programs and we often have to prioritize due to capacity. Supported Employment will move forward as soon as we can wrap up the Youth S.O.S. project and the Housing Initiative.
- There was nothing on your chart listed in "innovations". Are there innovations projects being funded or considered? Yes, the chart does not include programs. There are many programs under each local priority listed on the chart. We are currently wrapping up the Pride Center and are mid-way through the Help@Hand project. We also have three new Innovation Projects launching, the Social Enterprise Cafe, the PIONEERS program and PEI in low-income housing.
- When selecting plans or programs, it would be useful to know relative costs, how many people served. Can we do that? Yes, let's parking lot this item. A little later we will be discussing the MHSA Steering Committee structure, members' interests and goals. How can we provide this level of data (in what format) so that as a member you feel that you can provide meaningful input.
- There are requests to establish a non-law enforcement option for mental health crises from community members and local city councils. In response to last year's police reform and racial inequity protests, Santa Clara County MHSA added an innovation project to create a non-law enforcement team called community mobile response (like CAHOOTS in Oregon). Is there an opportunity to propose this for San Mateo County? We have been working on the Youth S.O.S. Team via the MHSARC Youth Committee. This was a priority that came through the MHSA planning process and a Taskforce that was brought together in 2017-18. Yes, there is always opportunity to bring priorities like this through the MHSA planning process. In terms of the current non-BHRS initiated efforts to develop law enforcement and clinician teams to respond to crisis, please stay connected to the MHSARC public meetings. Public comments can be provided at those meeting regarding that effort.

3. MHSA Fiscal Updates

- Fall 2020 projections showed an estimated decrease in revenue. As of this morning, we have received updated fiscal projections for MHSA. I don't have an updated chart yet, with the San Mateo County specific revenue numbers because our fiscal team will be doing this analysis. The impact of



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COVID was primarily to working class and millionaires made more money. In March, we will have a better idea of adjustments and we will have an updated chart by then.

- **Questions/Public Comments**

- My understanding is that our oversight is beyond SMI; obviously PEI is prior to onset. But, now that mild-to-moderate clients are being served out of BHRS; we shouldn't lose sight. Our focus shouldn't just be clients with SMI diagnosis, our focus should be mental health wellness of our County. The whole three-year plan is focused on SMI, what do we do about mild-to-moderate. What are we going to do about these clients? Within the structure of MHSA are we losing sight of the whole population and the mental health challenge? Within MHSA we have been able to serve mild-to-moderate in culturally responsive projects such as the Cariño Project, Pride Center, Ravenswood, within the PEI regulations of short-term treatment and the understanding that if a client needs longer, more intensive supports then they should be linked to these services through BHRS.
- Comment: The degree of MI and Substance Use is a moving target. It is difficult for families to know when/where to access these services. This is very relevant during COVID as it has led to
- Comment: MHSA doesn't break down funding for mild-to-moderate, it is for a public mental health system. Mild-to-moderate and severe MI is a diagnosis and a moving target; MHSA does not eliminate this.
- Comment: In the past few weeks, I have not encountered culturally responsive message related to COVID. FSPs are at greater risk for hospitalization, morbidity, mortality and more likely to live in congregate settings (all risk factors that intersect with COVID-19 pandemic). Individuals living with serious mental illness are less like to receive preventative or guideline appropriate care nationwide. And this is reflected in low uptake of recommended immunization among adults with serious mental illness. For example, estimated flu vaccine uptake in 2019 for adults was 48% vs. 25% for adults with SMI in the same year. I would like to recommend that the MHSA Steering Committee leverage the existing Health Equity Initiatives and partnerships within the community to support and collaborate on either the distribution of and/or the creation of linguistically and culturally-relevant vaccine education materials so that they can be accessed by providers and



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members of the community as part of their outreach and capacity building activities.

- Chat Question: When you say "co-occurring" does that mean mental health + alcoholism + addictive substances? or alcoholism + drug addiction? or mental health + alcoholism or drugs separately?? Answer: Co-Occurring is mental health and substance use challenges.
- Chat Question: Is MHSF funds used to fund MHSSA activities? Response: State managed MHSF funds but, not local.

- **Goal Setting**
- The Steering Committee makes recommendations to the planning of services and programs. How do we accomplish this role? What information (topics) and structures/venues (subcommittees) would you like to see to feel that you can participate as an active member of the MHSF Steering Committee.
- Michael: Are we closed to 4 meetings per year or can we expand this? We can explore this as we move forward; there. I'd like to advocate for more meetings (every other month) because MHSF is so complicated and there is so much information.
- Jean: propose separate subcommittees that then report back to the larger MHSF Steering Committee. For example, having #'s – how many people are served and gaps in order to transition to a more independent level vs. number of slots. Critical piece to advancing and have appropriate service... we don't know how many people have the need/demand. I would like to have QIC show us numbers and with a smaller group.
- Melissa: having too many people (meetings are too large) that having intense dialogues. Gather smaller groups to feed into the larger groups. I'm open to more meeting but want them more narrow.
- Mary (chat comment): We also need to consider the capacity of staff. Holding extra meetings is a lot of extra work. I would love to gather outside of this body and not create more work for staff.
- Lanajean (chat comment): Public comment should be limited to two minutes only I agree.
- Melissa (chat comment): Completely agree, and yes, it would be helpful if we can do some of the work that the staff are currently tasked with.
- Randall: Commission (not just MHSF) should form adhoc committees on topics that they are interested in.
- Chris (chat comment): task force would be the right term, not ad hoc. Task forces would be great for smaller break out groups. The



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Basics of Board Committee Structure; A task force can be formed if there is an objective that can be achieved in a relatively short period of time. Planning a special event or analyzing a merger proposal are examples of work that can be handled by a task force.

- Linder: As a family member and interest in developing new opportunities for housing w/quality support...I would appreciate organizing the committee to maximize talents because we can't wait for the rest of our lives for things to change. Make committees of small groups, bringing that information back and making recommendations quickly.
 - Jairo: list of actions that the Steering Committee can participate in; do we have a priority of what we want to accomplish – yes, we will do that and this is part of why we are having this conversation.
 - How can we bring the MHSA information in a much more digestible way, approachable, easy to process – I'd like to bring more of the voices of our clients. Advocacy training will be provided (6 class academy) to encourage participation, how decision-making bodies work, getting engaged and participate more actively to transform the BHRS system and beyond.
 - Carol (chat comment): I would like to know what programs are ongoing so we don't overlap. And how are they doing.
- **Next Steps**
 - Will be synthesizing all input received and work with Jeans to propose an MHSA structure.
 - At the next meeting, I will be presenting an MHSA Annual Update as this is required by the legislation. It will be a high-level presentation on program outcomes and implementation highlights. We will be discussing funding and a proposed budget. And, we will be presenting on the Housing Initiative outcomes.

4. Announcements

- Post meeting feedback survey sent through the chat, results attached.
- If you are a client and/or a family member of a client and would like a stipend, please stick around and we will get your information
- This is Tania's last MHSA meeting as she is transitioning to a permanent position in Public Health Policy & Planning. Thank you, Tania, for all you have done for MHSA and especially PEI evaluation work.
- There will be a flyer coming out for the new MHSA Housing Initiative Taskforce, be on the lookout for that



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- Please go to the MHSa website and subscribe to get the latest information on MHSa

5. Adjourn

*** Public Participation:** All members of the public can offer comment at this public meeting. During the meeting, participants will be muted and share screen and chat will be disabled to prevent background noise and disruptions. If you would like to speak, please click on the icon labeled "Participants" at the bottom center of the Zoom screen then click on "Raise Hand." The host(s) will call on you to unmute yourself. Please limit your question/comments to 1-2 minutes, the host(s) will be monitoring the time.

The meeting will be recorded.

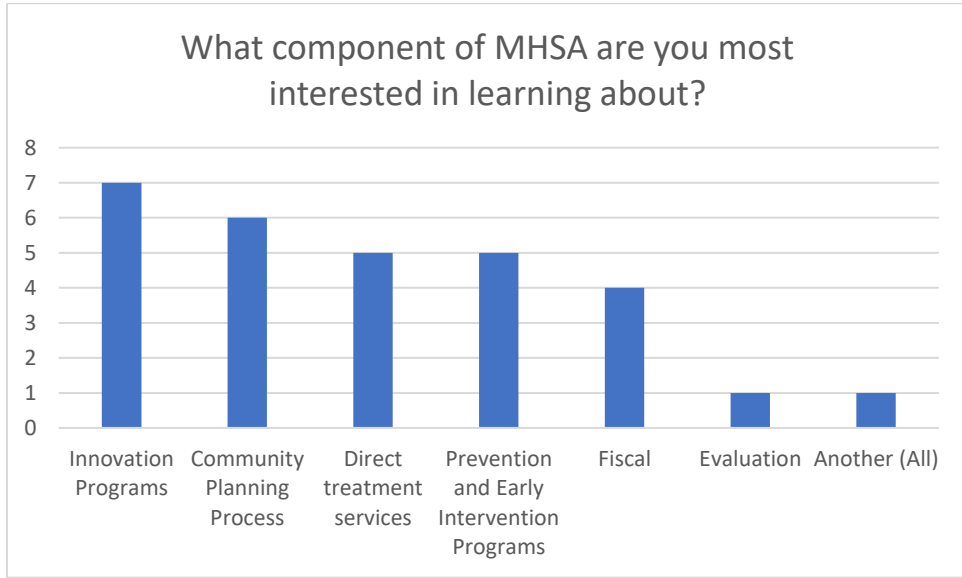
Questions and public comments can also be submitted via email to mhsa@smcgov.org.

***REMINDER – Please Complete the Steering Committee Feedback Survey**

https://www.surveymonkey.com/r/MHSA_MtgFeedback

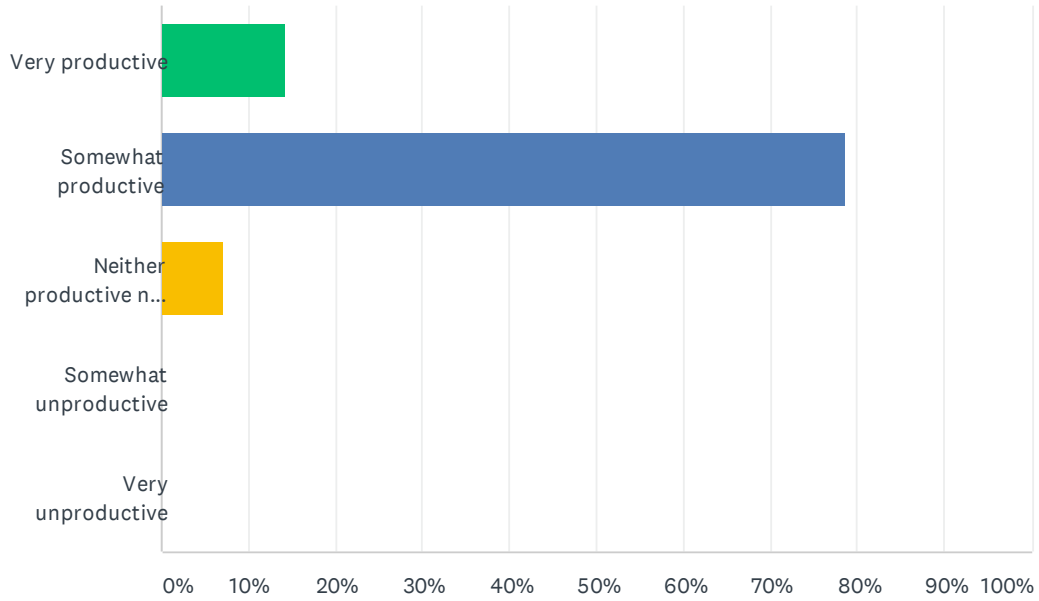


**MHSA Steering Committee – 2/4/21
Poll Results**



Q1 Overall, how productive do you think the meeting was?

Answered: 14 Skipped: 0



ANSWER CHOICES	RESPONSES	
Very productive	14.29%	2
Somewhat productive	78.57%	11
Neither productive nor unproductive	7.14%	1
Somewhat unproductive	0.00%	0
Very unproductive	0.00%	0
TOTAL		14

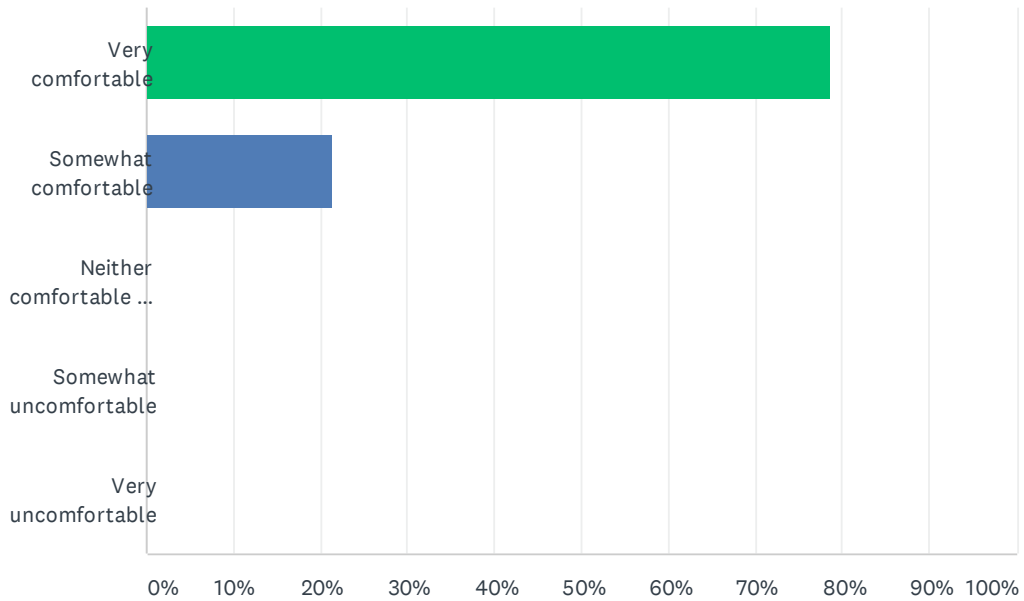
Q2 Please share with us why you feel that way about how productive the meeting was.

Answered: 13 Skipped: 1

#	RESPONSES	DATE
1	Sort of hard to follow and felt too high level.	2/4/2021 5:40 PM
2	attendees were able to ask questions re: their role, request information for decision making in the future, be introduced to each other, express how they want to be included in the processes. We still need to ask each member where they wish to focus and then combine those with similar passion.	2/4/2021 4:46 PM
3	Good initial meeting to reset, now that the SC is a BOS Subcommittee. Some discussion points, although important and relevant for participants, were outside of the scope of the steering committee/meeting.	2/4/2021 4:42 PM
4	It seemed to be an introductory meeting with no clear direction.	2/4/2021 4:42 PM
5	I'm afraid I might have misunderstood the structure of the meetings, and I made a somewhat awkward public comment--but everyone was very helpful!	2/4/2021 4:38 PM
6	Public commenting folks spoke too long too many times.	2/4/2021 4:35 PM
7	great to have more time aside from the commission meeting	2/4/2021 4:35 PM
8	There was a lot of discussion and ideas	2/4/2021 4:34 PM
9	While this is my first time attending the meeting, so I'm not sure what the standard protocol is. I felt like there were several interruptions and people giving their opinion, as opposed to staying focused on topics at hand.	2/4/2021 4:34 PM
10	Feedback was exchanged at the steering meeting today. There are more mini task force groups which can focus on certain topics among participants with different interest.	2/4/2021 4:32 PM
11	Too many comments that were, quite frankly, rude and out of place	2/4/2021 4:32 PM
12	I would have loved for Doris and Tania to have been able to complete their presentation rather than getting stuck on questions from folks and the process that folks wanted to have/not have for MHSA.	2/4/2021 4:32 PM
13	There needs to be more dialogue with participants.	2/4/2021 4:32 PM

Q3 How comfortable did you feel sharing your opinions in the meeting?

Answered: 14 Skipped: 0



ANSWER CHOICES	RESPONSES	
Very comfortable	78.57%	11
Somewhat comfortable	21.43%	3
Neither comfortable nor uncomfortable	0.00%	0
Somewhat uncomfortable	0.00%	0
Very uncomfortable	0.00%	0
TOTAL		14

Q4 Please share with us why you feel that way about sharing your opinions during the meeting.

Answered: 9 Skipped: 5

#	RESPONSES	DATE
1	I felt comfortable until one person shared her son and her would prefer if things move along faster and someone responded you have to understand this is how it is and you just have to persevere. When someone is living with it, we're tired of the status quo and something needs to change. Unfortunately we wait for a tragedy to happen for things to pick up. Otherwise it seemed very inviting!	2/4/2021 5:40 PM
2	Everyone was valued and treated with respect	2/4/2021 4:46 PM
3	Facilitators were very welcoming of everyone's contributions and comments.	2/4/2021 4:42 PM
4	I didn't have much to say because I was there to see what was happening.	2/4/2021 4:42 PM
5	People were quite helpful.	2/4/2021 4:38 PM
6	one guest was a little confrontational	2/4/2021 4:35 PM
7	It seems like everyone is open to having a dialogue and felt very comfortable.	2/4/2021 4:34 PM
8	Doris and Tania are very receptive giving all participants enough time to express their perspectives.	2/4/2021 4:32 PM
9	Doris and Tania made everyone feel welcome to voice their feedback.	2/4/2021 4:32 PM

Q5 Do you have any additional feedback for the organizer of the meeting?

Answered: 10 Skipped: 4

#	RESPONSES	DATE
1	I liked the idea someone mentioned about making it more digestible to the public, clients and family members.	2/4/2021 5:40 PM
2	I hope the survey can help group folks to work together in smaller groups on specific issues they are passionate about. It's hard to do a lot with huge group. Thank you for reviewing what MHSA is, what steering committee does, how we can bring the needs and wants from the community to a place where they will be addressed.	2/4/2021 4:46 PM
3	I	2/4/2021 4:42 PM
4	With \$30.7 million/year funding, how can two paid staff keep track of ongoing programs and prepare adequately for new ones? Focus groups and/or adhoc groups as I think Melissa Platte suggested would be very productive.	2/4/2021 4:42 PM
5	Only that a public comment portion in the beginning of the meeting might help keep discussion more streamlined later, and that I appreciate the warm welcome.	2/4/2021 4:38 PM
6	Good idea to break into some smaller task force groups with specific assignments	2/4/2021 4:35 PM
7	no	2/4/2021 4:34 PM
8	It is a productive meeting with a dense agenda.	2/4/2021 4:32 PM
9	Keep up the good work Doris and Tonia!!	2/4/2021 4:32 PM
10	Thank you Doris and Tania for all your great work. I hope more work doesn't get added to your plates. :))	2/4/2021 4:32 PM



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ATTENDANCE

There were up to 47 participants (at 5:38pm) logged in to the Zoom app; below is a list of attendee names as recorded from Zoom, some call-in numbers and names were unidentifiable.

MHSA Steering Committee

1. Adriana Furuzawa
2. Carolyn Herron
3. Cherry Leung (MHSARC)
4. Chris Rasmussen
5. Supervisor Dave Pine (MHSARC)/
Randy Torrijos (Staff to Dave Pine)
6. Don Mattei
7. Jean Perry (MHSARC)
8. Juliana Fuerbringer
9. Kava Tulua
10. Leti Bido (MHSARC)
11. Maria Lorente-Foresti
12. Mark Duri (MHSARC)
13. Michael Lim
14. Mike Krechevsky
15. Pat Way (MHSARC)
16. Sheila Brar (MHSARC)
17. Stephanie Morales
18. Michelle Platte
19. Yoko Ng

Community Participants

1. Greg Thompson
2. Vincent Osar
3. Bendan VORSM
4. Gina Beltramo
5. Tiana Wilson
6. #1 NAMI
7. Julie Marquez
8. Shannon Stockwell
9. Martin Fox
10. Evan Milburn
11. Lanajean Vecchione
12. Anna Marie VORSMC
13. Shaziana Ali

Staff & Supports

- Doris Estremera (MHSA Manager, Host)
Scott Gruendl, BHRS Director
Chantae Rochester, Executive Assistant
Tania Perez (MHSA Support, Co-Host)

Other BHRS Staff

1. Claudia Saggese
2. Ziomara Rodriguez

14. Ronald VORSMC
15. Veronica
16. Randall Fox
17. Carolyn Shepard
18. Voices of Recovery San Mateo County
19. Dominic DiMenna
20. Yraes VORSMC
21. Patricia Pepa
22. Chelsea Bonini
23. Jackie
24. John Butler



County of San Mateo

Inter-Departmental Correspondence

Department: HEALTH

File #: 21-086

Board Meeting Date: 1/26/2021

Special Notice / Hearing: None
Vote Required: Majority

To: Honorable Board of Supervisors

From: Louise F. Rogers, Chief, San Mateo County Health
Scott Gillman, Director, Behavioral Health and Recovery Services

Subject: Amendment to the Mental Health & Substance Abuse Recovery Commission Bylaws

RECOMMENDATION:

Adopt a resolution to amend the Mental Health & Substance Abuse Recovery Commission Bylaws.

BACKGROUND:

The Mental Health & Substance Abuse Recovery Commission (MHSARC) is mandated by the California Welfare and Institutions Code, Section 5604, to ensure citizen and professional involvement in planning processes regarding the behavioral health system of care. The MHSARC also advises your Board and the local Behavioral Health & Recovery Services (BHRS) Division Director regarding County behavioral health needs, services, special problems, and outcomes of mental health services. The MHSARC is required to have a set of bylaws by which they operate, and to submit an Annual Report to your Board.

DISCUSSION:

The MHSARC desires to amend its bylaws to reflect the addition of a Standing Committee for the Mental Health Services Act Steering Committee.

The Bylaws and resolution have been reviewed and approved by County Counsel as to form.

It is required by the California Welfare and Institutions Code that fifty percent (50%) of MHSARC members be consumers, or the parents, spouses, siblings, or adult children of consumers.

PERFORMANCE MEASURE:

Measure	FY 2020-21 Estimated	FY 2021-22 Projected
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Minimum percentage of MHSARC members who are consumers or the parents, spouses, siblings, or adult children of consumers (State criteria)	74% 14 of 19 members	74% 14 of 19 members
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FISCAL IMPACT:

Regular functions of the MHSARC are budgeted at a maximum of \$5,000, which is included in the BHRF FY 2020-21 Adopted Budget. These costs are 100% funded by Realignment. There is no associated Net County Cost.

RESOLUTION NO. 077970

BOARD OF SUPERVISORS, COUNTY OF SAN MATEO, STATE OF CALIFORNIA

* * * * *

**RESOLUTION TO AMEND THE MENTAL HEALTH & SUBSTANCE ABUSE
RECOVERY COMMISSION BYLAWS**

RESOLVED, by the Board of Supervisors of the County of San Mateo, State of California, that

WHEREAS, this Board has previously adopted a resolution, number 72299, specifying the responsibilities and membership of the Mental Health & Substance Abuse Recovery Commission (MHSARC) standing rules for its governance; and

WHEREAS, this Board now wishes to reflect the addition of a Standing Committee for the Mental Health Service Act Steering Committee; and

WHEREAS, Welfare and Institutions Code § 5604.5 provides that each local mental health board shall develop bylaws to be approved by the governing body which is defined as the Board of Supervisors; and

WHEREAS, the MHSARC desires to amend the bylaws to reflect the addition of a Standing Committee for the Mental Health Services Act Steering Committee; and

WHEREAS, the San Mateo County MHSARC has adopted the amended bylaws and this Board of Supervisors has been presented with a form of the amended bylaws and has examined it as to both form and content and desires to approve said

bylaws.

NOW THEREFORE, IT IS HEREBY DETERMINED AND ORDERED that the amended bylaws approved by the San Mateo County MHSARC is hereby approved.

* * * * *

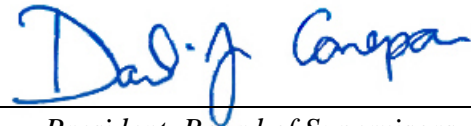
Regularly passed and adopted this 26th day of January, 2021

AYES and in favor of said resolution:

Supervisors: _____ *DAVE PINE*
_____ *CAROLE GROOM*
_____ *DON HORSLEY*
_____ *WARREN SLOCUM*
_____ *DAVID J. CANEPA*

NOES and against said resolution:

Supervisors: _____ *NONE*



*President, Board of Supervisors
County of San Mateo
State of California*

Certificate of Delivery

I certify that a copy of the original resolution filed in the Office of the Clerk of the Board of Supervisors of San Mateo County has been delivered to the President of the Board of Supervisors.



Assistant Clerk of the Board of Supervisors



MENTAL HEALTH AND SUBSTANCE ABUSE RECOVERY COMMISSION

Bylaws

December 21, 2020



SAN MATEO COUNTY HEALTH

**BEHAVIORAL HEALTH
& RECOVERY SERVICES**

MENTAL HEALTH AND SUBSTANCE ABUSE RECOVERY COMMISSION BYLAWS

PREAMBLE

The Mental Health & Substance Abuse Recovery Commission is committed to the goals of promoting wellness and recovery, enhancing public awareness and knowledge of mental illness and substance abuse disorders and eliminating stigma.

These bylaws have been amended to reflect the addition of a Standing Committee for the Mental Health Services Act Steering Committee.

ARTICLE I MEMBERSHIP

- a. Members are expected to attend all meetings of the Commission. A member who is unable attend a given meeting shall give advance notice of his/her inability to attend either to the Commission Chairperson or the administration office of the County Behavioral Health & Recovery Services Division.
- b. In the event a member misses more than three (3) Commission meetings in a 12-mnth period the Executive Committee will review with the member his/her ability to serve on the Mental Health Substance Abuse & Recovery Commission. If after efforts to achieve compliance are unsuccessful and a member does not maintain consistent participation in Commission activities, the member will be deemed to have automatically resigned and the Board of Supervisors will be advised of the vacancy. A member may be granted a one-time leave of absence, not to exceed three (3) months, for a serious illness; to care for a spouse, child or significant other who has a serious illness; to attend school; or for another reason deemed sufficient by the members of the Executive Committee.
- c. All members should serve on at least one committee of the Commission and shall participate in the activities of the Commission, including ad hoc committees and community outreach and engagement opportunities, as their other obligations permit.

Section 1.2 Resignation or termination

In the event that a member resigns or becomes ineligible to remain on the Mental Health & Substance Abuse Recovery Commission, it will be noted in the minutes of the next scheduled Commission meeting. The chairperson shall apprise the Supervisor, who is a member of the Commission, of the member's resignation or termination.

Section 1.3 Membership and composition

- a. The Mental Health & Substance Abuse Recovery Commission shall include twenty-two persons, including:
 1. Nineteen members (19) appointed by the Board of Supervisors

2. One (1) member of the Board of Supervisors, and
3. Two (2) members may be appointed from the Youth Commission, who shall be non-voting members

Except as specified in Section 3.a.3 above, all members are voting members. The membership should reflect the ethnic diversity of the client population in the county, and the composition of the commission should represent the demographics of the county as a whole to the extent feasible.

- b. Of the nineteen (19) appointed members:
 1. No fewer than ten (10) of the appointed members shall be consumers or the parents, spouse, sibling, or adult children of consumers, who are receiving or have received mental health services. Of these 10, no fewer than five (5) of the appointed members shall be consumers, and no fewer than five (5) of the appointed members shall be families of consumers of the mental health services.
 2. No fewer than four (4) members shall be substance abuse clients or family members.
 3. Four (4) members shall be public members who have knowledge and experience of the mental health and substance abuse services system and may include additional consumer/family members.
 4. One (1) member shall be a representative of law enforcement who shall be selected by the local chiefs of police. His/her appointment shall be deemed confirmed upon notification to the Board of Supervisors.
- c. Consistent with Welfare & Institutions Code 5604 (d), no member of the commission or his/her spouse shall be a full-time or part-time county employee of a county behavioral health service, and employee of the State Department of Behavioral Health, State Department of Alcohol and Drug Programs, or an employee of, or a paid member of the governing body of a mental health or substance abuse contract agency. "Mental health services" includes any service directed toward early intervention or alleviation or prevention of mental disorder, including, but not limited to diagnosis, evaluation, treatment, personal care, day care, respite care, special living arrangements, community skill training, sheltered employment, socialization, case management, transportation, information, referral, consultation, and community services.
- d. A consumer of mental health or substance use services who has obtained employment with an employer described in paragraph c and who holds a position in which he or she does not have any interest, influence, or authority over any financial or contractual matter concerning the employer may be appointed to the commission. The member shall abstain from voting on any financial or contractual issue concerning his or her employer that may come before the commission. (W & I 5604.3.C.2 as amended 7/16/15).

ARTICLE II FINANCES

The Board of Supervisors may pay from any available funds the actual and necessary expenses of the members of the Mental Health & Substance Abuse Recovery Commission incurred

incident to the performance of their official duties and functions. The expenses may include mileage and parking, travel, lodging, conference registration fees, childcare and meals for the members of the Commission while on official business as approved by the local behavioral health director. (W & I 5604.3) The members of the Mental Health & Substance Abuse Recovery Commission shall serve without additional compensation.

ARTICLE III MEETINGS

Section 3.1 Commission Meetings

The regular meetings of the Commission shall be held on the first Wednesday of each month or as such other times as the Commission shall designate. Special meetings may be called by the Chairperson or a majority of the Commission. The Commission shall be subject to the provisions of Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code, relating to meetings of local agencies (the Brown Act). [W&I 5604.1]

Section 3.2 Agenda

- a. The Chairperson shall prepare an agenda prior to each Commission meeting containing items agreed upon by the Executive Committee. Any member of the Commission may add an item to the agenda through the Chairperson.
- b. An item may be added to a meeting agenda by a simple majority vote of the members present at the time the agenda is presented for acceptance at the beginning of the Commission meeting.
- c. The agenda of all regular meetings shall contain an open agenda item during which time members of the audience may address the Commission.

Section 3.3 Quorum

- a. A quorum of any meeting of the Commission shall consist of one person more than 50% of the total number of appointment members, excluding Youth Commission members. (W&I 5604.5.c)
- b. In the absence of the Board of Supervisor, his or her designated representative shall be counted in the quorum.

Section 3.4 Voting

ARTICLE IV OFFICERS

Section 4.1 Personnel

The selected officers of the Commission shall be a Chairperson, Vice-Chairperson, representative to the statewide organization and a Member at Large.

Section 4.2 Election

At the regular October meeting the Commission shall elect members to their offices. Nominations shall be submitted by the Nominating Committee at the regular September meeting or made from the floor at the regular October meeting.

No member of the Nominating Committee may be nominated to serve as an elected officer of the Mental Health & Substance Abuse Recovery Commission. If a member of the Nominating Committee wishes to be considered for nomination as an officer of the Mental Health & Substance Abuse Recovery Commission, that person will relinquish his/her participation on the Nominating Committee prior to the Nominating Committee's consideration of the member's candidacy.

Section 4.3 Term

- a. The officers shall be elected to serve for one year commencing November 1.
- b. No officer shall be eligible to serve more than three full terms in the same office. If an officer has served a partial term, that officer shall still be entitled to serve three full terms.
- c. Notwithstanding Section 4.3.b above, except for the Chairperson, an incumbent may serve additional terms in the same office if there are no other members who are willing to stand for election to that office.

Section 4.4 Duties

The powers and duties of the officers shall be as follows:

- a. The Chairperson shall be the Executive Officer of the Commission and shall preside at meetings of the Commission and Executive Committee. The Chairperson shall be in consultation with the Behavioral Health & Recovery Services Director. [5604.5.d] The Chairperson shall, with the approval of the Commission, create ad hoc committees as deemed necessary and shall assign their duties.
- b. The Vice Chairperson shall assume the duties of the Chairperson in his/her absence.
- c. The Representative to the statewide organization shall attend its meetings and report to the Commission.
- d. The member-at-large shall serve on the Executive Committee and shall serve as a liaison to the consumer/client community through outreach and engagement activities.

ARTICLE V COMMITTEES

Section 5.1 Executive Committee

- a. There shall be an Executive Committee of the Mental Health & Substance Abuse Recovery Commission. (W&I5604.5.e). The Executive Committee shall be composed of:
 1. The elected officers of the Mental Health & Substance Abuse Recovery Commission.
 2. *The Chairpersons of the Adult Services, Children & Youth Services, Older Adult Services and Mental Health Services Act standing committees.*
- b. The Executive Committee shall meet regularly to develop the agenda for the full Commission meetings and shall have the power to handle matters between regular Commission meetings, such action to be ratified at the next regular Commission meeting.
- c. The Executive Committee will review applications for membership on the Mental Health & Substance Abuse Recovery Commission and provide feedback on each of the applicants to the Board of Supervisors.
- d. The chair of an ad hoc committee and other interested parties may be invited to attend an Executive Committee meeting when the subject matter of the ad hoc committee will be discussed.

Section 5.2 Nominating Committee

A Nominating Committee shall be appointed by the Chairperson at the regular July meeting with the majority vote of the Commission to meet one month prior to the election of officers, select a slate of officers for the coming year and secure verbal consent to serve of those selected. The Chairperson of the Nominating Committee shall temporarily assume the role Commission Chair to accept further nominations and conduct election of officers.

Section 5.3 Standing Committees

There shall be an Adult Services Committee, a Children & Youth Services Committee, an Older Adult Services Committee, and a Mental Health Services Act Steering Committee. All committees shall be inclusive of persons or representatives of clients who are engaged in substance abuse recovery services.

- a. The Commission Chairperson shall appoint the chairpersons of these standing committees.
- b. Each year, the goals and objectives of the standing committees shall be determined by the committee members and presented to the full Commission.
- c. *These committees shall hold regular meetings and consult with the heads of the Adult Services, Children and Youth Services, Older Adult Services, Alcohol and Other Drug Services, Mental Health Services Act, respectively.*
- d. These Committees will report to the full Commission at each Commission meeting.
- e. *The Chairpersons of the Adult, Children and Youth, Older Adult, and Mental Health Services Act Steering Committees shall be members of the Executive Committee.*
- f. Interested members of the public may serve on a standing committee at the discretion of the committee chairperson.

Section 5.4 Sub-Committees

Sub-committees may be established as needed, which may include persons who are not members of the Commission.

Section 5.5 Ad Hoc Committees

Ad Hoc committees may be established as needed and may include persons who are not members of the Commission.

ARTICLE VI AMENDMENT AND RULES

Section 6.1 Rules of Order

The meetings of this Commission shall be conducted in accordance with Robert’s Rules of Order, Revised. A parliamentarian may be appointed by the Chairperson.

The Mental Health & Substance Abuse Recovery Commission will comply with all standing rules for County boards, commissions and advisory committees that are established by the Board of Supervisors.

Section 6.2 Amendment of the Bylaws

These bylaws may be amended at any meeting by a two-thirds vote of the current membership, provided that copies of the proposed amendments are sent to all members of the Commission at least (30) days prior to the meeting at which such action is taken.

Section 6.3 Approval by the Board of Supervisors

Amendments to the Bylaws shall require the approval of the Board of Supervisors. [W&I Code 5604.5]

Section 6.4 Standing Rules

Standing Rules, not in conflict with these Bylaws, may be adopted from time to time. These rules are directed toward the conduct of the affairs of this Commission. They may be amended or rescinded by a majority vote of the Commission.

ARTICLE VII ETHICS

- a. Commission members must comply with California Government Code §§ 87100 and 1090 referring to financial conflict of interest and will sign an “Acknowledgement of Financial Conflict of Interest Laws” affidavit upon taking office.

- b. Commission members must comply with the County's Conflict of Interest Code and the Standing Rules for County Boards, Commissions, and Advisory Committees which state: "All members of boards, commissions, and advisory committees are conducting public business for the County of San Mateo and are subject to applicable California laws regarding conflicts of interest."
- c. Commission members shall take and pass State mandated ethics training within six (6) months of appointment and every two years thereafter. A certificate of completion shall be filed with Behavioral Health & Recovery Services Director.
- d. The Commission recognized that all persons have inherent dignity and shall be treated with respect.

APPENDIX 2. MHSA ANNUAL UPDATE MATERIALS & PUBLIC COMMENTS RECEIVED



Be the one to help



Mental Health Service Act (MHSA) NEW MHSA Steering Committee

Open to the public! Join advocates, providers, clients and family members to provide input on MHSA planning.

The MHSA Steering Committee meets the first Thursday at 3pm in February, May, September and December to provide input, make recommendations and stay up-to-date on new MHSA developments and ongoing programming.

Meeting objectives include:

- Recommend MHSA Steering Committee goals and a structure moving forward.
- Present MHSA Annual Update - learn about MHSA funded program outcomes.
- Provide input on the use of MHSA one-time and sustaining ongoing programs.

- ✓ Stipends are available for clients/family members
- ✓ Language interpretation is provided if needed*

*Please contact us at mhsa@smcgov.org at least 2 weeks in advance to reserve language services.

DATE & TIME

Thursday, May 6, 2021

3:00 pm – 4:30 pm

Zoom Meeting:

<https://us02web.zoom.us/j/83216209789>

Dial in: +1 669 900 6833

Meeting ID: 832 1620 9789

iPhone one-tap: +16699006833,,83216209789#

Contact:

Doris Estremera, MHSA Manager

(650) 573-2889 ♦

mhsa@smcgov.org

www.smchealth.org/MHSA



SAN MATEO COUNTY HEALTH

**BEHAVIORAL HEALTH
& RECOVERY SERVICES**

The Mental Health Services Act (MHSA) provides a dedicated source of funding in California for mental health services by imposing a 1% tax on personal income over \$1 million.



Mental Health Services Act (MHSA)
Steering Committee Meeting
May 6, 2021

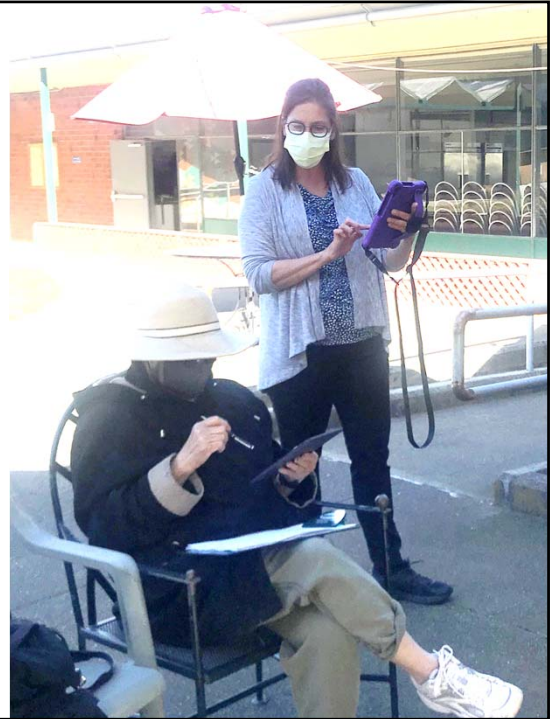


Before we begin...


- Introductions: your name, pronouns and affiliation in the chat
- Stipends for clients and family members participating
 - You can chat to me directly, please provide your email or please remain online after the meeting ends and I'll take down your information
- Meeting is being recorded
- Participation
 - Please enter your questions in the chat box; I will address those first
 - "Raise Hand" button; unmute yourself when called on
- Quick Poll


Agenda

1. MHSA Steering Committee Proposed Structure
2. MHSA Annual Update
 - One-time and ongoing funding
 - Implementation Highlights
 - Program clients served
3. General Public Comments



MHSA Components

76%  **Community Services & Supports (CSS)**
Direct treatment and recovery services for serious mental illness or serious emotional disturbance

19%  **Prevention & Early Intervention (PEI)**
Interventions prior to the onset of mental illness and early onset of psychotic disorders

5%  **Innovation (INN)**
New approaches and community-driven best practices

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

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

1% tax on personal income over \$1 million
San Mateo County: \$30.7M annual 5-year average through FY 19-20

1. MHSA Steering Committee – Proposed Structure



SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

Steering Committee Survey

- To structure a meaningful committee where input, voices and lived experience is valued
- To develop shared goals and understanding of our role as a steering committee members
- To understand our motivations, strengths and interests



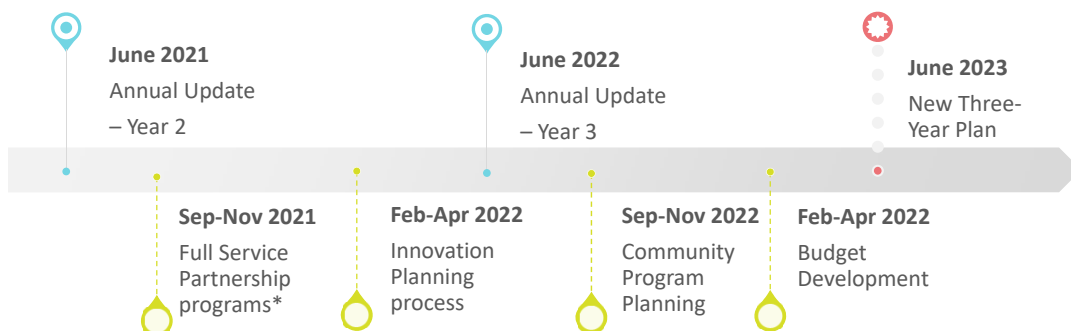
Survey Feedback- Workgroups

- Workgroups
 - Time-limited (3-4 months)
 - Meet monthly
 - Small in size (up to 10 participants)
- Workgroup Expectations
 - Focused on a specific topic - review outcomes and available data and develop recommendation(s) for improvements
 - Some “homework” in between meetings
 - Attend all meetings



Proposed Workgroups

- Workgroup Topics & MHSA Planning Timeline



Reference: Multi-County FSP Improvement Project – [Progress Report](#)



2. MHSA Annual Update

- MHSA Annual Update document will be posted May 28th
- **30-Day Public Comment @[MHSARC Meetings](#):**
 - June 2nd: Vote to open 30-day public comment period
 - July 7th: Public Hearing and Vote to close public comment and to recommend the Annual Update for approval by the BoS
- Public Comments may provided verbally at the meeting or in writing to: mhsa@smcgov.org

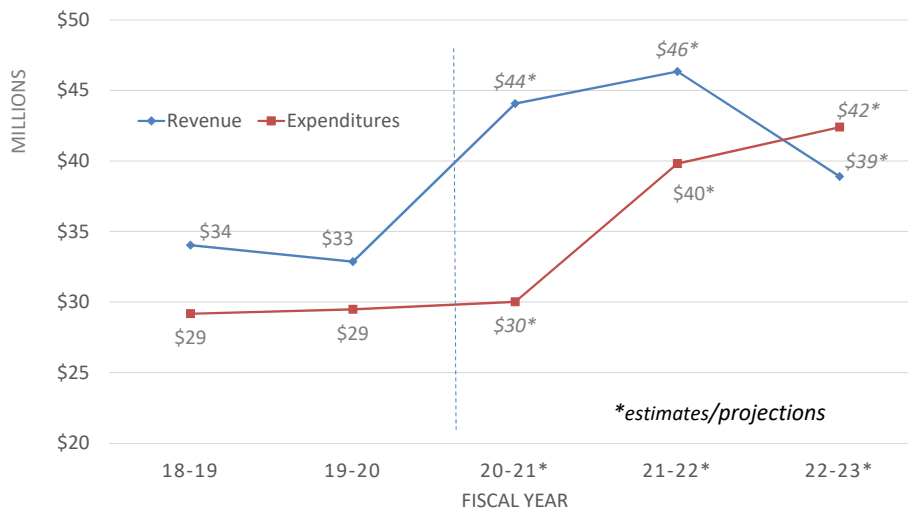
One-Time & Ongoing Funding

Updated One-Time Spend Plan

Priority	Item	FY 21/22	FY 22/23	Grand Total
System Improvements	Clinic/FSP productivity stop-gap	\$1,500,000	\$0	
	MHSA PEI data-informed improvements	\$80,000	0	
	Trauma-informed systems (BHRS, HSA, CJ, etc)	\$100,000	\$100,000	
	System Improvement Total	\$1,680,000	\$100,000	\$1,700,000
Technology Supports	Network Adequacy Compliance	\$100,000	\$0	
	IT Infrastructure	\$301,000	\$0	
	Increase access-telepsychiatry/health	\$80,000	\$0	
	Help@Hand (Tech Suite)	\$300,000	\$300,000	
Technology Total	\$781,000	\$300,000	\$1,081,000	
Workforce Training and Community Education	Workforce Capacity Development	\$295,000	\$85,000	
	Workforce pipeline and retention	\$274,000	\$24,000	
	Crisis Coordination	\$50,000	\$50,000	
	Supported Employment	\$400,000	\$300,000	
	Community Education	\$180,000	\$180,000	
Education and Training Total	\$1,199,000	\$639,000	\$1,838,000	
COVID Client Supports	Client activities/needs	\$50,000		
	Alternative Care Sites	\$83,500		
	Hotels for homeless	\$165,415		
	Co-occurring detox facility	\$200,000		
	COVID Testing/Vaccines for high risk	\$50,000		
COVID Client Supports Total	\$548,915		\$548,915	
Capital Facilities	EPA Clinic Renovations	\$700,000		
	Cordilleras Renovations	\$500,000		
	SSF Clinic Renovations		\$500,000	
Capital Facility Improvements Total	\$1,200,000	\$500,000	\$1,700,000	
TOTALS		\$5,408,915	\$1,539,000	\$6,947,915

See Meeting Handout for descriptions

MHSA Revenue Projections



Strategies for FY 21/22

- One-time Plan for \$12M excess revenue
 - Types of projects: housing development (Housing Initiative Taskforce recommendations); renovations on county-owned facilities, technology needs, system improvements
- Ongoing Budget increase to over-revenue
 1. New allocations to MHSA priorities
 2. Add existing BHRS systemic needs to the MHSA budget
 3. Add MHSA one-time programs to ongoing budget

Reference: [MHSA Funding Principles](#)

Item	FY 2021-22 Amount
NEW (Housing Initiative Taskforce)	\$2,200,000
NEW Infrastructure Supports	\$462,500
FSP Match	\$1,700,000
Housing Supportive Services	\$290,283
Client Flex Funds and Stipends	\$51,000
Communication Support	\$75,000
OASIS, CJ and Pre-to-3 Positions	\$750,000
AOD - Youth Residential	\$85,790
Adult Resource Management	\$1,037,593
School Based MH Clinicians	\$500,000
Adult NMT Interventions	\$200,000
Tech Supports	\$330,000
Pride Center	\$700,000
Health Ambassador Program- Youth	\$250,000
Primary Care Interface	\$1,337,972
TOTAL	\$9,970,138

Proposed Ongoing Budget Increases

• \$13.1M increase over two fiscal years

- Green = new allocations
- Black = BHRS systemic needs
- Red = BHRS systemic needs; new MHSA priorities
- Purple = one-time programs to ongoing

Item	FY 2022-23 Amount
Whole Person Care (HOPE Program)	\$1,444,188
Youth NMT Interventions	\$628,318
Youth Mental Health First Aid	\$189,313
Parent Project	\$160,896
Total Wellness	\$750,000
TOTAL	\$3,172,715

See meeting handout for descriptions



Implementation Highlights

Innovation Projects

- The Pride Center
 - Final outcomes in a future MHSA meeting
- Help@Hand
 - Device Distribution & Digital Literacy: Get App-y, Tech Cafe's, Peer Trainings
- 3 New Projects next FY
 - Social Enterprise and Wellness Cafe for Filipino/a/x youth
 - PIONEERS Program
 - Prevention services in low-income housing



Housing Initiative Taskforce

- Reviewed a Housing Continuum that includes pre-housing engagement, housing and housing supports
- Developed broad outcomes to begin narrowing down priorities based on the impact we want to make on clients, families and communities
- Brainstormed best practices
- Will be making funding recommendations to the MHSARC in June as part of the MHSA Annual Update.



Youth S.O.S. Team

- *Zena Andreani, Program Manager, StarVista Crisis Intervention and Suicide Prevention Center*



Mental Health Student Services Act - SYSTEMS Support

- *Molly Henricks, Coordinator, School Safety & Risk Prevention Coordinator, San Mateo County Office of Education*



Program Clients Served

Community Services and Supports

(Clients Served)

Full Service Partnership*

17/18: 479
18/19: 520
19/20: 608

Outreach & Engagement

17/18: 5,255
18/19: 475**
19/20: 412

System Development

17/18: 2,415
18/19: 2,739
19/20: 2,053

*There are 447 total available FSP slots across all age groups

** In FY 18/19 Outreach Collaboratives were moved to PEI

Full Service Partnerships

% improvement after first year in FSP (all age groups)*

	FY 17-18 (N = 755)	FY 18-19 (N = 746)	FY 19-20 (N = 780)
Hospitalizations	53% (128 to 60 clients)	49% (166 to 85 clients)	50% (169 to 84 clients)
Psychiatric Emergency Visits	31% (175 to 121 clients)	35% (312 to 204 clients)	36% (331 to 212 clients)

*Outcomes from BHRS Electronic Healthcare Records (EHR) data; the EHR data includes a larger sample size than self reported FSP data, as clients do not always complete the FSP survey tools



Prevention and Early Intervention

(Clients Served)

	Ages 0-25	Early Intervention	Prevention	Recognition of Early Signs of MI	Stigma & Discrimination Prevention	Access & Linkage to Treatment
FY 17-18	338	1244 2,834 SMART calls	4,146	279	96	1,347
FY 18-19	501	925 2,579 SMART calls	4,409	179	152	6,764*
FY 19-20	483	878 2,615 SMART calls	4,598	69	47	5,858

* FY 18/19 Outreach Collaboratives were moved from CSS to PEI



3. General Public Comments



SAN MATEO COUNTY HEALTH
**BEHAVIORAL HEALTH
& RECOVERY SERVICES**

Announcements

- **Mental Health Month:**
www.smchealth.org/post/mental-health-month
- **Digital Literacy for Peers and Community Tech Cafe's**
 - www.smchealth.org/bhrs/mhsa, under "Announcements"
- **Subscribe at MHSA website to stay informed:**
 - www.smchealth.org/MHSA
- **Get Involved:**
 - <https://www.smchealth.org/get-involved>



Thank you!

Doris Estremera, MHSA Manager

mhsa@smchealth.org

smchealth.org/MHSA

https://www.surveymonkey.com/r/MHSA_MtgFeedback



SAN MATEO COUNTY HEALTH
**BEHAVIORAL HEALTH
& RECOVERY SERVICES**





Mental Health Services Act (MHSA) Steering Committee Meeting

Thursday, May 6, 2021 / 3:00 – 4:30 PM

Zoom Meeting: <https://us02web.zoom.us/j/83216209789>

Dial in: +1 669 900 6833 / Meeting ID: 832 1620 9789

MINUTES

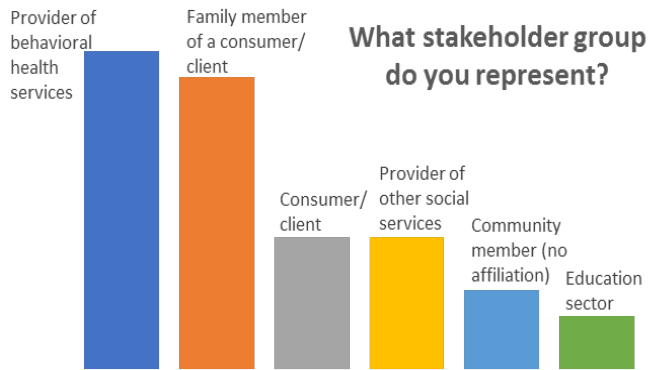
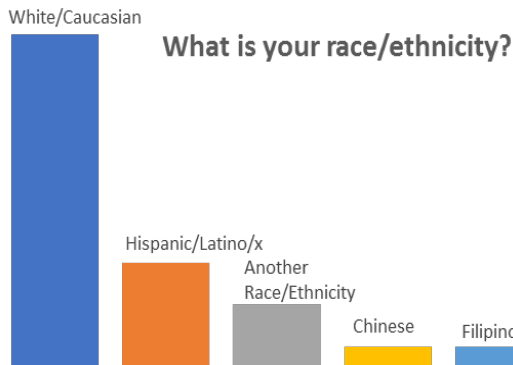
1. **Welcome** – *Doris Estremera, MHSA Manager and Jean Perry, MHSARC Commissioner* 5 min
 - Doris and Jean welcomed participants to the Steering Committee meeting and shared in the chat Mental Health Awareness month link to activities.

2. **Logistics & Agenda Review** – *Doris Estremera* 5 min
 - Introductions (name, pronouns, affiliation) were shared via chat
 - Stipends available to clients and family members participating; please let me know via chat or after the meeting if would like a stipend
 - Meeting is being recorded
 - Participation guidelines – enter questions in chat, will address those first, can also use raise hand button during question/answer and unmute when called on
 - Quick Poll – demographics, results below:

What is your age range?	
16-25	4%
26-59	52%
60+	43%

What is your gender identity?	
Female/Woman	61%
Male/Man	30%
Gender Non-Conforming	4%
Another Gender Identity	4%

What part of the county do you live in OR work in?	
Central County	35%
Coast	4%
County-wide	30%
East Palo Alto/Belle Haven	4%
North County	9%
South County	17%





- **MHSA Overview** 20 min
 - 1% tax imposed on personal income over \$1M to transform public mental health systems
 - 76% of revenue allocated to direct services and treatment for individuals living with serious mental illness; 51% of this must go to Full Service Partnerships (FSPs)
 - 19% goes to PEI; 5% to INN
 - Two components WET and CFTN do not have automatic allocations but, counties can allocate up to 20% per year to these components. In SMC, we transfer annually to WET

3. **MHSA Steering Committee Structure** 10 min

- **Goal Setting Survey Results**
 - Survey to MHSA Steering Committee members to help us structure meaningful participation; we want to bring in voices/input and in order to do that must have some shared goals and learn about each other's motivations, strengths and interests. We will cover goals and interests in the next MHSA Steering Committee meeting
 - Proposing one workgroup at a time, 3-4 months at a time, meet monthly and up to 10 participants.
 - Workgroups will be focused on specific topics, there will be some homework in between and would expect members to attend all meetings. Similar to Housing Initiative Taskforce in structure.
 - Will be timing the topics with what needs to be submitted annually with MHSA; proposing we take on FSP in the fall given that it is currently under study by the State MHSOAC via an independent consultant.
 - INN would be taken on in Feb-April and Community Program Planning process in the fall 2022 in preparation for the next Three-Year Plan.
- **Questions**
 - The Workgroup timeline slide, which are workgroups that you are proposing vs. workgroups that are already happening? Answer: these are all proposed workgroups.
 - Do the workgroups correspond to specific deadlines? Answer: Yes, they are aligned to the MHSA needs and deadlines. For example, it wouldn't make sense to start on a Community Program Planning Process workgroup now since we can wait for when we will be launching the Three-Year Plan. But, it is ideal to start an FSP workgroup given the current collaborative FSP improvement work that is happening across the State.
 - Comment: Members of the Lived Experience Education Workgroup have been expressing interest in joining some of these workgroups.
 - Question: Is it true that these workgroups will be open to the public. Answer: Yes
 - Question: How will that correspond with the idea of having 10 participants in the workgroup? Answer: the intention was to have a small group of folks that could work on a topic in depth. We have experience



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with larger groups and it's very challenging; we've added additional meetings to ensure we hear from all voices.

- Comment: I want to encourage a vetting process that it is a diverse group of folks; not heavily waited to one side.
- Question: An outside consultant was hired to study FSPs, can you send me information on that? Yes, I will add the link to the chat.
https://www.thirdsectorcap.org/wp-content/uploads/2021/03/Multi-County-FSP-INN-Progress-Report_March-2021.pdf. The consultant is Third Sector and is working with a collaborative of 5 counties, interviewing clients and stakeholders.
- Comment: I like this format, I think it's very organized and I can't wait to get to work.

30 min

4. MHSAs Annual Update – Doris Estremera

- The MHSAs Annual Update is a large document, typically 300+ pages full of stories, data, outcomes. Today we will be sharing highlights of our implementation and it's a preliminary presentation. As a reminder, the MHSAs Annual Update will be open to a 30-day public comment period by the commission, the MHSARC, on June 2nd and closing with a public hearing on July 7th during the MHSARC meetings. The full document will be posted on the MHSAs website by May 28th. Public comments can be provided verbally at the MHSARC meetings or in writing to mhsa@smcgov.org.
- One-Time & Ongoing Funding
 - At the last meeting I shared projections that were not accurate. COVID primarily impacted the working class and millionaires were not as impacted. MHSAs is not expecting a recession as was anticipated when COVID first started.
 - We had kept our budget status quo this FY due to the uncertainty. We are now able to move forward with budget increases and that is what our Three-Year Plan is for. We have priorities in the Three-Year Plan that we are able to now move forward.
- Updated One-Time Spend Plan: this is an update.
 - This One-Time Spend Plan was approved already in FY 19/20 for \$12.5M and we added another \$5M when COVID started.
 - The Update I am presenting tells us where we are with spending. We have spent about \$8.2M of the plans.
 - What we are proposing is to extend this plan. These plans were intended to end FY 21/22 but, due to COVID many items were delayed (Supported Employment for example) and we want to push it forward for a FY 21-22 start-up.
 - Some items were removed from the plan because we were sustaining them with one-time monies and are now able to move them into the ongoing budget (e.g. Innovation Projects: Pride Center, HAP-Y, NMT for Adults).
 - The link on the slide is to a larger document with short descriptions for each line item in the event that you want more information.



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- MHSAs Revenue Projections
 - Blue line is revenue, red line is expenditures; everything to the right of the dotted line are estimates/proposed and projections.
 - In FY 20/21, you see that the revenue is \$44M. We had projected almost \$7M less and a recession, which is why the expenditures did not increase from the previous FY. That gap between the revenue and projections is excess revenue.
 - The excess revenue is one-time spend. We can't count on that excess revenue moving forward. We will be proposing a one-time spend plan.
 - Our goal is to keep our expenditures (red line) as close to the revenue (blue line) as possible. It's a tricky process with a volatile revenue and especially determining how much to push the ongoing budget.
 - We are proposing an over-revenue budget even though we do not know where we will be in FY 23-24 because we have excess revenue and a healthy reserve.
- Strategies will include a one-time plan of \$12M and ongoing budget increase to over-revenue.
 - The Housing Initiative Taskforce is tasked with identifying expenditures for this one-time monies. We may also have additional opportunities for one-time expenditures types such as renovations to county-owned facilities, technology needs or system improvements.
 - Learning from the previous one-time plan; we recommend to stay away from starting new programs. There is limited capacity to start a new program on top of the priority projects that need to be implemented and once the funding runs out, we will need to figure out how to sustain the program.
- Proposed Ongoing Budget Increases
 - Will be focused on adding BHRS systemic needs to the MHSAs budget (existing programs that are experiencing reductions across our system).
 - Proposing increase of \$13.1M over two fiscal years because items in Year 2 will be experiencing reductions in FY 22-23.
 - Green items are new allocations (Housing Initiative Taskforce and Infrastructure Supports – MHSAs has grown and infrastructure for the oversight, planning, and management has not increased since inception)
 - Black items are BHRS systemic needs that are aligned with MHSAs priorities
 - Red items are BHRS systemic needs that are new to the MHSAs plans
 - Purple items are items that were being sustained with one-time funds and are proposing to move them to ongoing
- Questions/Comments:
 - Question: Are you proposing that the one time funds go into a reserve fund to cover projected losses? Answer: No, we have a reserve already and that is accounted for. The one-time funding is excess revenue.
 - Questions: Would renovation of the Maple Street shelter fall under capital improvements yet meet the priorities for housing needs? Answer: The one requirement would be that facilities are County-owned.



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- o Question: Going back to the Revenue Projections graphs. My request would be to see reserve funds on this graph to get a better idea of what our build-up of reserve looks like. Answer: yes, I've shared this in the past and can share again in the meeting notes. We have obligated funds in MHSA (reserve, INN, WET, housing). These are monies that are set aside.

Fiscal Year End	19/20	20/21(estimates)
Annual Cash Revenue Received	\$31,834,340	\$42,844,054
Interest Revenue Received - Cash	\$1,025,056	\$1,225,056
Ongoing Budget Expenditures	\$26,974,045	\$30,011,791
One-Time Fund Expenditures	\$83,996	\$8,140,457
Trust Fund Balance	\$43,198,965	\$49,115,827
Obligated Funds:	\$42,420,958	\$36,651,103
Reserve	\$17,013,720	\$22,034,555
5% INN	\$1,642,970	\$2,203,456
INN Ongoing	\$5,707,736	\$4,860,139
WET Ongoing*	\$535,490	\$500,000
Housing Funds	\$105,039	\$105,039
\$12.5M One-Time Spend Plan	\$12,416,004	\$6,947,915
One-Time Spend COVID	\$5,000,000	\$0
Available One-Time	\$778,007	\$12,464,724

- Comment: If you could, when you share dollar amounts can you right-align instead of center aligned? Answer: Sure, if that helps to read them.
- Question: Are the school-based clinicians being proposed for the ongoing budget, funded by MHSSA? Answer: No, they are not part of the MHSSA grant; they were primarily Measure K.
- Question: where do the MHSA projections come from and why do we see the increase for next year? Answer: the projections come from the State; it starts with the Governor's budget and a State consultant provides us our MHSA projections. In FY 22/23, you see what looks like a drop but, you see that it is still higher than FY 19/20. In FY 20/21-21/22, you see a spike in revenues because of delayed tax filing due to COVID and adjustments made from previous years' favorable economic growth. There is always a two-year delay on adjustments.
- Comment: these are just projections. It may be helpful to have an actual and a projection, change the color of the projections so that it is easier to understand.
- Question: what does NMT stand for? Answer: Neurosequential Model of Therapeutics (NMT)
- Question: where is the Total Wellness program, where are the monies coming for that? Answer: The Total Wellness program was an MHSA Innovation project that received monies from Health Plan of San Mateo and now is being reduced. We are proposing to use MHSA monies in FY 22/23 for Total Wellness.



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- Question: What youth have the ability to use NMT through MHSA? who will be training on YMhFA, which type of training? The less hour one? Answer: these programs are currently Measure K funded, we are proposing to change the revenue stream but not the program management. Question: Can it be expanded now that it is MHSA to non-MediCal students? With the decreasing size of MediCal recipients in this County it may be a wise use of funds to expand it. We have a lot of at-poverty line youth that have Kaiser or other insurance. NMT is such a great resource that I am hoping it gets expanded.
- Question: YMhFA used to be under the Office of Diversity and Equity (ODE) and for a while there was no YMhFA. Is that coming back, are we offering it to schools? How will that roll out. Answer: ODE has contracted out the work but, oversight remains with the office.
- Question: those School Based Mental Health Clinicians are those for your School Based Program or for General Education Students? Answer: these are only for special ed students and not the general population.
- **Implementation Highlights**
- **Housing Initiative Taskforce** – *Pat Way and Jean Perry, MHSARC Commissioners*
 - Have met three times under leadership of Judy Davila, housing consultant and Doris Estremera, MHSA manager.
 - There were two presentations prior to the launch of the Taskforce and this was homework prior to launch. The recordings are on the MHSA Housing webpage, <https://www.smchealth.org/general-information/mhsa-housing> along with presentation decks, question and answers and other documents.
 - The first meeting was a lot of information and identifying missing data and gaps in services. The second meeting was discussing expected outcomes and how we want clients to be supported so that they can progress. Guiding principles were developed and the 8 outcomes were prioritized. The third session was focused on brainstorming best practices to address the top three outcomes.
 - Next, we will be prioritizing Funding Recommendations to present to the Board of Supervisors.
 - Comment: #1 and #3 outcomes, that should be “keeping” it’s not just securing housing but, keeping it.
- **Mental Health Student Services Act (MHSSA)** – *Molly Henricks, Coordinator, School Safety & Risk Prevention Coordinator, San Mateo County Office of Education*
 - \$6M grant over four years; 12 school districts participating that started in October 2020.
 - Phase one is for all districts and includes Social Emotional Learning (SEL) curriculum, Community Resilience Model training for staff and data collection
 - Phase two is for the high need districts and includes more targeted SEL curriculum, universal screeners, wellness counselors and care coordination from Care Solace to link (warm hand-off) families to services regardless of insurance.



- o Three districts are receiving Care Solace, other revenues covered the rest of the school districts funded by the healthcare districts and the TUPE grant. Molly shared utilization data from Care Solace. Anxiety and Depression are most frequent reasons to access mental health resources; marital issues is also showing up. Common referrals for the 12 districts include group telehealth, BHRS, Kaiser, One Life and Women’s Therapy Institute.
- o Question: How is high needs determined for a school? Answer: this was based on data (demographics, low and reduced lunch, CHKS mental health data)
- o Question: Any break down for use by gender identity? Answer: Yes, female, male and non-binary are data collected.
- **Youth S.O.S. Team** – *Zena Andreani, Program Manager, StarVista Crisis Intervention and Suicide Prevention Center*
 - o Shared new website, www.sanmateocrisis.org. Has links to teen chat services, teen text line, and 24/7 Crisis Hotline.
 - o Hard at work recruiting for Youth S.O.S. clinicians and family partners. FURS, foster-care component has launched since March 2021. Hired a program coordinator who is focused on recruitment.
 - o Comment: Texting is cool but, as program progresses, we need to find out and follow-up to see how effective texting actually is. Youth are always in front of their phones but, this is not healthy.
 - o The texting services are intended to be there in the moment, not a replacement for long-term therapy.
 - o Comment: Substance use is a non-descriptive term, the proper use term is Substance Use Disorders or problematic Addiction
 - o Comment: Marijuana is a problematic category due to its legality what about prescription drug abuse, street drugs and so on

5. **Program Outcomes** 15 min
 • Due to time limitations, these were not presented

6. **General Public Comments** 5 min

*** Public Participation:** All members of the public can offer comment at this public meeting. There will be opportunity to provide Public Comment after each agenda item. You can also submit questions and comments in the chat; these will be addressed first. If you would like to speak, please click on the icon labeled “Participants” at the bottom center of the Zoom screen then click on “Raise Hand.” The host(s) will call on you and you will unmute yourself. Please limit your question/comments to 1-2 minutes. The meeting will be recorded. Questions and public comments can also be submitted via email to mhsa@smcgov.org.

***REMINDER – Please Complete the Steering Committee Feedback Survey**
https://www.surveymonkey.com/r/MHSA_MtgFeedback





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ATTENDANCE

There were up to 26 participants logged in to the Zoom app; below is a list of attendee names as recorded from Zoom, some call-in numbers and names were unidentifiable.

MHSA Steering Committee Members

1. Adriana Furuzawa
2. Chris Rasmussen (MHSARC)
3. Clarise Blanchard
4. Jairo Wilches
5. Jean Perry (MHSARC)
6. Juliana Fuerbringer
7. Kava Tulua
8. Maria Lorente-Foresti
9. Mary Bier
10. Melissa Platte
11. Michael Krechevsky
12. Michael Lim
13. Patricia Way (MHSARC)

BHRS Staff Supports

Doris Estremera (MHSA Manager)

Other BHRS Staff

25. Alen Yaghoubi
26. Terry Wilcox-Ritgers

Community Participants

14. Rebecca Kieler
15. Erica Wang
16. Junior Flores
17. Lanajean Vecchione
18. Lena Silberman
19. Molly Henricks
20. Randall Fox
21. Susan Houston
22. Tania Perez
23. Verna Barrientos
24. Zena Andreani



Mental Health Services Act (MHSA)

FY 2020-21 Annual Update

MHSARC Meeting – June 2, 2021

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MHSA Annual Update

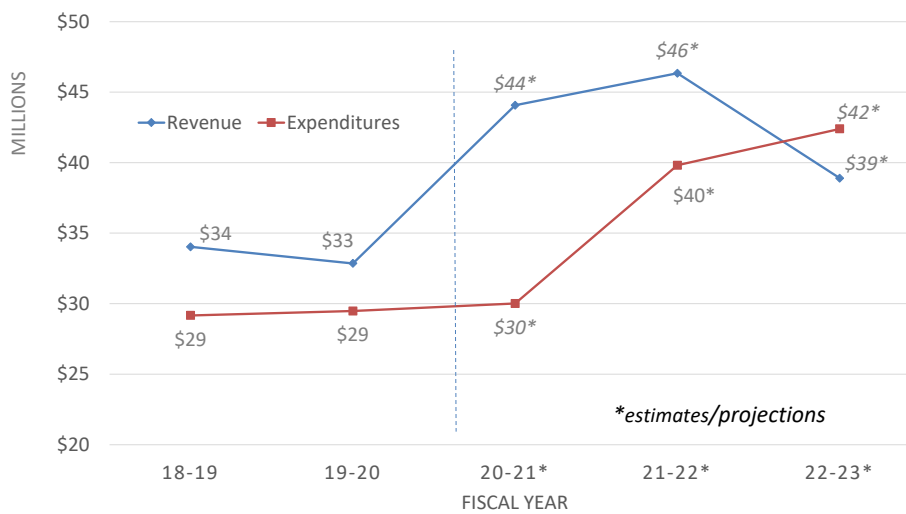
- [MHSA Annual Update document on the MHSA website](#) and includes
 - Implementation Highlights
 - Updates to the budget
 - Data and outcomes for each MHSA-funded program
- [30-Day Public Comment at MHSARC Meetings:](#)
 - June 2nd: Vote to open 30-day public comment period
 - July 7th: Public Hearing and Vote to close public comment and to recommend the Annual Update for approval by the BoS
- [Public Comments may provided verbally at the meeting or in writing to: mhsa@smcgov.org](mailto:mhsa@smcgov.org)

2

MHSA Funding Updates

3

MHSA Revenue & Expenditures



4

Strategies for FY 21/22

- Propose Ongoing Budget increases
 1. New allocations to MSHA priorities
 2. Add existing BHRS systemic needs to the MSHA budget
 3. Add MSHA one-time programs to ongoing budget
- Propose a NEW One-time Plan for \$12M excess revenue
 1. Housing Initiative Taskforce recommendations
 2. Other priorities

Reference: [MMSA Funding Principles](#)



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Item	FY 2021-22 Amount
NEW (Housing Initiative Taskforce)	\$2,200,000
NEW Infrastructure Supports	\$462,500
FSP Match	\$1,700,000
Housing Supportive Services	\$290,283
Client Flex Funds and Stipends	\$51,000
Communication Support	\$75,000
OASIS, CJ and Pre-to-3 Positions	\$750,000
AOD - Youth Residential	\$85,790
Adult Resource Management	\$1,037,593
School Based MH Clinicians	\$500,000
Adult NMT Interventions	\$200,000
Tech Supports	\$330,000
Pride Center	\$700,000
Health Ambassador Program- Youth	\$250,000
Primary Care Interface	\$1,337,972
TOTAL	\$9,970,138

Proposed Ongoing Budget Increases

- \$13.1M increase over two fiscal years

- Green = new allocations
- Black = BHRS systemic needs
- Red = BHRS systemic needs; new MSHA priorities
- Purple = one-time programs to ongoing

Item	FY 2022-23 Amount
Whole Person Care (HOPE Program)	\$1,444,188
Youth NMT Interventions	\$628,318
Youth Mental Health First Aid	\$189,313
Parent Project	\$160,896
Total Wellness	\$750,000
TOTAL	\$3,172,715

See packet of materials provided for specific item descriptions

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New \$12M One-Time Plan

- \$10,100,000 for Housing Initiative
- Remaining for post-COVID supports and anticipated behavioral health surge
 - \$1,080,000 must be spent in prevention and early intervention
 - \$820,000 for other supports
 - Stakeholder input on this will continue through June 30, 2021

See packet of materials provided for currently proposed item descriptions

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Implementation Highlights

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Housing Initiative Taskforce

- Reviewed a **housing continuum** that includes pre-housing engagement, housing and housing supports
- Identified broad **housing outcomes**
- Brainstormed **best practices**
- Developed and prioritized **funding recommendations**

See attached handout packet for the prioritized Funding Recommendations



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Program Expansions

- **The Cariño Project - July 2020**
 - Provides culturally centered community-based mental health and substance use services and programming to Coastside communities.
- **Mental Health Student Services Act (MHSSA) – October 2020**
 - Provides social emotional learning supports, universal screening, counselors and linkages to students and families in high need schools.
- **Youth S.O.S. Team - March 2021**
 - Non-law enforcement trauma-informed response to youth (age 0-21) who may be in a crisis in San Mateo County within 24-hours. The team will be dispatched via the StarVista Crisis Hotline, available 24/7.



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Innovation (INN) Projects

- The Pride Center
 - Completed final year of INN pilot
- Help@Hand
 - Device Distribution & Digital Literacy
- 3 New Projects approved
 - Social Enterprise and Wellness Cafe for Filipino/a/x youth
 - PIONEERS Program
 - Prevention services in low-income housing



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Thank you!

mhsa@smchealth.org
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Proposed MHSA Ongoing Budget Increases (with descriptions)

\$13.1M increase over two fiscal years

Green = new allocations

Black = BHRS systemic needs

Red = BHRS systemic needs; new MHSA priorities

Purple = one-time programs to ongoing

Item	FY 2021-22 Amount	Item Description
NEW (Housing Initiative Taskforce)	\$2,200,000	FSP increases in both Youth and Adult System of Care. Increasing slots for clients + housing supports
NEW Infrastructure Supports	\$462,500	BHRS administration, contracting, fiscal, planning, evaluation, and implementation to support the State and local requirements associated with MHSA.
FSP Match	\$1,700,000	FSP-related Federal Financial Participation (FFP) match to allow for draw down of Federal Government's share under the Medicaid program.
Housing Supportive Services	\$290,283	Adult /Older Adult Supportive Housing Services for clients in MHSA funded units. Supportive services include comprehensive case management on-site and recovery based education and activities.
Client Flex Funds and Stipends	\$51,000	Flexible Funds for Pathways Court Mental Health clients to fund short-term non-clinical services (i.e. transportation, moving costs, clothes, grooming, food, storage, etc.). Stakeholder stipends support participation of individuals with lived experience in key BHRS activities.
Communication Support	\$75,000	BHRS Communication supports including graphic design, digital communication, web-based and social media, brochure, flyer development, and reports.
OASIS, Criminal Justice and Pre to 3 Position	\$750,000	Child Welfare and Pre-to-Three positions in the BHRS Youth System to support services for high risk children/youth referred through child welfare. Criminal Justice Restoration position to support forensic mental health and jail diversion.
AOD - Youth Residential	\$85,790	Dedicated residential SUD treatment bed with at Advent in a co-occurring STRTP licensed facility which also provide fully co-occurring services.
Adult Resource Management	\$1,037,593	ARM Mental Health Counselor positions that support individuals with SMI or co-occurring disorders in shelters, sobering centers, social detox who are eligible but not connected to ongoing services.
School Based MH Clinicians	\$500,000	School-based programs provide integrated mental health and special education services for adolescents who are at risk of psychiatric hospitalization, more restrictive school placement, residential placement or school failure.
Adult Neurosequential Model of Therapeutics (NMT) Interventions	\$200,000	Application of the BHRS Youth System NMT to the Adult System for assessing trauma so that alternative interventions (educational, enrichment and therapeutic) can be provided in a way that will help best meet the needs of adult clients.
Tech Supports	\$330,000	Tech Supports to provide technology supports (devices and data plans) and digital mental health literacy for peers, clients and family members of clients that would benefit from telehealth and/or other behavioral health services, but do not have the resources.
Pride Center	\$700,000	The San Mateo County Pride Center, a behavioral health coordinated services center, addresses the need for culturally specific programs and mental health services for the LGBTQ+ community.
Health Ambassador Program- Youth	\$250,000	HAP-Y serves as a youth-led initiative where young adults act as mental health ambassadors to promote awareness of mental health, reduce mental health stigma, and increase service access for young people and their communities.
Primary Care Interface	\$1,337,972	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.
TOTAL	\$9,970,138	

Program	FY 2022-23 Amount	Item Description
Whole Person Care (HOPE Program)	\$1,444,188	The five-year Whole Person Care (WPC) initiative is entering its final year of grant funding. The pilot is aimed at improving the access, quality of care and efficiency of services delivered to those individuals with the most complex and often co-occurring conditions. Helping Our Peers Emerge (HOPE) Program assists BHRS adult clients transition from local psychiatric facilities into the community via trained Peer Mentors and Family Partners who provide emotional support, educational services and community resources.
Youth Neurosequential Model of Therapeutics (NMT) Interventions	\$628,318	BHRS Youth System practitioners are trained in the NMT for assessing children for trauma and other history and neural functioning so that interventions (educational, enrichment and therapeutic) can be provided in a way that will best meet the needs of the child.
Youth Mental Health First Aid	\$189,313	Youth Mental Health First Aid is an 8-hour public education training course provided to adults that focuses on how to identify a youth who is struggling with a mental health issue and how to connect that youth with services.
Parent Project	\$160,896	The Parent Project is a free, 12-week course that is offered in English and Spanish to anyone who cares for a child or adolescent. The classes meet for three hours each week. Parents learn parenting skills and get information about resources and other support available in their communities.
Total Wellness	\$750,000	Total Wellness is peer-driven coordinated care to holistically address behavioral health and physical health needs of clients.
TOTAL	\$3,172,715	

**MHSA Housing Initiative Taskforce
Prioritized Funding Recommendations – May 2021**

A Housing Initiative Taskforce, made up of diverse clients, family members, service providers and County departments, was convened between March and May 2021 to accomplish the following goals:

1. Define a housing continuum of services (attached)
2. Identify gaps at all levels of support or intensity in treatment
3. Articulate and prioritize broad housing-related outcomes
4. Identify and prioritize activities to fund under each prioritized outcome

As a final step, taskforce members were asked to prioritize the funding recommendations. Following is the Housing Initiative Taskforce Funding Recommendations listed in order as prioritized:

Funding Recommendations – listed in order of priority	One-Time Funding Amount	Ongoing Funding Amount
1. Establishment of an ongoing Housing Fund with Department of Housing for the development of Supportive Housing Units for clients (~24 units)	\$5,000,000 Year 1 \$5,000,000 Year 2	
2. Housing locator contract to oversee: a) Maintenance of BHRS Housing website services with real-time housing availability information; b) Linkages to BHRS case managers; c) Landlord engagement; d) Community mental health 101 education to housing agencies; and e) three housing locator positions (mental health counselors), three peer navigators + admin		\$ 575,000
3. Supportive services for new housing units developed		\$375,000*
4. Mental health workers for Homeless Outreach Teams (two clinicians)		\$325,000
5. Transitional housing supports and training to adequately serve SMI population, including special populations		\$100,000
6. Outreach and field-based services to support ongoing and long-term housing retention; a team of Occupational Therapist and Peer Counselor with co-occurring capacity to support independent living skills development and recovery		\$500,000
7. Development of an online BHRS Housing webpage with comprehensive one-stop housing information (including data dashboard for unmet need) for clients and staff	\$100,000	
8. Flexible funds for housing related expenses (moving costs, deposits, first month rent)		\$100,000*
9. Increase FSP housing funds		\$258,662 (\$8,097/client)
10. Incentives and supports for licensed Board and Cares to improve quality of services		\$50,000
11. Increase Full Service Partnerships (FSP) slots for children/youth and transition-age youth		\$607,835 10 Children/Youth and TAY FSP slots
TOTAL for FY 21/22 to 22-23	\$10,100,000	\$2,416,497

*Item #3 (supportive services) is not included in the total budget amount for FY 21/22 to 22/23 because implementation will occur in future years once new housing units are developed; item #8 (housing-related flex funds) is also not included in the total budget amount needed because there is a separate revenue source identified for this item.

Housing Continuum - example

Pre- Housing Engagement: Drop-In Centers / Shelters / Field Services / Post- Psychiatric Emergency Services, Hospitalization, Incarceration



Housing Continuum for Individuals with Mental Illness

** Based on Luke-Dorf Inc and Washington County, Oregon*

REHABILITATION CENTERS

- Locked
- 24/7 Staffing
- Most restrictive
- Ideal for highly symptomatic individuals

RESIDENTIAL TREATMENT

- Unlocked
- 24/7 Staffing
- Stabilization and skills building
- Ideal for individuals out of higher level of care

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

SUPPORTIVE HOUSING

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

INDEPENDENT LIVING

- Independent housing
- Some support
- Ideal for individuals who need minimal to no support

MORE STRUCTURED INTENSIVE CARE

LESS STRUCTURED SUPPORTS

San Mateo County Housing Continuum



Pre-Housing Engagement

Drop-In Centers	Shelters	Field Services	Post Psychiatric Emergency Services	Hospitalization	Incarceration
<p>Services or activities for homeless and/or those with mental illness.</p> <ul style="list-style-type: none"> • Available without an appointment • Range from M-F 8-5 to 1 x per week <p>➤ In county:</p> <ul style="list-style-type: none"> • 20 sites 	<p>Beds for homeless individuals</p> <ul style="list-style-type: none"> • Usually for 90 days or less. <p>➤ In County:</p> <ul style="list-style-type: none"> • 25 MH beds • 221 general beds 	<p>Services delivered by outreach teams to individuals who are homeless and/or have mental illness and/or substance use challenges.</p> <ul style="list-style-type: none"> • Services provided in community locations, place of residence, street or encampments <p>➤ In County:</p> <ul style="list-style-type: none"> • 11 BHRS Outreach Teams • 5 Homeless Outreach Teams (HOT) 	<p>Services to individuals following a psychiatric emergency room visit or hospitalization.</p> <ul style="list-style-type: none"> • New clients referred to Access for assessment for ongoing services and outreach Teams ensure linkage and ongoing peer support • Current clients follow up services are coordinated with care team and outreach team when needed 	<p>In-patient psychiatric stay for individuals with acute symptoms and are a danger to self or others.</p> <ul style="list-style-type: none"> • No discharge to homeless • Coordinated step down plan • Outreach team if needed <p>➤ In county:</p> <ul style="list-style-type: none"> • 34 locked beds • Additional beds on case basis 	<p>Behavioral health services for incarcerated and post incarcerated individuals.</p> <ul style="list-style-type: none"> • MH and AOD services in SMC county jail • Mental Health Court and diversion with mental health team case management

San Mateo County Housing Continuum



SMC Housing for Individuals with Mental Illness

Rehabilitation Center	Residential Treatment	Residential Board and Care	Transitional	Supportive Housing	FSP Supported Housing	Independent Housing
<ul style="list-style-type: none"> • Locked facilities • 24/7 Staffing • Most Restrictive • Ideal for highly symptomatic individuals ➤ In County: <ul style="list-style-type: none"> • 64 beds ➤ Out of County: <ul style="list-style-type: none"> • 65 beds 	<ul style="list-style-type: none"> • Unlocked • 24/7 Staffing • Stabilization and skills building • Ideal for individuals leaving higher level of care ➤ In county: <ul style="list-style-type: none"> • 29 Crisis Residential beds • 37 Social Rehabilitation beds • 163 AOD beds 	<ul style="list-style-type: none"> • Unlocked, eligibility requirements • 24/7 Staffing • Skill building and long-term stability • Ideal for support for basic ➤ In county: <ul style="list-style-type: none"> • 194 Beds ➤ Out of County: <ul style="list-style-type: none"> • 129 Beds 	<ul style="list-style-type: none"> • Independent units • Staffing on-site • Intensive support services on-site • Ideal for stable individuals needing support • Focus on moving to permanent housing ➤ In County: <ul style="list-style-type: none"> • 7 units, 6 bedrooms 	<ul style="list-style-type: none"> • Independent Integrated or dedicated housing • Permanent housing • Support Services on-site • Ideal for individuals who manage their needs with some support ➤ In County: <ul style="list-style-type: none"> • 165 units, 9 NPLH units pending 	<ul style="list-style-type: none"> • Range of housing includes Single Room Occupancy, Room and Board, Shared Housing, and independent housing • Individuals receive on site and off site services based on Assertive Care Treatment (ACT) ➤ In County: <ul style="list-style-type: none"> • 309 individuals enrolled in FSP 	<ul style="list-style-type: none"> • Independent housing in community • May have some supports • Ideal for individuals who need minimal to no support • Rental assistance include mainstream, Shelter Plus Care, Project-Based Vouchers, and Housing Choice vouchers and other rental support are utilized

Housing Assistance Services



Skill Development	Housing Case Management	Rental Assistance	Homeless Assessment and Housing Referral	Housing Locator	Landlord Tenant Assistance
Instruction on daily living skills for success in housing	Services to find and maintain successful housing	Short-term and long-term assistance	Identification of housing needs and referral to available housing	Services to identify available housing	Services to educate tenants, mediate issues with landlords, identify and support landlords who rent to special populations

Public Comments Received – for MHSARC Review

➤ MHSa Annual Update, Fiscal Year 2021-22

Public Comment submitted: I am very concerned about how I see \$10,000,000 of MHSa one-time funds being allocated. When I think about housing in the context of mental health, I think about what is going to be done to address the decades of long term, disastrous, effects stemming from the ill-conceived Lanterman-Petris Act. I really hoped the MHSa would be part of the solution. Many people with mental health challenges need supportive housing solutions. This means facilities with supervised living situations and access to clinical staff. The use of peer workers, which is encouraged by the MHSa can be a huge part of this, providing both support for clients and employment and housing for the peer. This is where I feel these MHSa funds need to go.

There are already MHSa funds being used to provide affordable housing solutions for mental health clients. And, priority for clients can be established within the subsidized housing system. And, some people with mental health challenges are quite capable of pursuing affordable housing, subsidized housing, and other solutions on their own. The conflating of affordable housing with housing for people with mental health challenges concerns me. There are many funding sources for affordable housing, ranging from local municipal budgets, to the twelve billion dollars recently pledged by the State, to the various Federal housing agencies. Mental Health services have historically been underfunded and the MHSa was intended to address that.

I also am concerned about MHSa funds going to the Department of Housing. Comingling funds with another agency, with a different purpose, can result in that agency's requirements superseding those of the funding source in this case, the MHSa. An example of this would be could lead to the opportunities created by these funds being limited to those who are presently homeless. There are too many people with mental health challenges who are in compromised living situations, or ones whose living situation is not sustainable. These are among some of the most vulnerable people in our society, and it is critical they be appropriately housed before they hit the streets. I ask that the above be taken into account, the plan for the use of the \$10,000,000 be reconsidered and/or refined.

Response to Public Comment: Thank you for your comment. We agree that supportive housing solutions is needed for individuals living with mental health challenges. The Mental Health Steering Committee and the Mental Health and Substance Abuse Recovery Commission have prioritized increasing Supportive Housing units to improve wellness and recovery for individuals living with mental health challenges.

The one-time funds are dedicated to Supportive Housing units specifically, within the affordable housing developments. These units are coupled with intensive coordinated services to help individuals living with mental health challenges retain their housing, support their recovery and resiliency, and maximize their ability to live and work in the community. There is a broad array of research that supports the effectiveness of this strategy of combining affordable housing with supportive services.

The funding ensures that there will be units set aside for this purpose specifically. It requires affordable housing developers to have a Memorandum of Understanding (MOU) with primary service provider(s) and BHRS. One component of the MOU is that BHRS determines the eligibility of individuals applying for tenancy in compliance with the MHSA target population criteria.

BHRS has successful experience funding Supportive Housing units through the Department of Housing, recently adding 12 additional Supportive Housing units in San Mateo County for a total of 62 MHSA units across the county. These funds have all been a collaboration with Department of Housing, State and Federal Sources.

Additional Response from Commissioner(s): A for profit developer is developing multi-use veterans housing units, the Veteran Administration determines eligibility for the veteran units in the affordable housing development. For this Department of Housing NOFA (Notification of Funds Availability), the MHSA units will be within a development that is considered fully “affordable” MHSA units will not be inserted in non-affordable housing developments. That offsets the concern... it doesn’t just get thrown in a pool of affordable housing units being developed. We need these units to have site specific vouchers and connected with services and those are the terms of the NOFA.

Letter from Solutions for Supportive Homes

Dear Doris,

I want to thank you, Judy Davila and the entire Housing Initiative Task Force for the work that you have done to tackle the issue of supportive housing for those who suffer from serious mental illness. Given the magnitude of the problem, you did well to identify gaps in needs and provide some funding solutions utilizing available MHSA funds. The three priorities that were identified are all positive steps to addressing the needs. The one-time funding of 25 new Supportive Housing units through the Department of Housing is very exciting, as well as the on-going funding for the support services in the new units. I understand from the reporting done at the June 2 MHSARC Commission meeting, that the FSP services will be studied in the fall in a similar fashion as was done with the Housing Initiative Task Force. I hope that by looking at specific support needs and how they can be implemented, this will help to ensure the success of the housing provided to those with mental health challenges.

Representing the parents of Solutions for Supportive Homes, I ask that San Mateo County please remember our aging parents who are taking care of their adult children who cannot live independently as fully functioning adults. The question was raised during one of the Task Force meetings about access to the supportive housing for those who are living with aging parents. The response was, “An individual with SMI who is living with aging parents (depending on the health, functioning of the caretaking parent and how soon the caretaker may no longer be able to do so) may be considered at risk of homelessness.” I ask that we not wait until the caretaker is no longer able to take care of their loved one. Transition to a supportive living situation needs to occur while the parent(s) are still capable of supporting that transition for their adult child. The parent needs the time to make this work!

Over the past two and a half years I have heard the difficult stories of not only the parents who participate in Solutions for Supportive Homes, but those who have either called me or contacted our

website. They all express the same anxiety of what will happen to their children. Where will they live and who will take care of them? These adult children are already at risk of becoming homeless simply by the fact that odds are high that the parents will not outlive them. Several of the adult children have already been homeless and were taken in by the aging parent. Living with and/or supported by parents is only a temporary solution.

I personally share the same anxiety of all of these other parents. I am essentially the case manager of my adopted son who was born with Fetal Alcohol Syndrome Disorder. He is living in an apartment with some independent living skills, but because of the effect on his cognitive skills due to the damage done to the brain, he will need a supportive housing situation in order to survive. I am very pleased that money will be invested in more supportive housing, even though we all know the need is so much greater. I just want to have the confidence that I can communicate with parents who have adult children with some independent living skills but need support that these supportive homes, provided by the MHSA units, will be available to them to apply for. Parents desperately need an option to plan for the future of their children.

Sincerely,
Carolyn Shepard, Coordinator
Solutions for Supportive Homes

Response to Letter from Solutions for Supportive Homes

Dear Carolyn,

Thank you so much for taking the time to submit a thoughtful public comment on behalf of Solutions for Supportive Homes for the MHSA Annual Update, FY 2021-22. As you know, the eligibility for MHSA-funded units, the associated supportive services and FSP services is determined based on requirements of the MHSA and BHRS. MHSA requires that programs serve 1) individual with serious mental illness and 2) individuals that are homeless or at-risk of homelessness. These are strictly defined for current FSP programs and Supportive Housing units developed through the MHSA Housing Program.

Where we may have some flexibility is with the newly proposed 25 units using one-time funding. Specifically, there may be flexibility with defining “at-risk of homelessness.” We appreciate your request to consider not waiting until a caretaker is no longer able to take care of their loved one in order to support the transition for their adult child living with mental health challenges. As we work on the definition, we will have to consider BHRS service provision requirements and current gaps between need and housing supports available to ensure that individuals with the greatest need and the most barriers are prioritized for units available.

Additional Comment from Commissioner: Who makes the interpretation that children of elderly parents are not eligible? Is it based on the parents not having terminal diagnosis, the ethnicity of the parents? Who has the power to make a policy that at-risk of homelessness involves these individuals? Because I know dozens of individuals I know of and parents don’t know when they are going to die. The stakeholders should decide and yes, there is a range of interpretation for what puts an individual at-risk and it does mean that some individuals will not be eligible for housing until they are on the streets.

Where can we take action? Where can we move the voice of the stakeholders to the decision-making body.

- **Response from BHR Director:** This will be a good topic to bring to housing experts, some of these are federal laws, state laws. The tools developed to assess at-risk of homelessness are developed by the state and may not give us the flexibility to decide ourselves. Single point of entry led to a bottle-neck in our system but, if we didn't do this it didn't get the federal funding. We will get more information for you and if the commissioners want to advocate we may want to engage elected officials.

Additional Comment from Commissioner: I recommend that this commission keep a close eye on the phrase "at-risk of homelessness" because it's been challenging for a long time. I think it is inhumane to wait until people become homeless, if they are at-risk they are seriously mentally ill, they have other extenuating circumstances. We need to have a say on this for constituents in our community. During our Housing Taskforce we learned that at-risk is defined differently at the State and federal level and is connected to the stream of funding and they get to make their rules about what is at-risk. It will behoove us to keep an eye on this.

- **Response from the Public:** The BoS appointed a Chief Equity Officer that can help answer our question... to the extent that they affect County decision-making. We know that we won't have people with addresses at-risk of homelessness. Which parts of our communities will be most impacted.

APPENDIX 3. MHSA HOUSING INITIATIVE TASKFORCE MATERIALS

Be the one to help



Mental Health Service Act (MHSA) Housing Initiative Taskforce

Join advocates, providers, clients and family members to provide input on MHSA housing priorities!

The MHSA Three-Year Plan prioritizes housing supports for individuals living with mental illness as an area to engage in deeper strategic planning and guide future funding allocations.

Join us for a time-limited Housing Initiative Taskforce!

Objectives include:

- Identify gaps in services based on a proposed Housing Continuum of housing support services
- Define and prioritize outcomes
- Develop and prioritize housing strategies for future funding consideration

-
- ✓ Stipends are available for clients/family members
 - ✓ Language interpretation is provided if needed*

**Please contact mhsa@smcgov.org or 650-573-2889, at least 2 weeks in advance, to reserve language services.*

DATES & TIME

Wednesday's 10:30am – 12:00pm

March 3, 2021

April 7, 2021

May 5, 2021

To join the Taskforce, we ask that you attend all three (3) meetings in March, April and May to allow for consistency in information sharing and decision making.

Contact Doris Estremera, MHSA Manager at mhsa@smcgov.org or (650) 573-2889 if you would like to participate in all three meetings and to receive the meeting links.

www.smchealth.org/MHSA



SAN MATEO COUNTY HEALTH
**BEHAVIORAL HEALTH
& RECOVERY SERVICES**

The Mental Health Services Act (MHSA) provides a dedicated source of funding in California for mental health services by imposing a 1% tax on personal income over \$1 million.

6/1/2021

Housing Information for BHRS Clients

**SAN MATEO
COUNTY HEALTH**
All together better.

Housing Continuum - example

Pre- Housing Engagement: Drop-In Centers / Shelters / Field Services / Post- Psychiatric Emergency Services, Hospitalization, Incarceration

Housing Continuum for Individuals with Mental Illness

* Based on Luke-Dorf Inc and Washington County, Oregon

<p>REHABILITATION CENTER</p> <ul style="list-style-type: none"> • Locked • 24/7 Staffing • Most restrictive • Ideal for highly symptomatic individuals 	<p>RESIDENTIAL TREATMENT</p> <ul style="list-style-type: none"> • Unlocked • 24/7 Staffing • Stabilization and skills building • Ideal for individuals out of higher level of care 	<p>RESIDENTIAL CARE "BOARD & CARE"</p> <ul style="list-style-type: none"> • Unlocked: eligibility requirements • 24/7 Staffing • Skill building and long-term stability • Ideal for support with basic needs 	<p>TRANSITIONAL</p> <ul style="list-style-type: none"> • Independent units • Staffing on-site • Intensive support services on-site • Ideal for stable individuals needing support 	<p>SUPPORTIVE</p> <ul style="list-style-type: none"> • Independent integrated housing • Support service staffing on-site • Ideal for individuals who are able to manage their needs with some support 	<p>INDEPENDENT LIVING</p> <ul style="list-style-type: none"> • Independent housing • Some support • Ideal for individuals who need minimal to no support
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← MORE STRUCTURED INTENSIVE CARE
LESS STRUCTURED SUPPORTS →

Objectives

- Discuss housing supports for BHRS clients with varied levels of need
- Learn about future housing programs and countywide collaborations
- Identify areas of focus from the continuum of housing supports

6/1/2021

Agenda- Housing Spectrum

- ▶ **Pre Housing Engagement: Coordinated Entry Services CES- A Program by Human Services Agency, Shelter Information**
- ▶ **Residential Treatment: BHRS Contracted Board and Care Homes**
- ▶ **Transitional Housing: MHA, MHA/CAMINAR YAIL Program**
- ▶ **Supported Housing: MHA Housing, FSP Housing, Caminar New Ventures, MHA Housing, PBAP, NPLH**
- ▶ **Independent Housing: Department of Housing Voucher Information: Shelter Plus Care, Project Based Vouchers, Mainstream Vouchers, Permanent Supported Housing Vouchers**
- ▶ **Housing Support & Housing Collaborations**
- ▶ **Questions**



Pre-Housing Engagement: Coordinated Entry System (CES) for Adults and Families

Coordinated Entry System (CES) began July 2017

- ▶ The Coordinated Entry System is a county-wide program operating via 8 Core Service Agencies.
- ▶ The CORE Service Agencies are the entry point for homeless services and also provide access to resources such as homeless prevention services, emergency food, diversion from homelessness, connections to benefits, rental assistance and other safety net services.
- ▶ Clients who are homeless or at risk of homelessness can go to one of the **CORE service** agencies. They can either walk in or call. The CORE service agencies will provide a **Coordinated Entry assessment** and potentially match individuals to Permanent Supported Housing (PSH) Vouchers or other housing opportunities if available. (No Waitlist as opportunities are very limited)
- ▶ CORE Service Agency Flyer: <https://hsa.smcgov.org/core-service-agencies>

6/1/2021

Pre-Housing Engagement: BHRS Contracted Shelter Beds

- ▶ Mental Health dedicated beds for BHRS clients are available at **Safe Harbor (5 beds) and Maple Street Shelter (5 beds)**- Clients receive wrap around case management
- ▶ Mental Health Association **Spring Street Shelter (15 beds)** –Clients receive wrap around case management

SPRING STREET SHELTER

Emergency shelter with support services.
15 beds – Opened 1986



6/1/2021

Residential Treatment: BHRS Contracted Board and Care Homes

- ▶ The Facilities Utilization Management Team oversees the referrals for placements at the BHRS contracted board and care homes in San Mateo County. This level of care requires a 24 hour staff support and medication management. All BHRS clients basic care needs are met including food and laundry. Staff assist clients with Appointments.
- ▶ There is a board and care coordinator on the Facilities Utilization Management Team who provides ongoing support to board and care operators. The coordinator also runs a monthly board and care operators' meeting.
- ▶ BHRS currently contracts with 14 B&C homes within San Mateo County
- ▶ Number of clients served FY 2019/2020 135*

**There are a number of other board and care homes throughout San Mateo County in which clients may reside. These numbers refer to clients placed at BHRS contracted board and care homes only.*

- ▶ **Questions: Clinical Services Manager II : Talisha Racy Tracy@smcgov.org**

6/1/2021

BHRS Contracted Board and Care Homes

24 hour staff support and medication management. All BHRS clients basic care needs are met including food and laundry. Staff assist client with Appointments.

- | | |
|---|--|
| <ul style="list-style-type: none"> ▶ A&E Home Care Services -RCFE – Armando Tria. 2 males. ▶ Hillcrest Manor – -RCFE -John Afanasiev. 8 males, 4 females. ▶ Ismaela's Home Care -RCFE – Rady Peredo. 6 females. ▶ Mariah's Garden Homecare-RCFE – Maria Zepeda. 2 Females and 4 Males. ▶ Millbrae Manor -RCFE – Mary Ann Lucero. 48 beds. Mixed male and female. ▶ 262 Station Home -ARF – Zenaida and Ernie Gueverra. 10 males and 1 female. | <ul style="list-style-type: none"> ▶ Bruce-Badilla Clean and Sober Home -ARF – Ligaya Bruce-Badilla. Dual diagnosed males. 12 males. ▶ Blanca's Place --ARF– Everst Barillas. 6 males. ▶ Care Plus --ARF– James Hsiao. 5 males, 1 female. ▶ Perpetual Help Home --ARF– James Hsiao. 6 males. ▶ Portobello Care Home --ARF– Perrine Salariosa and her daughter Minerva. 19 males. ▶ Rice Residential --ARF– Ruby Palattao. 1 female, 4 males. ▶ Simple Living --ARF– Mary Jane Que and Michael Que. 6 females. ▶ University Guest Home --ARF– Juanita Peoples. 4 males. |
|---|--|

Transitional Housing

1) Mental Health Association (MHA)- Spring Street Transitional Housing 7 Units. Clients obtain onsite CM support. (Transitional Housing up to 6 months)

2) CAMINAR YAIL – YOUNG ADULT INDEPENDENT LIVING Partnership with MHA – 3 shared units 2 clients per unit (Transitional Housing up to 24 months)

Services provided by CAMINAR:

On site support- Case Management support, clinical therapy and groups, psychiatry, supported education/ supported employment, housing retention skills, & peer support

SPRING STREET TRANSITIONAL HOUSING

Eighteen-month SRO housing with case management. 7 units - Opened 1990



YOUNG ADULT INDEPENDENT LIVING (YAIL)

Transitional housing for 18 to 23 year old individuals. 6-bedrooms – Opened 1995



Supported Housing

- ▶ **Mental Health Service Act (MHSA) Housing**
- ▶ **Full Service Partnership (FSP) Housing**
- ▶ **Caminar New Ventures**
- ▶ **Mental Health Association (MHA) Housing**
- ▶ **Provider Based Assistance Program (PBAP)**
- ▶ **No Place Like Home (NPLH) (Future Project)**

Mental Health Services Act (MHSA) Housing Units

- ▶ The Mental Health Services Act (MHSA), Proposition 63 in 2004, provides increased funding, to support County behavioral health programs
- ▶ The MHSA Housing Program was established to create permanent supportive housing for individuals with serious mental illness who are homeless or at risk of homelessness, and are enrolled in Full Service Partnerships, receiving wraparound services and supports. Since 2006, the funding has supported 62 housing units across six housing developments in Redwood City, South San Francisco, San Mateo and North Fair Oaks community.
- ▶ More information can be obtained: <https://www.smchealth.org/general-information/mhsa-housing-program>

6/1/2021

Year	Housing Development and Location	UNITS
2009	Cedar Street Apartments 104 Cedar St., Redwood City Mental Health Association	5 MHSA units 15 total units
2010	636 El Camino Apartments 636 El Camino Real, South San Francisco Mid Pen Housing	20 MHSA units 106 total units
2011	Delaware Pacific Apartments 1990 S. Delaware St., San Mateo Mid Pen Housing	10 MHSA units 60 total units
2017	Waverly Place Apartments 105 Fifth Ave, North Fair Oaks Mental Health Association **Referrals via Coordinated Entry System	15 MHSA units 16 total units
2019 In Construction	Arroyo Green- Senior Housing 62+ 707-777 Bradford Street, Redwood City Mid Pen Housing – Completion by Spring 2021	6 MHSA units 177 total units
2019 In Construction	Fair Oaks Commons -2821 El Camino Real, North Fair Oaks Palo Alto Housing – Completion by Winter 2020	6 MHSA units 67 total units
		62 Total MHSA units

MHSA Eligibility Criteria

Clients are eligible for an MHSA unit if they obtain services from Behavioral Health Services and meet the following criteria:

- 1) **Person with Serious Mental Illness or a Family with an SED child or youth**
- 2) - **Homeless** - living on the streets, or lacking a fixed regular and adequate nighttime residence **OR**
 - **At risk of homelessness** which includes:
 - Individuals discharged from institutional settings including:
 - Hospitals including acute psychiatric hospitals, psychiatric health facilities (PHF), skilled nursing facilities (SNF) with a certified special treatment program for the mentally disordered (STP), and mental health rehabilitation centers (MHRC)
 - Crisis and transitional residential settings
 - Individuals released from local city or county jails
 - Individuals temporarily placed in residential care facilities upon discharge from one of the institutional settings cited above
 - Individuals who have been deemed to be at imminent risk of homelessness, as certified by the BHRS mental health director.
- 3) **Active in BHRS services and enrolled or eligible for the following programs:**
 - Full Service Partnership (FSP) (San Mateo Criteria)
 - Intensive Case Management (ICM) (San Mateo Criteria)
 - Integrated FSP (San Mateo Criteria)

6/1/2021

MHSA Housing Supported Services

BHRS has a 20 year commitment to provide services to MHSA tenants living in the MHSA apartment buildings


On site Supportive Services offer the following services:

- Tenant engagement
- Housing Retention Skills
- Case Management
- Harm Reduction
- Motivational Interviewing
- Crisis intervention/de-escalation
- Effective service coordination

BHRS or BHRS contracted services include:

- Mental health care
- Substance Use Services
- Linkage to physical health care
- Case Management
- Daily Living Skills Training
- Benefits counseling and advocacy
- Housing retention skills
- Peer Support Activities
- Recreational and social activities
- Educational services
- Employment services
- Access to other services

6/1/2021



636 El Camino Real Apartments MidPen Corp - 2010

- ▶ El Camino Apartments
- ▶ 636 El Camino Real, South San Francisco
- ▶ Mid Pen Housing
- ▶ Referrals by BHRS/ Housing Authority
- ▶ 20 MHSA units
- ▶ 106 total units
- ▶ Onsite support by Telecare FSP services along with Mid Pen Supportive Resident Services. If clients are linked to FSP services they obtain wrap around support by the FSP (Telecare/Caminar).
- ▶ If clients are connected to a Regional Clinic they will also receive CM support via the Outpatient MH clinics.

6/1/2021



Full Service Partnership (FSP)

Full service partnership or “FSP” programs provide mental health services for the highest risk adults/older adults.

The purpose of these programs is to assist consumer/members to enroll and once enrolled, to achieve independence, stability and wellness within the context of their cultures, and communities.

We currently have 2 FSP providers **Telecare & Caminar**

6/1/2021

FSP Criteria

FSP Referral Criteria

Consumers will be referred for FSP services based on acuity and need for intensive level services based on the following criteria:

- ▶ LOCUS level 4 or higher AND at least one of the following
 - ▶ Three(3) PES/ED visits in last 60 days AND/OR
 - ▶ Two (2) inpatient psychiatric hospitalizations in last 6 months with most recent hospitalization in past 30 days AND/OR
 - ▶ Transitioning out of a locked/secure facility (i.e. MHRC, Secured SNF, Jail, or Out of County Placement) AND/OR
 - ▶ Loss of current support system that would potentially result in hospitalization, incarceration or other form of locked placement without FSP level services based on past history.

6/1/2021

Telecare FSP Housing

- ▶ Total FSP slots with Telecare **167 - Current FSP Housing slots 114**
 - Case Management 30 slots**
 - Wellness slots 10**
- ▶ Telecare offers a variety of housing opportunities based on clinical needs, availability and share of cost.
- ▶ Industrial Hotel in South San Francisco 42 slots
- ▶ Supported Independent Living Homes- 45 slots
- ▶ Types of housing: Apartments, Single Room Occupancy, Supported Independent Living, Provider Based assistance program, WISH House opened to free up beds at 3AB post Pandemic.
- ▶ Location: Throughout San Mateo County, SSF, EPA, Redwood city



89 Buchanan, East Palo Alto

6/1/2021

Telecare FSP Housing Continued...

What onsite support does each location have?

- ▶ All locations except the apartments have 24 hour onsite staff that support with medication monitoring, crisis intervention, and promoting activities of daily living.
- ▶ PBAP beds and WISH offers a higher staff to member ratio to offer more support as needed. PBAP clients may also have In Home Support Services
- ▶ WISH home also includes weekend support.
- ▶ Clinical groups offered (pre-pandemic) at Industrial Hotel and Independent living Homes.
- ▶ Every FSP Telecare client receives Case Management support, Clinical Groups, Telecare Nursing, med monitoring, ADL coaching, access to vocational specialist.

6/1/2021

Caminar FSP Housing

- ▶ Caminar FSP Slots **30** Total cts FSP / REACH /AOT Housing slots **21**
- ▶ Caminar REACH **55 slots**
- ▶ Caminar Assisted Outpatient Treatment AOT **50 slots**

Caminar Housing Opportunities:

Full Service Partnership clients supported through Caminar Housing funding are in Independent Living Apartments. There are studios, one and two bedroom units. Some units have double occupancy. FSP/REACH/AOT clients receive housing subsidy through their respective programs unless they have a voucher.

Services offered to Caminar FSP clients:

- ▶ Case Management support, clinical therapy and groups, psychiatry, supported education/supported employment, housing retention skills, & peer support
- ▶ FSP AOT clients may call an internal emergency line to obtain support.

6/1/2021

Caminar New Ventures

New Ventures Colma Ridge Apartments – Partnership with MidPen Housing- **22**

New Ventures Tehanan – Partnership with MHA – **14**

New Ventures clients in independent apartments Redwood City/San Carlos/Burlingame – **49**

New Ventures is lower level of care support. Clients obtain onsite CM 1-2 times a month.

Independent living with case management support. Clients have to be enrolled in Caminar New Ventures programs in order to be eligible.



6/1/2021

Mental Health Association (MHA)

- ▶ The Mental Health Association owns **10 properties** up and down San Mateo County from Daly City to Redwood City
- ▶ Just under **100 slots of supported housing** with an emphasis on living independently
- ▶ Clients living in MHA supported housing receive case management support and field based case management.
- ▶ Client obtain support from case managers, 2 full time occupational therapist, 2 public health nurses, and a licensed professional clinical counselor.
- ▶ MHA provides field based case management to **250+ clients** for clients with Mainstream vouchers, Shelter plus care vouchers, connected WPC, Safe at Home Vouchers

6/1/2021

MHA Permanent Supported Housing

BELMONT APARTMENTS

Subsidized housing with case management and support services. 25 unit apartment building – Opened 2005



CEDAR STREET APARTMENTS

Subsidized housing with case management and support services. 15 unit apartment building – Opened 2012



WAVERLY PLACE APARTMENTS

Subsidized housing with case management and support services. 15 unit apartment building – Opened 2018



Provider Based Assistance Program (PBAP)

PBAP: Partnership with HPSM, DOH & Brilliant Corners. **Program targets older adults who can live independently with supportive services. Clients have to be HPSM members and be eligible for In Home Support Services.**

- ▶ BHRS currently has **9 clients** housed through PBAP and they obtain supportive services from either Telecare FSP or one of our Adult Regional Clinics
- ▶ Eligibility criteria:
 - a person with disabilities or an elderly person as defined by HUD regulations, **and**
 - eligible for MediCal long-term care service and support; **and**
 - eligible for In-Home Supportive Services (IHSS) in San Mateo County; **and**
 - at-risk of entering or currently living in a skilled nursing facility but can successfully live independently with supportive services; **and**
 - be connected with Intensive Care Management services through The Institute on Aging, or another case management agency.
- ▶ This is a pilot program

6/1/2021

No Place Like Home NPLH

No Place Like Home Program

Purpose: To acquire, design, construct, rehabilitate, or preserve permanent supportive housing for persons who are experiencing homeless, chronic homelessness or who are at risk of chronic homelessness, and who are in need of mental health services.

Background info:

On July 1, 2016 Governor Brown signed landmark legislation enacting the No Place Like Home program to dedicate \$2 billion in bond proceeds to invest in the development of permanent supportive housing. The bonds are repaid by funding from the Mental Health Services Act (MHSA)

BHRS along with Eden Light Tree applied for the NPLH Non Competitive funds - 2020

Eden Light Tree (Developer) in RWC was **awarded** the non competitive award 1.7M

There will be **9 NPLH Units for NPLH Participants**. Client will be referred via Coordinated Entry System (**CES**) Targeted population will be SMI clients who are homeless, chronic homelessness or who are at risk of chronic homelessness.

Rehabilitation construction due to start 2021

6/1/2021

Independent Housing

Department of Housing Voucher Information:

BHRS clients may also be eligible for the following types of vouchers:

- ▶ Project Based Vouchers
- ▶ Tenant Based Voucher
- ▶ Permanent Supportive Vouchers
- ▶ Moving to work vouchers

Shelter Plus Care Vouchers- 200+ clients granted vouchers. BHRS committed to providing case management for clients with a Shelter Plus Care voucher.

Shelter Plus Care program provides **rental assistance**, in combination with supportive services from other sources, to assist homeless individuals with disabilities.

For more information: <https://housing.smcgov.org>

6/1/2021

Independent Housing Mainstream Voucher Program

The Housing Authority of the County of San Mateo 2018 were awarded **45** Mainstream Housing Vouchers (similar to Section 8) targeting disabled adults under 62 years of age.

- ▶ 2019 HA was awarded **90** Mainstream Vouchers
- ▶ 2020 HA was awarded an additional **41** Mainstream Vouchers
- ▶ BHRIS is one of the agencies that can refer clients to the Mainstream Voucher Program.
- ▶ BHRIS committed to provide case management support to Mainstream voucher holders.
- ▶ 45 Housing Locator slots funded by HPSM for clients who are HPSM members and have a Mainstream Voucher.

6/1/2021

Mainstream Eligibility Criteria

- ❑ The household meets HACSM Voucher Program requirements such as income, assets, citizenship/immigration, criminal background, etc. (Generally speaking income limits for 1 and 2 person households. 1 person = \$51,350 2 people = \$58,650)
 - ❑ The qualifying person must be at least **18 yrs old and under 62 years** of age at the time of move in
 - ❑ The qualifying person has a disability as defined by HUD (physical, developmental, chronic health, HIV/AIDS, **SMI**)
*Disability form has to be signed by MD not an NP
- AND at least one (1)
- ❑ Homeless-Letter of support is required
 - ❑ At risk of being homeless (i.e. 14 days from being homeless) Letter of support is required
 - ❑ Transitioning out of institutional or other segregated setting
 - ❑ At serious risk of institutionalization

6/1/2021

Mainstream Voucher Data 10.26.2020

From 2018 with the first allocation to present the Dep of Housing has issued a total of **231 vouchers**.
As of 10/26/2020 125 have leased up and moved into a unit.

Mainstream Applications submitted by BHRS to the Dep of Housing:

- ▶ Total number of Mainstream Voucher issued to BHRS clients: **131** **57% of total Mainstream Vouchers issued**
- ▶ **65 clients have been housed**
- ▶ 48 voucher holders are still searching for a unit
- ▶ Currently 37 additional applications are pending an eligibility interview

6/1/2021

Housing Support

- ▶ **Housing Groups-** The adult Behavioral Health Regional clinics offer housing support groups to help clients connect with the various housing opportunities they may be eligible for.
- ▶ Ct also obtain support for looking for units, filling out applications, and support/tips when meeting with landlords.

6/1/2021

Housing Committees/Collaborations

- ▶ Housing Operations and Policy Committee (HOP) – Collaboration with Dept of Housing and other community providers. We hold a yearly annual appreciation breakfast for landlords to encourage more landlords to participate renting to voucher holders.
- ▶ Housing our People Effectively Intra agency Council (HOPE IAC) – Quarterly meeting chaired by the Board of Supervisors - Supervisor Horsley.
- ▶ Continuum of Care (CoC) – CoC is coordinated by Human Service Agency. BHRS is a voting member.
- ▶ Housing Our Clients- Monthly meeting chaired by HSA which includes Directors and Deputy Directors of HPSM, HSA, DOH, CMO, BHRS, HEALTH, Sheriffs office, Probation, WPC
- ▶ Change Agent Housing Committee- Organizes annual BHRS Housing Heroes Awards

6/1/2021

Future Housing Opportunities

- ▶ **Fair Oaks Commons** -2821 El Camino Real, North Fair Oaks
Palo Alto Housing – Completion by Winter 2020 (Waiting list closed)

- ▶ **Arroyo Green- Senior Housing 62+**
707-777 Bradford Street, Redwood City
Mid Pen Housing – Completion by Spring 2021

- ▶ **NPLH - Eden Light Tree (Developer) in RWC.** There will be 9 NPLH Units for NPLH Participants. Client will be referred via Coordinated Entry System (CES)

Targeted population will be SMI clients who are homeless, chronic homelessness or who are at risk of chronic homelessness.

Rehabilitation construction due to start 2021

6/1/2021

Future Housing Opportunities

Arroyo Green- Senior Housing 62+

707-777 Bradford Street, Redwood City

Mid Pen Housing – Completion by Spring 2021

- ▶ Arroyo Green is a brand new 117-unit affordable senior housing community in Redwood City. This property offers 89 Section 8 Project-Based Voucher (PBV) units consisting of studio, one-bedroom, and two-bedroom apartments.
- ▶ Apply Online: www.mysmchousing.com from 10/12/20 8:00 am to 11/9/20 5:00 pm.
- ▶ *Arroyo Green leasing office at (650) 509-5020 or email arroyogreen@midpen-housing.org to make an appointment for in-person application assistance, including the Housing Authority online application.*



6/1/2021

Q&A & Future Areas of Focus

- ▶ Identify areas of focus from the continuum of housing supports
- ▶ Questions???

6/1/2021

My Contact Info

- ▶ **Mariana Rocha, LCSW**
- ▶ Clinical Services Manager II
- ▶ Behavioral Health and Recovery Services
- ▶ San Mateo County Health
- ▶ 802 Brewster Ave Redwood City CA 94063
- ▶
- ▶ (650) 599-1208 Phone
- ▶ (650) 454-6055 WCell
- ▶ (650) 364-6927 Fax
- ▶
- ▶ mrocha@smcgov.org

6/1/2021

**Housing for BHRS Clients Presentation
MHSARC Older Adult Committee Meeting – 11/4/20**

Question & Answer

1. Why does someone have to become homeless or at-risk of becoming homeless to get housing?

Response: Mainstream housing vouchers is one way we have been able to support clients regardless of homelessness status. It also depends on the level of care that a client may need, which is how they get matched to housing programs and supports.

Most affordable and supportive housing construction and ongoing operations requires funding from federal, state or local governments. These forms of funding require units to be restricted to certain income levels and some funding is restricted to individuals who are chronically homeless, homeless or at risk of homelessness.

Affordable housing that is restricted only by income does not require an individual to be homeless or at risk of homelessness.

2. Do the housing supports include substance use adults, or do they have to qualify under mental health? There are clients who have those

Response: If not connected to MH services, got primary care providers to sign off on documentation that DOH requires in terms of disability.

AOD residential housing, sober-living environments are not considered at risk of homelessness. Some one who was homeless before entering residential treatment is considered home when completing treatment.

BHRS/AOD however, provides supportive services to voucher holders who are disabled and have substance abuse disorders. Those with cooccurring disorders are included in the housing support programs.

3. Are there Waiting lists?

Response: There are no current wait lists for buildings funded with MHSA funding. When there is an opening which is not very often BHRS notifies the FSPs and the case managers with FSP eligible individuals. Those that have NPLH funding or federal Permanent Supportive Housing funding must rely on the Coordinated Entry System (CES) for referrals of BHRS certified individuals

4. How many slots for FSP are available in San Mateo county? Who decides who gets them? What happens to individuals who are eligible that do not get FSP?

Response: Currently there are a total of 309 FSP slots: Telecare has 207 BHRS/MHSA slots and 22 Criminal Justice/MHSA slots. Caminar has 30 BHRS/MHSA and 50 AOT/MHSA slots. In addition, there 55 slots in Caminar's Reach Intensive Case Management. This program is pre-MHSA version of FSP. Individuals who met the FSP criteria are identified by their clinical case manager and reviewed by clinical team who approves the referral. The client agrees to participation in the FSP, If there is no open slot the client can remain on the wait list or participate in a lower level of service such as the Integrated FSP, Intensive case management until a slot opens up.

5. How many BHRS clients are unhoused?

Response: This is a good question. There is no accurate way to determine when BHRS clients are unhoused as this would be a self-report by the client in most cases. Often at discharge from 3AB or other institutions, the lack of housing becomes known. BHRS has found that few homeless individuals registering with CES are actually BHRS clients.

6. Many clients cannot live on their own, even with much support, are there any efforts to develop new contracts for licensed B&C homes?

Response: We've gone through the list that is kept by the State on individuals that have expressed interest and have not had much success in getting folks to go through the licensing that is required for many reasons. It's not a lucrative business and BHRS cannot compete with the private B&C. Cost makes it difficult. "Mom and pop" establishments are often for-profit so they are not eligible for state funding for capital improvements.

7. Please explain what integrative FSP is.

Response: The Integrated FSP is a service applying ACT (assertive community treatment) principles to regional clients who live in the community and need additional supports to order to participate in treatment and maintain themselves in the community.

Some supportive housing for regional clients are considered integrated FSPs

8. Why someone has to be homeless, is how can a person who is living with aging parents access supportive housing?

Response: An individual with SMI who is living with aging parents (depending on the health, functioning of the caretaking parent and how soon the caretaker

parent may no longer be able to so) maybe be considered at risk of homelessness. The need would be identified and documented by the BHRS case manager.

9. How does MHSA money get to the Housing Dept to be distributed (if I have that right)?

Response: In the past we have set up an MOU agreement with the Department of Housing (DOH) to allow us to transfer MHSA Housing Program funds. DOH facilitates the bidding process for housing developers, which typically includes a mix of funding sources. This allows for MHSA funds to be highly leveraged.

10. How do we get more set aside units for BHRS clients in all the new low-income housing developments that are going up? (For comparison, the Firehouse Square project in Belmont I believe has 12 units set aside for people with Intellectual or Developmental Disorders. Services will be provided by a contractor.)

Response:

In order to answer this question, we need to provide an overview of the funding that nonprofit affordable and supportive housing developers access in order to be able to build and provide long term commitments to serve special needs populations.

The first aspect of set aside units is funding for construction. The second is rental subsidy to maintain rents at a very low level.

Funding

Funding for construction of units comes from multiple sources. Affordable and supportive housing requires funding from have come from federal HOME and CDBG, 811 funding for special needs, San Mateo County Affordable Housing Funds, MHSA Housing Program, No Place Like Home Program, State funds such as Multifamily Housing and other agency funds that provide services to special needs populations. These funds are available through complex and competitive application process. Some of these funds such as the MHSA Housing Program are no longer available as the program was not refunded.

It takes a few years to gather the different funding commitments in order to have enough funds to begin construction.

At the time of requesting funding that targets special populations, the developer is making a long-term commitment to serve that population.

Ongoing Rental Subsidy

In order for units to be restricted to target populations such as homeless individuals with serious mental illness and who are extremely low income, projects need an ongoing source of funds in order to keep the rents affordable to individuals with little or no income. The Housing Authority with project-based vouchers and housing choice vouchers is a major source of rental assistance subsidy. Some funding sources provide additional operating funds to keep the tenant portion of the rent low.

The San Mateo County Department of Housing (DOH) is often the beginning source of funding for affordable and special needs housing. They work to identify those developers who are interested in special needs populations and the available sources of funding to help with the construction of units.

BHRS does outreach to developers when there are available targeted funds for construction of supportive housing.

The Developer also makes an application to the housing authority in order to secure project-based vouchers for the rental assistance.

BOARD AND CARE SUPPORTS

Behavioral Health and Recovery Services

Talisha Racy, MFT, Clinical Services Manager II, Licensed Facilities

Housing Continuum - example

Pre- Housing Engagement: Drop-In Centers / Shelters / Field Services / Post- Psychiatric Emergency Services, Hospitalization, Incarceration



Housing Continuum for Individuals with Mental Illness

* Based on Luke-Dorf Inc and Washington County, Oregon

REHABILITATION CENTERS

- Locked
- 24/7 Staffing
- Most restrictive
- Ideal for highly symptomatic individuals

RESIDENTIAL TREATMENT

- Unlocked
- 24/7 Staffing
- Stabilization and skills building
- Ideal for individuals out of higher level of care

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

SUPPORTIVE HOUSING

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

INDEPENDENT LIVING

- Independent housing
- Some support
- Ideal for individuals who need minimal to no support

← MORE STRUCTURED INTENSIVE CARE

LESS STRUCTURED SUPPORTS →

LICENSED B&C'S WITHIN SAN MATEO COUNTY

Community Care Licensing website:

- 240 licensed Residential Care Facilities and 4 pending
- 107 licensed Adult Residential Facilities

BHRS CONTRACTED BOARD AND CARES

- All BHRS in county contracted Board and Cares are under FUM Team
- B&C's maintain licensure through CCL
- B&C's provide meals, medication management, and support clients with scheduling appointments, and attending to their activities of daily living.
- All clients have a treatment team that provides case management, medication support (i.e. Regional, FSP, or OASIS)

B&C Adult Residential Facility (ARF) 18-60

➤ 13 facilities

➤ 117 beds

**One board and care specializes in providing care for clients that are SMI and have substance use issues.*

B&C Residential Care Facility for the Elderly (RCFE) 60+

➤ 5 facilities

➤ 74 beds

ADDITIONAL CONTRACTED BEDS

Cordilleras Suites (Telecare)

- Enhanced b&c licensed as an ARF-49 beds
- The facility provides 24/7, non-medical care, meals, medication management, and groups.
- Shuttle services are provided to support getting to treatment appointments and going on community outings.
- The Suites goal is support clients transitioned from locked placements to community level placement.
- provides community based transitional services that enable clients to further develop their community living and social skills before community placement.

ADDITIONAL CONTRACTED BEDS CONT.

Cassia House (Mateo Lodge)

- 14 bed Adult Residential facility
- Provides 24-hour supervision, support and case management services.
- Food is provided and residents are responsible for preparing their own breakfast and lunch; dinner is provided.
- Residents are expected to maintain their living area, do their laundry weekly, and participate in one house chore daily.
- Recreational classes and social gatherings are provided weekly.

ADDITIONAL CONTRACTED BEDS CONT.

Humboldt House (Mateo Lodge)

- 3 shared bedrooms within the licensed part of the home (6 beds)
- 7 independent living apartments with two shared bedrooms in each apartment.
- The licensed portion of the home provides 24-hour supervision, support, case management and all meals are provided.
- Residents residing in the apartments are expected to cook for themselves.

BOARD AND CARE ELIGIBILITY

Clients must meet the following criteria:

- San Mateo Health Client
- SMI, or co occurring (SMI and substance use issues)
- Functional impairment in attending to Activities of Daily Living (ADL's)
- Ambulatory

**Hillcrest and Milbrae Manor able to take clients with assistive devices (canes, walkers, wheelchairs).*

- Does not require a skilled nursing level of care
- Must have a source of income (SSI/SSP)

BOARD AND CARE REFERRAL PROCESS

All referrals for any of the contracted board and cares are sent by treatment teams to the BHRS FUM Board and Care Coordinator.

- The board and care coordinator reviews all referrals to ensure they are appropriate for a community level placement.
- If appropriate, the board and care coordinator proceeds with setting up a meeting with the client to further assess needs, and ensure appropriateness for a community level setting.
- If determined an appropriate referral, board and care coordinator forwards the referral to the board and care operator.
- Board and Care Operator reviews the referral and schedules interview with the client
- Once accepted into placement the Board and Care Coordinator will support the board and care operator by gathering the admission paper work needed before a client can be placed.
- Admission Date is set after board and care operator receives a completed admission packet.

BOARD AND CARE COORDINATOR ROLE

- Weekly-bi weekly check ins with b&c operators
- Provide clinical support and assist with triaging issues
- Share covid-19 resources and identify any gaps in needs
- Admission and discharge planning
- Assist with developing client behavioral plans
- Check in's with clients to monitor their progress; support with addressing any concerns
- Assist with coordinating with treatment providers
- Participate in case conferences to support clients placement stabilization
- Facilitate monthly b&c operator meeting
- Set up board and care operator trainings (10 trainings per year)

BOARD AND CARE WAITLIST

FACILITY PLACEMENT STATUS (Week of: 2/1/21)			
Referrals on Waitlist	Referrals		Relevant issues/concerns
ARF	13		
Bruce Badilla	1		
RCFE/Ambulatory	12		
RCFE/Non-Ambulatory	3		
Board & Cares	Open Beds	Referrals	Relevant issues/concerns
A&E Home Care Serv (RCFE/2/male)			
Rice Residential (ARF/5/male)	1		on HOLD due to COVID
Blanca's Place (ARF/6/male)			COVID Lockdown
Care Plus (ARF/6/male)	1		
Perpetual Help Home (ARF/6/M)			
University Guest Home (ARF/6/M)	2	2	Referrals sent, pending interviews
Hillcrest Manor (RCFE/12/M/F)	1		2 referrals
Ismaela's Homecare (RCFE/6/F)			Ruth is on 30 day notice-continuing case conference scheduled
Mariah's Garden Homecare (RCFE/6/3F3M)			
Portobello Care Home (ARF/19/M)	1		1 ct. accepted and pending COVID test
Simple Living (ARF/6/F)			
Bruce-Badilla (ARF/12/M)	1		1 ct. served notice/1 ct referred.
Millbrae Assisted Living (RCFE 4B)	2F		2 isolation rooms for COVID and 1 bed hold for. 1 ct pending interview

MHSA FUNDED BOARD AND CARE ACTIVITIES

Care Packages

Adult Coloring books

Fidget Toys

Fuzzy Posters

Markers/coloring pencils

Word Searches



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MHSA FUNDED BOARD AND CARE GROUPS

1. Illness Management and Recovery
2. Seeking Safety
3. Wellness Recovery and Action Plan (Wrap)
4. Co-occurring/Harm Reduction



**Covid-19 pandemic-Health Officer shelter orders shift from in person to virtual groups*

MHSA funding to Support Virtual Groups

- 30 chrome pads/data plans, covers, earphones, sanitizing machine
- Chrome pads set up to enable easy use, font size, auto-saving log in info, basic user instructions, staff assistance for logging into first virtual group.
- Group supplies needed to facilitate the groups

BENEFITS OF THE GROUPS

- ❖ Board and Care Operators appreciative of the groups being offered, and that they are facilitated by BHRS staff.
- ❖ All clients are allowed to participate in the group if they chose (screen in vs out)
- ❖ Building coping skills
- ❖ Support with managing symptoms

PAYMENT/FUNDING

Non-Medical Out-of-Home Care (NMCHC)
Payment Standard for Individuals Licensed Facility or
Without In-Kind Room and Board
Effective January 1, 2021

Source	Amount
Supplemental Security Income (SSI)	\$ 794.00
State Supplementary Payment (SSP)	\$ 493.37
Total NMCHC Payment Standard	\$1,217.37*

The NMCHC Payment Standard includes the following components:

Component	Amount
Room and Board	\$ 520.37
Care and Supervision (maximum)	\$ 204.00
Amount Payable for Basic Services	\$1,179.37*
Personal and Incidental Needs Allowance (minimum) (Must be provided to the recipient)	\$ 138.00
Total NMCHC Payment Standard	\$1,217.37*

*This total NMCHC payment standard is doubled for SSI/SSP couples.

† NOTE: Recipients who have income in addition to their SSI/SSP check (for example, a pension, Social Security retirement, or disability benefits) can be charged the \$1,079.37 amount for basic services plus an additional \$20. Because federal rules do not count the first \$20 of a recipient's income against their SSI/SSP grant, an SSI/SSP recipient with other income has an extra \$20 that people who receive only an SSI/SSP check do not have. Neither federal nor state law restricts the recipient in how this additional \$20 amount is spent. Thus, if the recipient agrees in the admission agreement to pay the additional \$20 for basic services, the facility may charge the additional amount.

In addition to the SSI payment, BHRS pays:

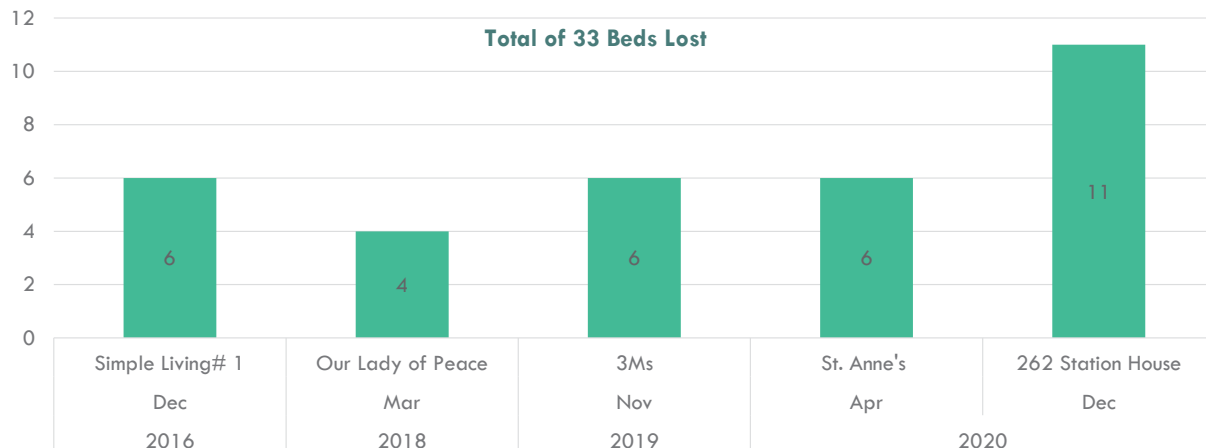
Daily Patch (net county costs/MHSA)

➤ \$36.76

*only 1 b&c paid \$44.05 Bruce B. co-occurring specialty provider.

BOARD AND CARE CLOSURES

Board and Care # of Beds Lost by Year



CURRENT CHALLENGES

COVID-19 pandemic

- Some clients not consistently following shelter in place orders, or wearing PPE.
- B&C Operators concern for their own health and wellbeing and the potential of the virus being brought into their facility.
- Rise in notices being given to clients

NEEDS AND OPPORTUNITIES

- Demand for RCFE beds continue to rise
- Transition from ARF to RCFE as clients age, and require more support to maintain a community level placement.

B&C Operators are retiring

- Need targeted recruitment to recruit new board and care operators
- B&C Informational sessions
- Explore board and care sign on bonus and/or monies for start up costs

QUESTIONS

Talisha Racy, CSM II, Licensed Facilities

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BHRS Board and Care (B&C) Supports Presentation MHSARC Older Adult Committee Meeting – 2/3/21

Question & Answer

1. Does BHRS only house their clients in the contracted B&Cs?

Housing resources for BHRS clients can include a variety of levels including independent, Board and Care, and supported housing. Both BHRS and Full-Service Partnership program clients, are eligible for placement in BHRS contracted B&C's. FSPs also utilize room and board arrangements with care being provided by the FSP.

2. Are there non-BHRS clients residing in the BHRS contracted B&C facilities? All clients are open to either BHRS or a Full-Service Partnership provider (i.e. Edgewood, Telecare or Caminar).

3. Is there a list of the non-licensed B&Cs? There is no comprehensive list. Case Managers over time find out about places and develop their own list. The Bridges to Wellness Team use these types of placements and could be a good resource.

4. You mentioned shortage of beds. Do you have figures on what the needs are, and the projections 5yrs down the road?

In San Mateo County, there are 240 licensed Residential Care Facilities for the Elderly (RCFE) and 107 licensed Adult Residential Facilities (ARF), which serves clients ages 18-60. BHRS contracts with B&Cs include 5 RCFE (74 beds) and 13 ARF (117 beds); including Cordilleras Suites and one facility that specializes in co-occurring substance use issues. Additional BHRS contracted ARF licensed facilities (not considered B&C) provide support services to clients that are more independent and higher functioning (20 beds).

In terms of the need, over the past four years BHRS has lost 33 beds. B&C operators are retiring and closing their facility. The waitlist for B&Cs at any given week, can range from 15-20 referrals. Demand for RCFE for aging clients that require more support continue to rise. For our smaller B&Cs we have fewer beds available for females ages 18-60, so we could use more female ARF beds. Overall, we have more male clients.

5. What is the difference between the B&C coordinator and a clients' case manager?

All B&C clients have to have a case manager and connected to a treatment team. The B&C Coordinator is responsible for overseeing the B&C placement and keep track of who is entering and exiting B&C placements. They review all referrals to ensure appropriate placement, set up meetings with the clients to further assess needs as needed, forwards the referral to the B&C operator and supports them with obtaining paperwork needed for placement. B&C Coordinators have regular check-ins with the B&C operators and support clients placement stabilization. At times, the B&C Coordinator does conduct case management activities but, most of the time they are linking with the treatment team to ensure that they are aware of any issues and following up.

6. Are Peer Support Services used in these facilities? If so, who employs them?

Peer Support is usually offered via the BHRS regional clinics, Older Adult System of Integrated Services (OASIS) program or the Full-Service Partnership program that clients are receiving treatment from. There are some occasions where a client may be connected with peer support via programs such as Helping Our Peers Emerge, which provide peer support to clients at the point of step-down from a locked program, for example, or other higher level of care. In those instances, the peer mentor stays with the client and supports the transition to a lower level of care.

7. How are the tablets being used by B&C?

The tablets are being used for virtual groups such as illness management and recovery, Seeking Safety, Wellness Recovery Action Plan (WRAP), and co-occurring harm/reduction sessions

8. How many clients vs. how many chrome pads (tablets)?

30 tablets with data plans were procured to rotate through B&C facilities. Given, the Covid 19- pandemic, each client is provided a tablet to use to log into the group. A current goal is to have more than one B&C participating in any given group session vs. one virtual group per B&C to expand the reach of group topics.

9. What are the training topics?

A variety of training topics are provided to B&Cs, below is a sample training topic list.

CEU Schedule of Classes
BHRS – B&C Operators

Title	Approved #	Hours	Proposed Date	Time	Duration	Location	Instructor
Managing Alzheimer's and Related Dementia's		2hrs	10/8/20	10 am-12 pm	2hrs.	Zoom	Dr. Barbara Weisman MD
Behavioral Health Emergencies		2hrs	1/7/21	10 am-12 pm	2 hrs.	Zoom	Jennifer Blaser LMFT
Hospice Continuum of Care		2hrs	2/4/21	10 am-12 pm	2 hrs.	Zoom	Bethany Berkowitz LCSW
Preventing Coronary Artery Disease		2 hrs.	4/1/21	10 am-12 pm	2 hrs.	Zoom	TBA
Trauma Informed Care Part II		2 hrs.	5/6/21	10 am-12 pm	2 hrs.	Zoom	Cindy Donis LMFT
Cultural Humility		2hrs.	6/3/21	10 am-12 pm	2 hrs.	Zoom	ODE
SOGI		2hrs	7/8/21	10 am-12 pm	2 hrs.	Zoom	PRIDE Center

10. What kind of assistance are you contemplating offering to entice new Board and Care startups?

We are competing with private B&Cs that can charge up to \$7K per month. Some ideas mentioned include having targeted recruitment that could include B&C informational sessions to showcase the amount of support they will get from BHRS if they do sign up. Additionally, sign on bonuses or covering start-up costs.



Mental Health Services Act (MHSA) Housing Initiative March 3, 2021



SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

Before we begin...

- Meeting is being recorded
- Stipends for clients and family members participating
 - Please remain online after the meeting ends
- Raise hand button - test
- Quick Poll



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BEHAVIORAL HEALTH
& RECOVERY SERVICES



Agenda

1. Introductions & Ground Rules
2. Overview & Purpose
 - Objectives for all 3 meetings
3. Background Information
4. Housing Continuum & Housing Assistance
5. Next Steps



1. Introductions



Participation Guidelines

- Please enter your questions in the chat box as we go
- There are “Q&A” slides incorporated into the presentation
 - “Raise Hand” button
 - Host will call on one participant at a time; you can then unmute yourself
- Ground Rules
 1. Share the airtime; allow every voice to be heard (step up/step back)
 2. Practice both/and thinking; consider all ideas along with your personal advocacy
 3. Be brief and meaningful when voicing your opinion
 4. Success depends on participation (share ideas, ask questions)
 5. Share your unique perspective and experience
- Decision points – majority vote
- A recommendation will be made for public hearing, 30-day public comment and final approval by the Board of Supervisors



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2. Overview & Purpose



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MHSA Housing Priority

- MHSA & Three-Year Plan Priorities
- MHSA Housing Initiative Goals:
 - Identify gaps in services based on a proposed Housing Continuum of housing support services
 - Define and prioritize outcomes
 - Develop and prioritize housing strategies for future funding consideration



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Meeting Objectives

- Meeting #1 (March 3rd):
 - Review background information and opportunity for additional Q&A
 - Present additional layers to the Housing Continuum to include:
 - Programs and numbers served
 - Eligibility and State requirements were applicable
- Meeting #2 (April 7th):
 - Present set of outcomes and data to support/inform decisions
 - Brainstorm additional outcomes as necessary
 - Prioritize across all outcomes to focus strategic direction
- Meeting #3 (May 5th):
 - Present set of best practice solutions
 - Brainstorm additional solutions as necessary
 - Prioritize across all strategies to recommend



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Questions?

3. Background Information



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MHSA Available Funding

- Inequitable impact of COVID has led to higher revenues than expected for MHSA
- [Ongoing](#) budget for FSP services, including supportive services and other housing supports will be increased by at least \$1M
- [One-time](#) funding for housing developments, system development efforts, facility renovations and technology infrastructure; amount TBD
 - As we move forward the exact amounts will become clearer and the proposed MHSA budget will be presented to the MHSARC for a public hearing, 30-day public comment process and approval.



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Materials High-Level Review

- What MHSA can fund
 - Fact Sheet – How Can MHSA Be Used To Support Homeless Individuals
- Q&A
 - Any additional questions



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A photograph of a woman with dark, curly hair, wearing a blue top, speaking into a microphone. She is looking slightly to her left. The background is blurred, showing other people and what appears to be a community meeting setting. The entire image is overlaid with a semi-transparent teal color.

Questions?

4. Housing Continuum & Housing Assistance



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Housing Continuum - example

Pre- Housing Engagement: Drop-In Centers / Shelters / Field Services / Post- Psychiatric Emergency Services, Hospitalization, Incarceration



Housing Continuum for Individuals with Mental Illness

** Based on Luke-Dorf Inc and Washington County, Oregon*

REHABILITATION CENTERS

- Locked
- 24/7 Staffing
- Most restrictive
- Ideal for highly symptomatic individuals

RESIDENTIAL TREATMENT

- Unlocked
- 24/7 Staffing
- Stabilization and skills building
- Ideal for individuals out of higher level of care

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

SUPPORTIVE HOUSING

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

INDEPENDENT LIVING

- Independent housing
- Some support
- Ideal for individuals who need minimal to no support

MORE STRUCTURED INTENSIVE CARE

LESS STRUCTURED SUPPORTS

Housing Continuum



Pre-Housing Engagement

Drop-In Centers	Shelters	Field Services	Post Psychiatric Emergency Services	Hospitalization	Incarceration
<p>Services or activities for homeless and/or those with mental illness.</p> <ul style="list-style-type: none"> • Available without an appointment • Range from M-F 8-5 to 1 x per week <p>➢ In county:</p> <ul style="list-style-type: none"> • 20 sites 	<p>Beds for homeless individuals</p> <ul style="list-style-type: none"> • Usually for 90 days or less. <p>➢ In County:</p> <ul style="list-style-type: none"> • 25 MH beds • 221 general beds 	<p>Services delivered by outreach teams to individuals who are homeless and/or have mental illness and/or substance use challenges.</p> <ul style="list-style-type: none"> • Services provided in community locations, place of residence, street or encampments <p>➢ In County:</p> <ul style="list-style-type: none"> • 11 BHRS Outreach Teams • 5 Homeless Outreach Teams (HOT) 	<p>Services to individuals following a psychiatric emergency room visit or hospitalization.</p> <ul style="list-style-type: none"> • New clients referred to Access for assessment for ongoing services and outreach Teams ensure linkage and ongoing peer support • Current clients follow up services are coordinated with care team and outreach team when needed 	<p>In-patient psychiatric stay for individuals with acute symptoms and are a danger to self or others.</p> <ul style="list-style-type: none"> • No discharge to homeless • Coordinated step down plan • Outreach team if needed <p>➢ In county:</p> <ul style="list-style-type: none"> • 34 locked beds • Additional beds on case basis 	<p>Behavioral health services for incarcerated and post incarcerated individuals.</p> <ul style="list-style-type: none"> • MH and AOD services in SMC county jail • Mental Health Court and diversion with mental health team case management

Housing Continuum cont'd



SMC Housing for Individuals with Mental Illness

Rehabilitation Center	Residential Treatment	Residential Board and Care	Transitional	Supportive Housing	FSP Supported Housing	Independent Housing
<ul style="list-style-type: none"> • Locked facilities • 24/7 Staffing • Most Restrictive • Ideal for highly symptomatic individuals <ul style="list-style-type: none"> ➢ In County: <ul style="list-style-type: none"> • 64 beds ➢ Out of County: <ul style="list-style-type: none"> • 65 beds 	<ul style="list-style-type: none"> • Unlocked • 24/7 Staffing • Stabilization and skills building • Ideal for individuals leaving higher level of care <ul style="list-style-type: none"> ➢ In county: <ul style="list-style-type: none"> • 29 Crisis Residential beds • 37 Social Rehabilitation beds • 163 AOD beds 	<ul style="list-style-type: none"> • Unlocked, eligibility requirements • 24/7 Staffing • Skill building and long-term stability • Ideal for support for basic <ul style="list-style-type: none"> ➢ In county: <ul style="list-style-type: none"> • 194 Beds ➢ Out of County: <ul style="list-style-type: none"> • 129 Beds 	<ul style="list-style-type: none"> • Independent units • Staffing on-site • Intensive support services on-site • Ideal for stable individuals needing support • Focus on moving to permanent housing <ul style="list-style-type: none"> ➢ In County: <ul style="list-style-type: none"> • 7 units, 6 bedrooms 	<ul style="list-style-type: none"> • Independent • Integrated or dedicated housing • Permanent housing • Support Services on-site • Ideal for individuals who manage their needs with some support <ul style="list-style-type: none"> ➢ In County: <ul style="list-style-type: none"> • 165 units, 9 NPLH units pending 	<ul style="list-style-type: none"> • Range of housing includes Single Room Occupancy, Room and Board, Shared Housing, and independent housing • Individuals receive on site and off site services based on Assertive Care Treatment (ACT) <ul style="list-style-type: none"> ➢ In County: <ul style="list-style-type: none"> • 309 individuals enrolled in FSP 	<ul style="list-style-type: none"> • Independent housing in community • May have some supports • Ideal for individuals who need minimal to no support • Rental assistance include mainstream, Shelter Plus Care, Project-Based Vouchers, and Housing Choice Vouchers, and Housing Choice vouchers and other rental support are utilized

Housing Assistance Services

Skill Development	Housing Case Management	Rental Assistance	Homeless Assessment and Housing Referral	Housing Locator	Landlord Tenant Assistance
Instruction on daily living skills for success in housing	Services to find and maintain successful housing	Short-term and long-term assistance	Identification of housing needs and referral to available housing	Services to identify available housing	Services to educate tenants, mediate issues with landlords, identify and support landlords who rent to special populations



Pre-Housing Engagement



Drop-In Center

- Services or activities for homeless and or those with mental illness
- Available without an appointment
- Range from M-F 8-5 to 1x per week
- In County:
 - 20 sites



Shelters

- Beds for Homeless Individuals
- Usually 90 days or less
- Case Management
- Linkage to housing resources
- In County:
 - 25 beds mental health beds
 - 221 general population beds



Field Services

- Services delivered by outreach teams
- Services provided in community locations, place of residence, street or encampments
- Outreach to homeless individuals, individual with mental illness and or substance abuse disorder
- In County:
 - 11 BHRS outreach teams
 - 5 Homeless Outreach Teams (HOT)

Post Psychiatric Emergency Services

- Services to individuals following a psychiatric emergency room visit or hospitalization
- New clients
 - Referred to Access or Regional Clinic for same day assessment
 - Outreach Teams to ensure linkage
 - Peer Support
- Current clients
 - Follow up services are coordinated with care team
 - Outreach team when needed.

Hospitalization

- Inpatient psychiatric stay
- Individuals with acute symptoms and are a danger to self or others
- No discharge to homelessness
- Coordinated step down plan
- Outreach team if needed
- In county: 34 locked beds
 - Additional beds on case basis



Incarceration

- Behavioral health services for incarcerated and post incarcerated individuals.
- In County Jail:
 - Mental Health Services
 - AOD treatment program
- Mental Health Court
 - Drug Court
 - Service Connect



Housing for Individuals with Mental Illness



Rehabilitation Centers

- Locked Facilities
- 24 hour, 7 days a week staffing
- Most Restrictive
- Ideal for highly symptomatic individuals
- In County: 64 beds
- Out of County: 165 beds



Residential Treatment

- Unlocked
- 24/7 Staffing
- Stabilization and skills building
- Ideal for individuals leaving higher level of care
- In County
 - Crisis Residential: 29 beds
 - Social Rehabilitation: 37 beds
 - AOD Residential Treatment: 163 beds



Residential Board and Care

- Unlocked
- Eligibility requirements
- 24/7 Staffing
- Skill building and long-term stability
- Ideal for basic support
- In County: 194 Beds
- Out of County: 129 Beds

Transitional

- Independent Units
- Time limited stay
- Staffing and intensive support services on-site
- Ideal for stable individuals needing support
- Focus on moving to permanent housing
- In County: 7 units, 6 bedrooms
 - Some space in shelters

Supportive Housing

- Independent, integrated or dedicated housing
- Permanent housing
- Support services on-site
- Ideal for Individuals who are able to manage their needs with some support
- In County: 165 units
 - Pending: 29 total



Supportive Housing Financing

- Total Project Cost: \$9,554,270 16 units at 15%-30% AMI
- City of RWC: \$610,875
- SMC DOH HOME/CDBG \$1,018,700
- SMC DOH HOME/CDBG \$ 400,000
- SMC AHF \$950,000
- CALHFA –MHSA \$1,973,895
- HCD MHP \$1,334,263
- General Partner Equity \$350,000
- Tax Credit Equity \$2,916,537





Full Service Partnership Supported Housing

- Range of housing includes Single Room Occupancy (SRO), Room & Board (R&B), shared housing, and independent housing
- All receive on-site and off-site service based on Assertive Community Treatment (ACT) model
- In County: 309 individuals enrolled in FSP



Independent Housing

- Independent housing in community
- May have supports not connected to housing
- Ideal for individuals who need minimal to no support
- May have rental assistance.

Housing Assistance



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Rental Assistance

- Short-Term (Often 1x only)
 - Rapid Re Housing
 - Move in Deposit
 - Moving costs
 - Utility Deposit/Payment
 - Back rent
- Permanent Assistance
 - Main Stream Vouchers
 - Project Based Vouchers
 - Housing Choice
 - Master Leasing
 - Affordability restrictions



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Housing Case Management

- Independent housing with mainstream and Shelter Plus Care vouchers
- Assistance with housing applications, securing documents, interview preparation
- Tracking housing openings
- Provided by FSP, Regional BHRS case managers, peer employees and peer volunteers

Skill Development

- Independent living skills
- Wrap for housing
- Occupational therapy for independent living skills
- Peer coaching

Homeless Assessment and Housing Referral

- Housing Locator service
- Core Service Agency
 - Coordinated Entry System (CES)
 - Homeless Assessment
 - Housing Referral System
 - Rapid Re-Housing
 - Rent and Utility Assistance
- Basic Needs
- Information and Referral



Landlord Tenant Assistance

- How to be a good tenant
- Eviction prevention
- Fair Housing
- Landlord/ Tenant Mediation
- Outreach to potential landlords
- Landlord support for special needs populations
- On site Resident Services Coordinator



Collaborative Planning

- Continuum of Care
- Housing Operations and Policy (HOP) Committee
- Housing Our People Effectively (HOPE) Interagency Council (IAC)
- Housing Our Clients
- Department of Housing
- Human Service Agency
- County Health
- Health Plan of San Mateo
- Non-Profit Housing Providers
- Non-Profit Mental Health Housing and Service Providers
- Consumers and Family Members

San Mateo County Health
Behavioral Health & Recovery Services

Future Developments & Events

- County to purchase and renovate hotels for homeless and seniors
 - Towne Suites: 95 units for seniors
 - Pacific Inn: 74 units
 - Coastside Inn: 52 units
- New source of rental assistance funds
 - Rent and utilities: current and in arrears



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Questions?



5. Next Steps



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What additional information do you need?

- Type in chat
 - Data, programs/services, other?
- Email Judy Davila: c_jdavila@smcgov.org or MHSA@smcgov.org



THANK YOU!

Judy Davila

c_jdavila@smcgov.org

Doris Estremera

mhsa@smcgov.org

www.smchealth.org/MHSA

Meeting Feedback:

www.surveymonkey.com/r/HousingTaskforce



SAN MATEO COUNTY HEALTH
**BEHAVIORAL HEALTH
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BRADLEY P. GILBERT, MD, MPP
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



GAVIN NEWSOM
GOVERNOR

March 23, 2020

FACT SHEET

How Can MHSA Be Used To Support Homeless Individuals?

MHSA statute acknowledges that a system of care for individuals with severe mental illness is vital for successful management of mental health. It requires a comprehensive and coordinated system of care that includes criminal justice, employment, housing, public welfare, health, and mental health to address mental illness and deliver cost-effective programs.¹

Like any program funded through MHSA, the program must be set forth in the 3-year expenditure plan and annual update pursuant to W&I Code § 5847 and be vetted through a local stakeholder process.

MHSA funded services and assistance are available to persons who are homeless or at risk of being homeless, who are also suffering from serious mental illness.²

Counties are authorized to fund services to the homeless and housing assistance through the **Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), and Capital Facilities and Technological Needs (CF/TN) components** of MHSA.

CSS Programs

CSS is the largest MHSA component at 76% of county MHSA funding.³ CSS funds may be used to serve the homeless population through the following services and programs.

Full Service Partnership (FSP)

Counties are required to direct a majority of their CSS funds to FSPs.⁴ Individuals eligible for an FSP include those who are unserved or underserved and may be homeless or at risk of becoming homeless.⁵ FSPs

¹ Welfare & Institutions (W&I) Code § 5802.

² W&I Code §§ 5600.3(b)(4)(A) and 5600.4(j).

³ California Code of Regulations (CCR) § 3420; W&I Code § 5892(a)(5).

⁴ CCR § 3620(c).

⁵ CCR § 3620.05(b)(c)(d).

provide wrap-around or “whatever it takes” services to clients. FSP mental health services and supports⁶ include:

- Mental Health Treatment
- Supportive Services to Assist the Individual in Obtaining and Maintaining Employment, Housing and/or Education.
- Peer Support
- Wellness Centers.
- Personal Service Coordination/Case Management
- Needs Assessment
- Individual Services and Supports Plan (ISSP) Development
- Crisis Intervention/Stabilization Services
- Family Education and Reunification Services

FSP non-mental health services and supports⁷ include:

- Food
- Clothing
- Housing, including, but not limited to:
 - Rent Subsidies
 - Housing Vouchers
 - House Payments
 - Residence in a Drug/Alcohol Rehabilitation Program
 - Transitional and Temporary Housing
- Cost of Health Care Treatment
- Cost of Treatment of Co-Occurring Conditions, such as Substance Abuse
- Respite Care

General System Development (GSD) Programs

CSS funds can also be used to fund GSD programs, which may include mental health treatment, peer support, and personal service coordination. Such programs could include assistance in accessing housing and crisis intervention/stabilization services.⁸ Examples of such programs include:

- Countywide housing specialist teams that provide housing placement services.
- Crisis teams that provide linkage to county mental health programs.

Additionally, under GSD, a county may transfer funds to their local government housing entity for a specific Project-Based Housing Program.⁹

Examples of Project Based Housing include:

- Rehabilitation of a hotel for short-term housing.
- Purchase of a house for transitional housing.
- Construction of a building for master leasing of units.

⁶ CCR § 3620(a)(1)(A).

⁷ CCR § 3620(a)(1)(A).

⁸ CCR § 3630(b).

⁹ CCR § 3630.05(a).

Outreach and Engagement (O&E)

CSS can be used to fund outreach activities/programs that are intended to identify unserved individuals who meet certain criteria¹⁰, in order to engage them in the mental health system so that they receive the appropriate services.¹¹

- O&E funds may pay for food, clothing, and shelter, *but only when* the purpose is to engage unserved individuals, and when appropriate their families, in the mental health system. Examples:
 - Multi-Disciplinary Teams that Engage Homeless
 - Peer Services
 - TAY Targeted Teams
 - Navigators
- O&E activities include:
 - Outreach to entities such as schools, tribal communities, public places such as streets and trails, jails and hospitals.
 - Outreach to individuals who are homeless and those who are incarcerated in county facilities.

Housing Assistance

CSS funds may be used for “housing assistance”¹² which includes:

- Rental assistance or capitalized operating subsidies.
- Security deposits, utility deposits, or other move-in cost assistance.
- Utility payments.
- Moving cost assistance.
- Capital funding to build or rehabilitate housing for homeless, mentally ill persons or mentally ill persons who are at risk of being homeless.¹³
- Housing may include short-term housing (ex. hotel), transitional and permanent supportive housing.

No Place Like Home (NPLH) MHSA-Funded Supportive Services

NPLH funding is a separate funding source from MHSA, but to get the funding through NPLH, an applicant county has to commit to providing the NPLH tenant population mental health supportive services for at least 20 years. They can use multiple funding sources to provide the supportive services, including MHSA funding. The NPLH program is dedicated to the development of permanent supportive housing for persons who are in need of mental health services and are experiencing homelessness, chronic homelessness, or who are at risk of chronic homelessness. Under this program, counties can use the money awarded them to fund housing, and subsidize extremely low rent levels. If a county is awarded NPLH funding, then the program requires

¹⁰ W&I Code § 5600.3 (criteria).

¹¹ CCR § 3640(a).

¹² W&I Code § 5892(a)(5).

¹³ W&I Code § 5892.5.

the following mandatory supportive services (which can be funded through MHSA) to be provided to NPLH tenants¹⁴:

- Case management.
- Peer support activities.
- Mental health care, such as assessment, crisis counseling, individual and group therapy, and peer support groups.
- Substance use disorder services, such as treatment, relapse prevention, and peer support groups.
- Support in linking to physical health care, including access to routine and preventive health and dental care, medication management, and wellness services.
- Benefits counseling and advocacy, including assistance in accessing SSI/SSP, and enrolling in Medi-Cal.
- Basic housing retention skills (such as unit maintenance and upkeep, cooking, laundry, and money management).

And the following services to be made available and encouraged¹⁵:

- Services for persons with co-occurring mental and physical disabilities or co-occurring mental health and substance use disorders not listed above.
- Recreational and social activities.
- Educational services, including assessment, GED, school enrollment, assistance accessing higher education benefits and grants, and assistance in obtaining reasonable accommodations in the education process.
- Employment services, such as supported employment, job readiness, job skills training, job placement, and retention services, or programs promoting volunteer opportunities for those unable to work.
- Obtaining access to other needed services, such as civil legal services, or access to food and clothing.

MHSA Housing Program

This program provided funding for the capital costs and operating subsidies to develop permanent supportive housing for individuals with serious mental illness who are homeless, or at risk of homelessness. In 2016 the MHSA Housing Program was replaced with the Local Government Special Needs Housing Program (SNHP), which was intended to be a bridge between the MHSA Housing Program and NPLH. Effective January 3, 2020, the California Housing and Finance Agency (CalHFA) discontinued SNHP. While no longer in effect, this program:

- Created over 2,500 supportive housing units dedicated to individuals with serious mental illness.
- Used MHSA funds to leverage public, local, state, and federal funding to develop over 10,000 affordable housing units.

¹⁴ [NPLH Program Guidelines](#), pp 24-25.

¹⁵ [NPLH Program Guidelines](#), pp 25.

- For each dollar that MHSA provided, the federal government provided \$4.50, private banks and non-profit organizations provided \$3.50, locals provided \$1.50, and the Housing and Community Development agency provided \$1.

PEI Programs

PEI is the second largest component at 20% of a county's MHSA funding.¹⁶ PEI programs emphasize strategies to reduce negative outcomes that may result from untreated mental illness, including, but not limited to, prolonged suffering and homelessness.¹⁷ Some examples of PEI programs offering support to the homeless or at risk of being homeless are:

- **Landlord Outreach and Recruitment**
These programs may prevent homelessness and build relationships that may lead to the availability of additional housing units. The county/provider acts as an intermediary by providing support to the tenant and conflict resolution assistance with the landlord.
- **Emancipating, Emancipated, and Homeless TAY Targeted Projects**
These projects identify, support, treat, and minimize the impact for youth who may be in the early stages of a serious mental illness.
- **Wellness Centers**
These centers provide recovery/supportive services for people with co-occurring conditions (mental, substance use or physical health conditions). This may include linkage to housing.

INN Projects

INN projects are funded with 5% of the total of CSS and PEI funds.¹⁸ An INN project may affect virtually any aspect of mental health practices or assess a new or changed application of a promising approach to solving persistent, seemingly intractable mental health challenges, including, but not limited to, permanent supportive housing development.¹⁹ A primary purpose of an INN project may be to:

- Increase access to underserved groups, which may include providing access through the provision of permanent supportive housing.²⁰
- Support innovative approaches by participating in a housing program designed to stabilize a person's living situation while also providing supportive services on site.²¹

¹⁶ W&I Code § 5892(a)(3).

¹⁷ W&I Code § 5840(d).

¹⁸ W&I Code § 5892(a)(6).

¹⁹ W&I Code § 5830(c)(9).

²⁰ W&I Code § 5830(b)(1)(A).

²¹ W&I Code § 5830(b)(2)(D).

CF/TN Projects

A county may transfer CSS funds to the CF/TN component provided the transfer does not exceed 20 percent of the average amount of funds allocated to the county for the previous five fiscal years.²² CF/TN projects are meant enhance the infrastructure needed to support implementation of MHSA, which includes improving or replacing existing technology systems and/or developing capital facilities to meet increased needs of the local mental health system. All plans for proposed facilities with restrictive settings must demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting, such as permanent supportive housing.²³ Examples include homeless shelters and navigation centers.

MHSA funding can be versatile in its application to assist individuals with mental health issues at risk for homelessness or experiencing homelessness. It is important to remember that if a county is interested in using MHSA funding for such programs, every program must be reflected in the Three-Year Program and Expenditure Plan and annual update, and counties are required to partner with constituents and stakeholders throughout the planning and development process. The next county plan is due to the Mental Health Services Oversight & Accountability Commission (MHOAC) and the Department of Health Care Services (DHCS) in FY 2020 and will cover FY 2020-2023.

²² W&I Code §5892(b).

²³ W&I Code § 5847(b)(5).

**Housing Initiative Taskforce Meeting #1
MHSARC Older Adult Committee Meeting – 3/3/21**

Question & Answer

- 1. Would it helpful to include some quantitative goals also? For example, increase housing availability by 20% in next three years.**

A: Absolutely, this is what the Taskforce Meeting #2 in April will be about ... to identify and prioritize outcome goals that will then inform the strategies we fund

- 2. Will this revenue that is higher have to wait until the next 3-year funding cycle?**

A: No, MHSA Annual Updates allow us to make updates to the current Three-Year Plan, including updates to the budget allocations. The next Annual Update will be submitted after we complete the Taskforce recommendations so that these can be incorporated, which means funding will be available to spend in the next Fiscal Year 2021-22.

- 3. Will the one-time funding allotment be voted on and divided and promised toward some of those aspects, for example, housing renovation, etc.**

A: Yes, Taskforce participants will prioritize across funding allocations and make a recommendation to the MHSA Steering Committee and the Mental Health and Substance Abuse Recovery Commission (MHSARC) for use of both ongoing budget allocations and one-time funding. The final recommendations will be open to a public hearing and 30-day public comment then voted on by the MHSARC to submit to the Board of Supervisors for final approval.

- 4. Can we get a list of those [one-time spend] suggestions so we can think about them?**

A: Suggestions for how to spend one-time monies will come from this Taskforce process. The slides describe categories for the types of items that can be one-time including, brick and mortar, housing projects, system development efforts, technology infrastructure, renovations.

- 5. I know our topic of discussion is Housing but, is that a distinct silo or does it include the types of supports that clients need even if not living in an MHSA unit?**

A: Absolutely. [The Fact Sheet – How Can MHSA Be Used to Support Homeless Individuals](#) that was reviewed during the presentation and provided in your meeting materials outlines all items that are eligible for MHSA Funding

- 6. You mentioned No Place Like Home (NPLH) funding, does that mean we are committed to the program and that we will abide by their restrictions regarding criteria for clients use of the units.**

A: Yes, for the NPLH funded units.

A: At this point we only have one project with 9 units that will be under the NPLH funding and restrictions.

7. The Governor's Budget includes \$750 million allocation for infrastructure, will we be discussing way to utilize this funding?

A: The MHSA funds you are referring to are state-level (not County). The State will allocate these specific infrastructure funds, whether it will be a competitive process and when this funding will be available... we do not know and we may not know by the time we have completed our Taskforce. So, we will not focus on this specific funding during the Taskforce. Nonetheless, any priority ideas that come out of our process that apply to this funding, once we know more, we may pursue.

8. What is the possible range for the one-time MHSA allotment for housing projects?

A: We do not know yet. This will become clearer within the next month as we receive the State budget adjustments. We will have a dollar amount allocated by no later than our final Taskforce meeting in May.

9. Will this initiative be discussing the needs and upkeep of the current units that we have and what resources those clients need in terms of support?

A: The upkeep of current units is something that can be discussed further as we move into development of activities and strategies to fund, Taskforce Meeting #3. Resources for clients is something that will be addressed in the Housing Continuum and Housing Assistance Services.

10. Was Marianas Housing for BHRS Clients presentation recorded?

A: Yes, all presentations have been recorded and posted on the MHSA website (www.smchealth.org/MHSA) under "Announcements."

11. Are models such as St. Matthews being discussed.

A: As we move into development of activities and strategies to fund, Taskforce Meeting #3, best practices will be identified.

12. Is it possible to get a listing of all these Drop-in centers and their locations?

A: Following is a list of agencies that provide drop-in services for clients, including links to their website for the most current information:

- Mental Health Association [Friendship Center](#)
- [Heart & Soul, Inc.](#) (for enrolled members)
- [California Clubhouse](#) (for enrolled members)
- [Voices of Recovery](#) (for enrolled members)
- [Edgewood Transition Age Youth Drop-in Centers](#)
- [Core Service Agencies](#)
- [The Barbara A. Mouton Multicultural Wellness Center](#)

13. Since COVID how do homeless individuals get in a shelter? Can we get info on number of beds broken down by men, women veterans and those with mental health?

A: Homeless individuals must register with their local Core Service Agency in their community via the Coordinated Entry Services process to get connected to shelter or other housing resources aligned with rapid re-housing model.

The Coordinated Entry Services does address needs of specific populations (women, veterans, mental health needs, etc.). COVID-19 has changed the availability of beds quite a bit. Currently, we do not have bed availability broken down by subgroups of populations but, we have requested it and will share it as it becomes available.

14. At the end of 3AB renovation, we will get the 12 beds back, correct?

A: Currently, there is a rolling closure of 12 units until renovations are completed. There may be other budgetary issues; we will follow this closely and keep you all updated.

15. What is going on with Hotel Housing during COVID?

A: 77 hotel rooms leased currently during COVID. The County has purchased three motels to add more transitional housing capacity and permanent supportive housing for seniors. We will keep you posted as we learn about plans for occupancy in the new units.

16. Do we have Alcohol and Other Drug (AOD) Residentials for Youth & TAY? How many transitional housing is there for AOD?

A: TAY 18+ can use adult programs. There are efforts to have a TAY component in our current residentials. There is no under 18+ residential program in San Mateo County.

17. What is the difference between Whole Person Care and Full Service Partnership (FSP)?

A: These are two different programs. Whole Person Care serves individuals who struggle with chronic homelessness, mental illness and substance use and are high-end users of medical services, they receive care navigation supports including field-based medical care and care coordination, transition from institution to community living and substance use recovery supports.

<https://www.hpsm.org/community-impact/whole-person-care>

FSP provides community-based services for individuals with Serious Mental Illness (SMI) and behavioral issues that require more intensive supports to remain successful in the community.

<https://www.smchealth.org/article/mhsa-dollars-help-create-support-systems-around-clients>

18. Is Whole Person care new? We have residents with serious substance abuse issues as well as physical issues that could benefit from either of these programs, are providers identifying older clients that need these services.

A: The Whole Person program started in 2016. The program focuses persons who are high end users of the County Medical Center Emergency Department. Many are those who participate in the program are seniors.

19. What does whole person services eligibility mean?

A: Whole person care targets individuals with co-occurring mental illness and substance use as a key criterion along with being high-end users of the San Mateo Medical Center services.

20. When a person's recovery makes them not FSP eligible, what happens? Do they lose their supportive housing, case management services?

A: FSPs if individual moves along in the continuum of recovery they can continue as FSP participant but, move into a lower tier of support. FSP participants are not discharged just because they become well. Recognizing that the supportive services and housing contributed to their recovery.

21. How much of the funding will be allocated to those currently housed who are at risk of homeless on fixed incomes, whose housing payment standards have not been adjusted to the cost of living increases, sometimes raising the rents to where people can't afford to relocate to cheaper housing and risk being one rent increase from homeless.

A: This is an example of a strategy we may prioritize for funding. Thank you for bringing it up. As we move into development of activities and strategies to fund, Taskforce Meeting #3, best practices will be identified and prioritized. After the prioritization, we will then conduct the research to propose budget allocations.

Participant Comment 1: Funding for housing for AOD and Peer Support Counselors needs to also be addressed. Many of us who have lived experience and are now working on the front lines of SUD and Mental Health are having to live in transitional houses, sober living houses or have to rent a room.

Participant Comment 2: the rent abatement and payback program was useless to those of us still struggling to pay rent due to COVID because we still get SSI and SSDI so we cannot show a decrease in employment wages.

22. On the MHSA fact sheet the 3rd bullet point under "MHSA Housing Program" "For each dollar MHSA provided, the federal govt. provided \$4.50...", is that statement correct or should it be a percentage (45%)?

A: This is correct. This is speaking to the federal dollars that were leveraged for every State dollar (via MHSA) used on developing housing units.

23. I get asked a lot by clients who need housing coming from AOD residential how to submit an application for Mainstream Housing Voucher. Does the individual need to have a case worker from a core agency to submit the application?

A: A client typically must be linked to a case worker (via BHRS, shelter programs, etc.) although, the Dept. of Housing has made some exceptions. If you have specific questions about enrollment for mainstream reach out to Mariana Rocha, mrocha@smcgov.org. Some types of AOD residences such as sober living environment have different qualification rules, versus residential treatment facilities, because temporary placement may be considered at risk of homelessness.

24. Has any thought been given to holding a focus group for those currently in one of these living situations to hear firsthand what their needs are?

A: This is a great recommendation, thank you. We will look into this. A few years ago, the MHSARC hosted a listening session on this topic where we heard from a lot of clients firsthand and they published a report based on the recommendations. The report was used to inform this process. Additionally, in 2018, the No Place Like Home planning process also interviewed clients, peers and family members with lived experience accessing housing supports. We will be building off of this report as well.

25. How does quality control happen for out of county rehabilitation centers?

A: The Collaborative Care Team under BHRS Licensed Facilities are responsible for placing clients out of county in BHRS contracted facilities. There is a CCT clinician assigned to each out of county facility and check in with clients and support clients reaching their treatment goals. The CCT clinicians provide in person visits with clients, and check in with facility staff. They go out to facilities and meet with clients at their placements. They follow all reporting laws in terms of any reported or suspected abuse. In addition, they are required to follow up with their supervisors pertaining to any suspected or reported abuse. All conserved clients their conservators also schedule visits with clients and they follow all laws pertaining to suspected or reported abuse.. If there are any concerning issues for any clients pertaining to quality of care these issues are raised to a supervisory level by CCT staff and/or Deputy Public Guardian Supervisor and BHRS Licensed Facilities Manager (contract monitor for licensed facilities) and Aging and Adult Services Manager are informed for higher level or contractual issues that need to be addressed at a Managerial level.

26. What is duration of housing support for Pathways and FSP?

A: Housing support for clients in Pathways and FSP is available for the duration of their enrollment in the program. When a client graduates the Pathway program, a housing maintenance plan is established to support them ongoing.

When FSP participants are eligible for a lower level of service in the FSP, they are able to maintain their housing.

27. I want to ask about the money for help with rent and utilities but Judy said that was for past due amounts, unfortunately to stay housed and keep out lights on many of us have to struggle to pay those bills. There needs to be some support for SSI and SSDI clients who struggle during covid and have gone into debt to pay rent and bills or have been forced to live on credit cards. Can't we get some support?

A: SSI and SSDI clients did qualify for COVID stimulus payment. Any immediate issues should be shared with a case manager who might be able to identify additional resources. As we move into development of activities and strategies to fund, Taskforce Meeting #3, best practices will be identified.

28. What are qualifications for at risk for homelessness?

A: Depending on funding sources there are slight variations. For the purposes of the MHSA Housing Program it was individuals at risk of eviction, losing board and care, release from institutions like Cordilleras or temporary residential treatment. The federal definition was much more expansive and included individuals paying more than 50% of income on housing. We will look into this and what the current standard is.

29. There seem to be many different paths to get housing for the mentally ill each with their own criteria and entry portals. Wouldn't it be helpful to consolidate all of these to make it easier for the mentally ill homeless people in our county?

A: Yes, this would be helpful. As we move into development of activities and strategies to fund, Taskforce Meeting #3, best practices will be identified.



Mental Health Services Act (MHSA)

Housing Initiative
April 7, 2021



SAN MATEO COUNTY HEALTH
**BEHAVIORAL HEALTH
& RECOVERY SERVICES**

Welcome, before we begin...

- Meeting is being recorded
- Stipends for clients and family members participating
 - Chat your email with the word "stipend"



SAN MATEO COUNTY HEALTH
**BEHAVIORAL HEALTH
& RECOVERY SERVICES**



Agenda

1. Introductions, Ground Rules & Overview
2. Housing Continuum Gaps in Services
3. Housing Outcomes
4. Next Steps



1. Introductions, Ground Rules & Overview



Participation Guidelines

- Please enter your questions in the chat box as we go
- “Q&A” slides incorporated into the presentation
 - “Raise Hand” button - host will call on you and you can then unmute yourself
- Ground Rules
 1. Share the airtime; allow every voice to be heard (step up/step back)
 2. Practice both/and thinking; consider all ideas along with your personal advocacy
 3. Be brief and meaningful when voicing your opinion
 4. Success depends on participation (share ideas, ask questions)
 5. Share your unique perspective and experience
- Decision points – majority vote
- A recommendation will be made for public hearing, 30-day public comment and final approval by the Board of Supervisors



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Meeting Objectives

- Meeting #1 (March 3rd):
 - Review background information and opportunity for additional Q&A
 - Present additional layers to the Housing Continuum to include:
 - Programs and numbers served
 - Eligibility and State requirements were applicable
- Meeting #2 (April 7th):
 - Present set of outcomes and data to support/inform decisions
 - Brainstorm additional outcomes as necessary
 - Prioritize across all outcomes to focus strategic direction
- Meeting #3 (May 5th):
 - Present set of best practice solutions
 - Brainstorm additional solutions as necessary
 - Prioritize across all strategies to recommend



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High-Level Review

- Taskforce Meeting #1 Q&A



Questions?

2. Housing Continuum Gaps in Services



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Sources of Information

- Task Force Comments
- Housing and Board and Care presentations
- Key Informants
- Solutions for Supportive Homes Presentation
- MHSA Input Sessions for 3-year Plan (2020)
- BHRS Plan to Address Homelessness for People with Mental Illness (2019)
- MHSARC Housing Report (2016)



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Homeless Data 2019 One Day Count

- 1512 both sheltered and unsheltered
- 1110 single adults, TAY 38
- 26% self report Mental Health issues: 305 report SMI
- 14.3% self report Substance Use Disorder (SUD)
- Homeless in CES system self report SMI 10% know to BHRS



Housing Continuum Gaps – Categories

1. Pre Housing Engagement

- Drop-in Centers
- Shelters
- Field Services
- Post Psychiatric Emergency Services (PES)
- Hospitalization
- Incarceration

2. Housing

- Rehabilitation Centers
- Residential Treatment
- Residential Board and Care
- Transitional Housing
- Supportive Housing
- FSP Supported Housing
- Independent Housing

3. Housing Assistance

- Skill Development
- Housing Case Management
- Rental Assistance
- Homeless Assessment and Housing Referral
- Housing Locator
- Landlord Tenant Assistance

Reference: San Mateo County Housing Continuum (meeting materials)



Gaps (Pre Housing Engagement)

Drop-in Centers

- Need East Palo Alto Drop-in Center
 - 107 unsheltered homeless (2019 Homeless Count) 11.8% of County homeless, 3.8% of County population

Shelters

- Need more shelters for the SMI population
 - County has added 32 shelter beds, 77 transitional beds and will add 125 transitional units.
- Need training of shelter staff on behavioral health issues

Field Services

- Need for Mental Health Workers in the field to provide mobile mental health assessment, treatment and support to community service provider (at Core Service Agencies, Homeless Outreach Teams, etc.).
 - Homeless Engagement and Linkages (HEAL) program grant funding ended - mental health assisted homeless outreach

PES, Hospitalization and Incarceration

- Need for expanded peer support at discharge from PES, hospitalization and jail (to provide housing navigation and other support services).



Discussion – Does this resonate, what is missing?

Gaps (Housing)

Residential Board and Care (B&C)

- Need supports for B&C residents who could step down to independent living with appropriate level of supportive services
- Need for additional B&C homes and support for the existing B&C including incentives for sustainability
 - Loss of 11 B& C beds in 2020
 - 127 individuals in B& C out of county

Transitional Housing

- Need transitional housing that is developmentally and culturally appropriate for TAY
 - Too few TAY Housing Units
 - 45 TAY FSP: 20 in unstable housing
 - 91 YTAC: 38 in unstable housing
- Need transitional housing for women with children



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Gaps (Housing)

Supportive Housing

- Need more MHSA units
 - 65 certified applicants for 20 MHSA units @ 636 El Camino
- Need supportive housing units with expanded qualifications
 - Too few clients qualify for MHSA or NPLH units
 - Must be SMI and Chronically homeless, Homeless or at Risk of Homelessness
 - BHRS case loads between 4-9% are homeless
- Need more Transition Aged Youth (TAY) units
 - BHRS & FSP 58 youth without permanent housing

FSP Housing

- Need increased allocation of housing funds for FSP programs
 - There have been limited increases over the years
 - Unable to provide housing for new clients



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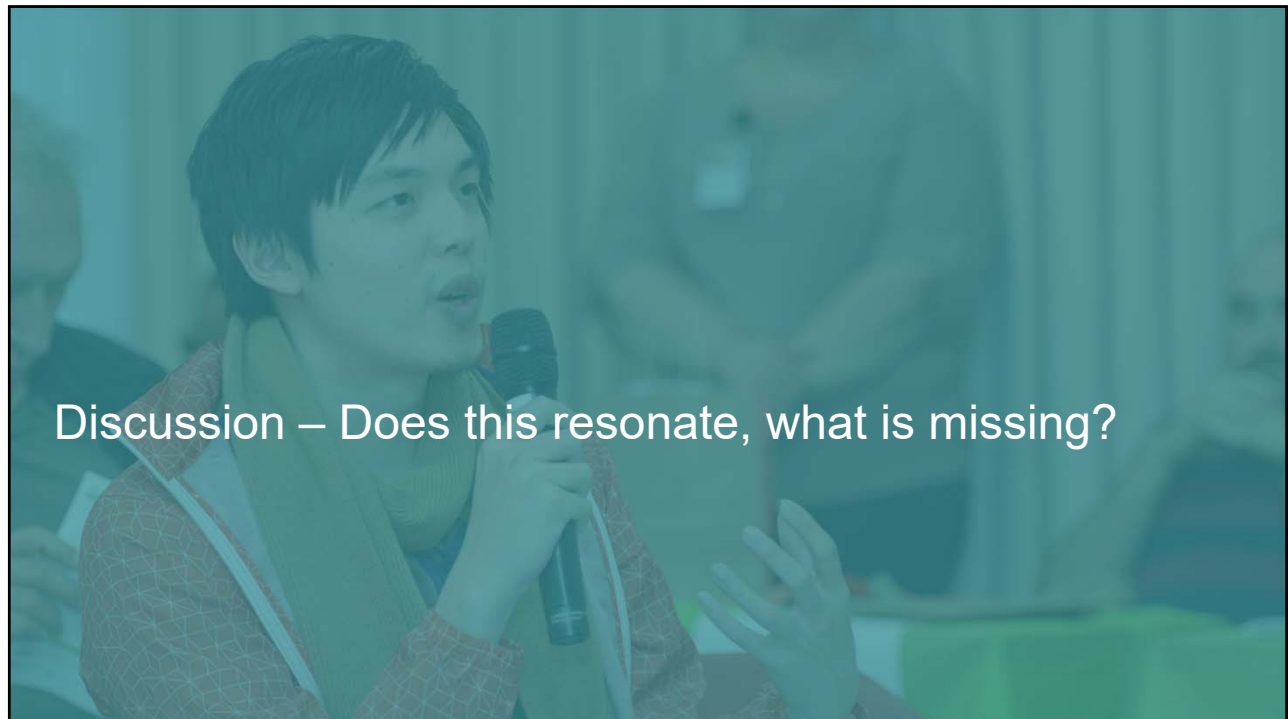
Gaps (Housing)

Independent Housing

- Need affordable housing for clients that do not need intensive services of Supportive Housing
 - Restricted units @15% Area Medium Income (AMI)
 - No access for undocumented individuals with serious mental illness

Other Housing Financing Gaps

- Need ongoing MHSA funding for supportive housing services for new developments
 - Developers need BHRS commitment of service provision for a minimum of 20 years
- Need local subsidies to keep rents very low
 - Capital operating revenue to offsets tenant portion of the rent (30% of their income)



Discussion – Does this resonate, what is missing?

Gaps (Housing Assistance)

Skills Development

- Need more independent living skills supports for adults

Housing Case Management

- Need coordinated case management for step down process from higher level of care to lower levels of care
- Need housing case management and supports for clients living independently
- Need peer engagement in planning/delivering supportive services of Supportive Housing
 - Funding sources require specific services
- Need more peer support in housing related services



Gaps (Housing Assistance)

Rental Assistance

- Need increased rental assistance resources for immigrant communities
- Need housing subsidies for those not on Housing Authority funded programs
- Need improved knowledge and access to rental assistance services (Housing Authority programs, short term assistance, etc.)

Homeless Assessment and Housing Referral

- Need improved access to homeless assessment system and subsequent housing referrals
 - Client reluctance to use CES and or shelter system



Gaps (Housing Assistance)

Housing Locator

- Need expansion of resources to help match clients to affordable housing

Landlord Tenant Relations

- Need increased supports for tenants (legal intervention, mediation) when addressing client housing related issues (eviction, breach of lease, fair housing, etc.)

Access to Housing Assistance

- Need improved access to existing resources
 - Difficulty accessing available housing due to lack of knowledge, support, behavioral issues, etc.
- Need mental health, trauma-informed, culturally responsive door ways for special populations (TAY, immigrants, women w/children, etc.)



Discussion – Does this resonate, what is missing?

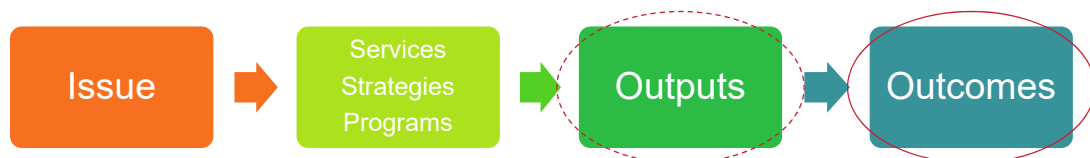
3. Housing Outcomes



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Framework for prioritizing

- How do we begin to narrow down what to fund?
- ✓ We prioritized a broad **issue**: Homelessness and Housing Stability
- ✓ We identified many **gaps** (services, strategies, programs) based on an ideal Housing Continuum



- ⇒ Before we can decide what to fund, we will spend some time discussing client, families and community **outcomes**
- To *think backward* to identify how to best achieve what we want to accomplish, “planning with the end in mind.”

Breakouts

- Breakout into 2 groups
 - Pre Housing Engagement and Housing Assistance
 - Housing
- Question – What is the impact we want to see on the **health, wellbeing and lives** of:
 - Clients
 - Family members of clients
 - Communities



4. Next Steps



Prioritizing outcomes

- We will follow-up with a summary of outcomes the week of April 12th and provide a one week deadline for additional input, comments.
- We will then send an online survey to cast your vote and rank the outcomes.



What additional information do you need?

- Type in chat
 - Data, programs/services, other?
- Email Judy Davila: c_jdavila@smcgov.org or MHSA@smcgov.org



THANK YOU!

Judy Davila

c_jdavila@smcgov.org

Doris Estremera

mhsa@smcgov.org

www.smchealth.org/MHSA

Meeting Feedback:

www.surveymonkey.com/r/HousingTaskforce



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Housing Initiative Taskforce Meeting #2
MHSARC Older Adult Committee Meeting – 4/7/21

Additional considerations for Housing Continuum:

1. Pre-Housing Engagement
 - Providing incentives for people to engage in pre-housing activities, education, training and services is missing and probably vital for engagement and long-term success.

2. Housing
 - Transitional housing needed for chronic homeless to assure more successful transition to permanent housing.
 - Alternative housing options such as communal living communities ... more housing, less expensive, healthier social environments.
 - Special Populations: clients returning home to SMC from prison who are SMI (e.g. halfway house). Clients are being put on waiting lists when released when they need immediate transitional housing support to avoid committing new crimes.

3. Housing Assistance
 - Regular workshops regarding applying for rental assistance programs.
 - Assistance filling out the housing assistance rental applications. Housing Groups help support people to complete paperwork. It's an easy activity that peers can facilitate including making requests for accommodations for things like extended time for individuals with disabilities.
 - Moving supports to find more affordable housing. Housing navigators can support this.

Other considerations:

- There are some new field services from the San Mateo County Healthcare for Homeless/Farmworker Health Program - both that recently started and some that are in the planning stages:
 1. As of late 2020/early 2021, a Behavioral Health Outreach Specialist has been attached to the Street Medicine Team, this is in addition to a psychiatrist. The type of activities are include Alcohol and Drug Counseling, Motivational Interviewing, and Screening, Brief Intervention, Referral to Treatment (SBIRT) screenings.
 2. Planning to start summer/fall 2021, care coordination to support people exiting homelessness* into more stable housing (i.e. leaving shelter into a rent-subsidized apartment) and to stay connected to healthcare -- behavioral health, primary care, and dental
 3. Planning to start summer/fall 2021, increased behavioral health services for sheltered and unsheltered homeless individuals via BHRS

- People on assistance are required to pay the difference whenever there is a rent increase, often bumping their contribution to up to 75% of the rent.

Breakout Notes – Housing Outcomes

Question: What is the impact we want to see on the health, wellbeing and lives of clients

Housing for Individual with mental health challenges

Comments	Outcome
<ul style="list-style-type: none"> • Clients’ natural resources and family/community connections would be utilized in their recovery as they want it so that their self-determination continues to drive their progress and their level of independence. Their recovery path is supported at every stage, including housing. • Continue with supports for independent living skills. • Clients are independent and self-sufficient and functioning at their highest level possible 	<p>Clients’ recovery and self-actualization is supported at every stage to improve their independence</p>
<ul style="list-style-type: none"> • People have safe, decent and affordable housing. • That everyone has a safe home • Have a stable home • Those that do get better...those that are more resilient are the TAY population. Housing is a prevention and early intervention for TAY. 	<p>Clients have safe, adequate and affordable housing that meets their level of functioning</p>
<ul style="list-style-type: none"> • Once someone gets housed and are in housing for a while, they fall off the radar because they have the level of support that they need... Need to make sure this is available long-term. • Adequate, appropriate level of support for individual being housed. • Peer supports, FSP providers follow-through and if not, then people will give up. • Developments (Housing Choices) working for years to get units for developmentally disabled population; these adult children are supported through the regional centers and there’s funding to do that. For SMI population, parity funding is not there • Groups that are chronically disabled, older adults, don’t have other supports or means or providing for themselves, those are most vulnerable groups and have to be taken care of. 	<p>Clients have the adequate, ongoing, long-term supports and resources to help them maintain their housing</p>

<ul style="list-style-type: none"> • Greater opportunity for engagement with the community via vocational, educational, volunteering. They're entire identity doesn't have to be as a consumer. • Engagement with the community (vocational, friendships, productive). • Have increased stability in the community 	<p>Clients meaningfully engage and are connected with the community via occupational, volunteer, education, etc.</p>
<p>Families:</p> <ul style="list-style-type: none"> • Feel that adult children are going to be ok • Supports so that children are not lost in the system – don't manage financials (medi-Cal, social security). • Families want a peace of mind, want to make sure children are going to be ok • Confidence that all people providing supports and services are going to be there when needed. As a parent, would like to know that if son has a medical problem that someone will take care of it. • A&AS supports the parents but in terms of housing, there needs to be supports for the adult children. 	<p>Families feel trust and confidence that clients receive quality supports and services</p>
<ul style="list-style-type: none"> • Transparency and outreach/education to end stigma (fear of unknown is what people react to housings developments for SMI). Getting community to buy-in to address negative comments for housing developments • For SMI population... they are not as welcome in these developments. • When clients are released from hospitals, prisons or asked to leave shelters without housing... those are the individuals that end up on the street and others are concerned about. 	<p>Community is welcoming and supportive of safe and stable homes for clients</p>
<ul style="list-style-type: none"> • Decreased need for emergency services. • When individuals have safe and affordable stable housing, we reduce community crisis. 	<p>Community crisis and need for emergency services is decreased</p>

Pre-Housing Engagement and Housing Assistance

Comments	Outcome
<ul style="list-style-type: none"> • Simplified, centralized way to reach out for help without all the run around (person, dept, resources). Be able to get a hold of someone who can help you with housing (not a counselor, case manager). Single point of contact for housing assistance. • Peer case manager or navigator to provide the support necessary, occupational therapy, connections, community resources. • Need coordination across the Bay Area - between housing locators 	<p>Clients have simplified, easy to navigate supports for finding and securing housing</p>
<ul style="list-style-type: none"> • One-to-one support; assigned personal navigator for the duration of need (vs. from one counselor to another) and not doing hand-offs or registered in a centralized system so that clients are not repeating themselves over and over. • Family members can step in to support when have staff turnover • Consistent case managers - a lot of turnovers, undervalued (living wage to case managers, pay them more, support them more); it's difficult for clients to attach and reconnect • What elements of best practices (e.g. Assisted Outpatient Treatment) can we implement? Upgrade the profession of case management. If we are going to have retention of case managers, we need to pay them more, support them and have them feel like this is their calling. • Self-sufficiency for both programs and clients. Peer certification will support this if we are able to bill appropriately. 	<p>Clients have the adequate, long-term supports and resources to help them maintain their housing</p>
<ul style="list-style-type: none"> • Housing has allowed me to heal and give back to the community... would like others to experience this • Positive outcomes on clients will have corresponding impact on families and communities 	<p>Clients meaningfully engage and are connected with the community via occupational, volunteer, education, etc.</p>

Housing Initiative Taskforce Meeting #2
MHSARC Older Adult Committee Meeting – 4/7/21

Question & Answer

1. Please define FSP – Full Service Partnership.

A: FSP programs provide a broad array of coordinated and intensive services for individuals with serious mental illness that can function in the community with adequate support. The Assertive Community Team model or Wrap-around model for youth provides full-scope service providers from peers, case managers to psychiatry. The FSP program philosophy is to do “whatever it takes” to help individuals achieve their recovery goals. The services provided may include, but are not limited to, mental health treatment, housing, medical care, and job or life-skills training.

2. Will the funded FSP expenditure be for new or existing FSP Providers?

A: This is to be determined. FSP services go through a Request for Proposal (RFP) process to select the appropriate providers. The RFP process engages BHRS staff, clients/family members, peers and out-of-county representatives in evaluating proposals submitted.

3. Can you describe the process for evaluation of quality and quantity of FSP services?

A: There are different parts to evaluating quality of FSPs: contract monitoring, ongoing annual reporting and point-in-time formal evaluations.

- Contract monitoring: a BHRS Manager assigned as the contract monitor meets regularly with FSP providers to discuss services, challenges, status of clients and of the services.
- Ongoing annual reporting: FSP providers collect ongoing data outcomes of clients at intake, every three months and at every key event related to housing status, psychiatric emergency visits, substance use, among other outcome measures. These annual reports are presented to the MHSA Steering Committee and the commission as part of the MHSA Annual Update and made available online. All annual outcome reports can be found on the MHSA Website, www.smchealth.org/MHSA, under the “Evaluation” tab.
- Formal point-in-time evaluations: There have been two formal evaluations of FSPs. One was conducted in 2014, also available on the MHSA Website, under the “Evaluation” tab. Currently, we have a statewide Multi-County Full Service Partnership Project looking into the standards, quality and outcome reporting to make recommendations for FSP improvements. This process is being informed by BHRS staff, FSP providers, FSP clients and family members via workgroups, focus groups and key interviews. A Progress Report of this project can be found here, https://www.thirdsectorcap.org/wp-content/uploads/2021/03/Multi-County-FSP-INN-Progress-Report_March-2021.pdf

4. Is FSP considered top of the line service?

Full Service Partnership (FSP) programs were designed under the leadership of the California Department of Mental Health (DMH) in collaboration with a wide range of stakeholders including the California Mental Health Directors Association, the California Mental Health Planning Council, the Mental Health Services Oversight and Accountability Commission, individual mental health clients and their family members, and mental health service providers. Mental Health Act (MHSA) core principles are integrated into the FSP model: client and family-driven mental health services within the context of a partnership between the client and provider; accessible, individualized services and supports tailored to a client's readiness for change that leverage community partnerships; delivery of services in a culturally competent manner, with a focus for wellness, outcomes and accountability.

5. Have consumers been involved in development of standards?

A: Consumers and family members were involved in the development of FSP standards. Locally, we are engaging consumers and their family members in the statewide Multi-County Full-Service Partnership Project, which will be making recommendations to the State Department of Health Care Services for outcome reporting and will provide best practice recommendations to counties across the State.

6. Do FSP Providers actually employ and utilize peer providers? What is the qualifying standard used for designating a person or provider as a 'peer'?

A: Yes, contracted FSPs employ and utilize peer providers. Telecare provides a career ladder for consumer staff up to management.

Standards for peer employment: A peer must have personal lived experience and is at a level of recovery where they are need limited services for support for themselves. Peers have to demonstrate their ability to maintain their activities of daily living (ADLs) and are participating in personal mental health services, as these are skills that they will teach clients. Also, they need to be able to use their personal story as part of the engagement with clients.

7. Do clients who secure housing through FSP services lose their housing when they no longer receive FSP services?

A: In general, a client is able to keep their housing as it is an integral part of their recovery and stability. Both Telecare and Caminar have step down levels of services for those who need less service. There may individual circumstances that affect a disenrolled clients' housing.

8. It seems to me that making decisions based on 2019 information that is most likely outdated won't really reflect today's issues and gaps. Do we have more updated homeless data?

A: The bi-annual homeless count scheduled for January 2021 has been put on hold due to COVID. We have reached out to the Center on Homelessness to see if there are other indicators of need in the homeless community.

9. Could you repeat interventions where County commitment can make a difference?

A: The interventions that have been identified thus far via various input processes are included in the Taskforce Meeting #2 presentation slides, available on the MHSA website, www.smchealth.org/MHSA, under “Announcement” tab. Taskforce Meeting #3 will be focused on prioritizing evidence-based strategies.

10. Some communities are using emergency housing (low cost tiny house villages) to engage individuals in wanting housing and into relationships that could be therapeutic, is this missing in our “Pre-Engagement” category?

Best practice that we can research for Taskforce Meeting #3.

11. Since we know that individuals are reluctant to go to shelters, has there been any conversation internally about what prevents individuals from utilizing the shelters and how can we correct this?

A: The issue of not wanting to use shelters is an important discussion to have ongoing between BHRS and Human Services Agency (HSA), which runs the shelters. We have reached out to HSA to discuss the issue of safety and other challenges further. In the past, expanding transitional housing to get folks out of shelter has been one of the key strategies.

Participant Comment: Many refuse to go to shelters because after going through a 90-day substance use recovery program, they weren’t able to afford transitional housing or have to wait for their housing voucher or there wasn’t enough sober living facilities and there is a lot of drug use in shelters and fear relapsing. There needs to be something after a 90-day program that supports sober living, especially for women.

12. Do we have any idea of how many clients are in need but, invisible in our data because they do not meet the homeless criteria (for example, living with family and will likely be homeless)?

A: Data related to housing needs of individuals with mental illness is not readily available. We will need technical support to capture data about individuals housing needs.

Participant Comment: In 2019 Solutions for Supportive Homes surveyed San Mateo County NAMI families, 54 families reported that they are caring for an adult child with mental illness who will become homeless.

13. In addition to TAY and women with children, the regular adult population has a need for transitional housing. Can that be included in the slide?

A: Yes, that can be included. TAY and women with children are a special population.

14. What happens to all the homeless currently housed due to COVID when that funding ends?

A: The county has expanded its capacity to serve the homeless by adding shelter beds and investing in transitional housing that the county will own after COVID-19 funding ends. The County will continue to operate the shelters and the transitional housing after the COVID restrictions end. The County's capacity to house the homeless will be greater than before COVID.

15. Will there be any plans to purchase hotels and create housing as some other counties have done?

A: Yes. San Mateo County has purchased three motels to create transitional and permanent housing for a total of 221 units for formerly homeless.

16. Could non-profits, such as MHA offer tax deductible donation status to landlords in lieu of a part of rents?

A: This depends upon the manner in which the donation is structured. It would have to meet tax requirements as well as benefit the nonprofit organization.

17. How about tiny homes like they did in Redondo Beach?

A: Yes, as we move into development of activities and strategies to fund, Taskforce Meeting #3, best practices will be identified.

18. Are we able to view the recording that happened in the other break out room? Could that be posted?

A: Yes, the full presentation, including a summary of the break out room input and the recording will be posted on the MHSA website, www.smchealth.org/MHSA, under the "Announcement" tabs.

MHSA Housing Initiative Taskforce

Outcomes Review Optional Meeting – 4/22/21

(Edits provided by Taskforce participants via email and during the meeting are in red)

During the April 7, 2021 Housing Initiative Taskforce meeting, participants brainstormed broad outcomes in response to the question: What is the impact we want to see on the health, wellbeing and lives of clients, family members and communities? A set of outcomes were developed by incorporating input from stakeholders received during the brainstorming and previous community planning processes. Members of the MHSA Housing Initiative Taskforce were then asked to provide comments to these outcomes via email. The following includes a synopsis of those comments.

Themes:

- The outcomes are presented as broad, value-based vision statements for housing-related priorities... they are not measurable outcomes at this point and not tied to any specific strategy. The intent was to begin narrowing down the focus of the Taskforce as we prepare for identifying best practice strategies to recommend for funding.
- The word “adequate” is used to describe services that are appropriate **in quality and the intensity is** adjusted for the individual’s needs at any point in time. Defining what these adequate services are (e.g. housing that is located close to amenities, services based on level of support needed, etc.), will happen during the planning phase once decisions are made about what to fund.
- The word “clients” is used for all individuals living with a serious mental illness, which includes peers. Currently, MHSA legislation requires that funding used for housing developments serve 1) individual with serious mental illness and 2) individuals that are homeless or at-risk of homelessness. There may be some flexibilities with defining “at-risk of homelessness” and we have reached out to appropriate State entities for guidance.

Guiding Principles:

There are MHSA-required and locally-defined guiding principles and values. All MHSA funded programs, services and strategies will be:

- Client-focused, client and family-driven
- Collaborative and coordinated across systems in planning and service delivery
- Co-occurring substance use and mental health capable
- Culturally responsive and welcoming
- Peer integrated
- Trauma-informed

Updated Outcomes (Vision Statements):

1. Clients have **sufficient**, safe, adequate and affordable housing that meets their **evolving** level of **need**.
2. Clients have simplified, easy to access **(e.g. no wrong door, single-point of entry)** supports for finding and securing appropriate housing.
3. Clients have the adequate, ongoing, long-term supports and resources to help them maintain their housing **through all phases of recovery, including relapse**.
4. Clients meaningfully engage and are connected with the community via occupational, volunteer and/or educational **opportunities**, etc.
5. Clients' recovery and self-actualization is supported **and enhanced** at every stage to improve their independence **and quality of life**.
6. Community crisis and need for emergency services is decreased.
7. Community is welcoming and supportive of safe and stable homes for clients
8. Clients receive quality, **integrated** supports and services; **both clients and families report satisfaction with housing and the services provided**.

Email Comments:

- Support staff functions as an integrated client-focused wellness team
- Also, I notice that the word “adequate” appears in some of the important outcomes. Words matter and can be an important driver of outcomes. Could it be useful for us to agree on the definition of adequate so we’re all on the same page?
- One of the outcomes I did not see on here is my input regarding housing for individuals with lived experience who are now working the front lines with clients who have mental health and substance use disorders like myself. My peers in this field (peer counselors, recovery coaches and certified aod counselors) all have expressed to me, and I have experience presently with this myself, not being able to afford housing in San Mateo County. Most non profits pay between 19 - 25 per hour in this field which is far below the approximately 40.00 per hour needed to be considered to be a living wage. San Mateo County is the most expensive county in the nation to live in. Google reflects a single person living in this county needs to make 6300.00 per month to support themselves. My peers and myself need to have a serene place to go home to at night to re-group, re-center and refuel ourselves so we can pour into our clients the next day. It is difficult to do when we go home at night to unstable living environments. Most of my peers have to live with family, friends, rent a room, are considered homeless because they live in a Sober Living Environment or a Transitional House (like myself), live out of their cars or have to move out of the area entirely, meaning this county loses quality, well trained AOD workers to other counties. AOD workers who are trained with co-occurring disorders, who work on the front lines in this county and help to reduce recidivism to the emergency rooms, ambulance calls, police calls, and fire dept. calls

saving the county thousands if not millions of dollars. Some individuals, who are in programs and think they would love to work in this field get discouraged after investigating the pay rates in this field and ultimately choose another field making us lose even more qualified lived experience people. San Mateo County prides itself on leading the state and the nation with programs available to its citizens, to its employees through contracts with non profits. Please consider being trailblazers in the state and making a way for my peers and myself to have access to affordable housing through a voucher, a grant, or some kind of funding, where we can go home every night to a peaceful serene environment and take care of ourselves as much as we give to others.

- As I review the notes, I'm thinking whether it might be appropriate to have an outcome tied to system efficiency – this can be phrased from the client perspective i.e. it is easy to navigate the myriad of available services” but it can also be stated from the side of the care delivery system, i.e. “services, particularly if they are new, leverage and mindfully augment the existing service delivery infrastructure”. This is really stemming from the feeling that there are a lot of funding sources at the moment for behavioral health for people experiencing homelessness, and wanting to be very strategic how each funding pool is used so we can do the best by the clients!
- The 8 bullet points in the 'draft' of outcomes do resonate and seem to be as inclusive as the committee suggested. You captured the essence of the meeting and the various comments folks made. I do have one minor suggestion: On the 2nd bullet: Clients have simplified, easy to access supports for finding and securing appropriate housing. **Can something be added to call out that it would be via single point of access?**
- Thank you for your continued dedication to this really important taskforce project. am in agreement with the outcomes listed but want to suggest that the biggest outcome all of us want to see is an INCREASE in available housing. Perhaps some type of target in a certain period of time? Say 10% in 3 years?
- I think the outcomes listed resonate as needing further discussion. Without discussion re what programs or activities look like or will be expected/undertaken I don't think I would endorse these as actual outcomes. I am open to another meeting but I appreciated the original vision you and Judy had for this as I am not sure what the purpose would be at this stage of the game.
- My only comment is for this bullet “Clients meaningfully engage and are connected with the community via occupational, volunteer, education, etc.”, I think that maybe it might sound better with the addition of opportunities or a word like that so it reads: “Clients meaningfully engage and are connected with the community via occupational, volunteer, education opportunities etc.”
- I see a black and white approach in responding to symptoms related to “relapse”. If yes, hospitalization, with cascade of loss of housing, social supports, other things important to recovery. If no, larger intervals between episodes of client/team interaction. No crisis results in less support, when reality is the type of support needed changes. Current

structure has little safety net before calling 911. Ideal team would have better inter-team communication (including family members that client identifies) as well as uncomplicated route to intermediate responses like Serenity House, adjustable peer support, support in resolving inter-neighbor disputes. Team would have tool boxes full of options, so clients will have choices. Caseloads that are realistic to accommodate changes in level of function with adjustable levels of support.

- Definition of “adequate” in relation to housing, services, important outcomes, needs precision.
- Please add these outcomes:
 - Clients report they are happy with their supportive homes and the services provided.
 - Clients have assurance they will have their home to return to in case of symptom relapse requiring hospitalization.



Mental Health Services Act (MHSA)

Housing Initiative - May 5, 2021



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Welcome, before we begin...

- Meeting is being recorded
- Stipends for clients and family members participating
 - Chat your email with the word “stipend”



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Agenda

1. Introductions, Ground Rules & Overview
2. Outcome Prioritization Results
3. Best Practices and Funding Recommendations
4. Next Steps



1. Introductions, Ground Rules & Overview



Participation Guidelines

- Please enter your questions in the chat box as we go
- “Q&A” slides incorporated into the presentation
 - “Raise Hand” button - host will call on you and you can then unmute yourself
- Ground Rules
 1. Share the airtime; allow every voice to be heard (step up/step back)
 2. Practice both/and thinking; consider all ideas along with your personal advocacy
 3. Be brief and meaningful when voicing your opinion
 4. Success depends on participation (share ideas, ask questions)
 5. Share your unique perspective and experience
- Decision points – majority vote
- A recommendation will be made for public hearing, 30-day public comment and final approval by the Board of Supervisors



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Meeting Objectives

- Meeting #1 (March 3rd):
 - Review background information and opportunity for additional Q&A
 - Present additional layers to the Housing Continuum to include:
 - Programs and numbers served
 - Eligibility and State requirements were applicable
- Meeting #2 (April 7th):
 - Present set of outcomes and data to support/inform decisions
 - Brainstorm additional outcomes as necessary
 - Prioritize across all outcomes to focus strategic direction
- Meeting #3 (May 5th):
 - Present set of best practice solutions
 - Brainstorm additional solutions as necessary
 - Prioritize across all strategies to recommend

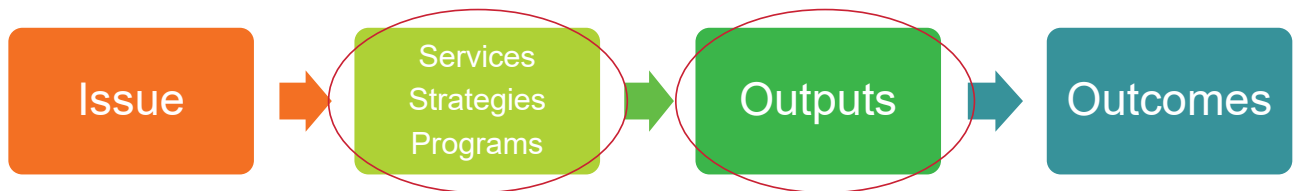


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High-Level Review

1. Framework for Prioritizing

- ✓ We prioritized a broad issue “Homelessness and Housing Stability” and identified many needs based on an ideal Housing Continuum
- ✓ We prioritized broad-based outcomes
- ✓ Next we will hone in on best practice strategies and measurable outputs



3. Taskforce Meeting #2 Q&A

4. Guiding Principles (next slide) – from optional meeting

Guiding Principles

- Client-focused, client and family-driven
- Collaborative and coordinated across systems in funding, planning and service delivery
- Co-occurring substance use and mental health capable
- Culturally responsive and welcoming
- Peer integrated
- Trauma-informed





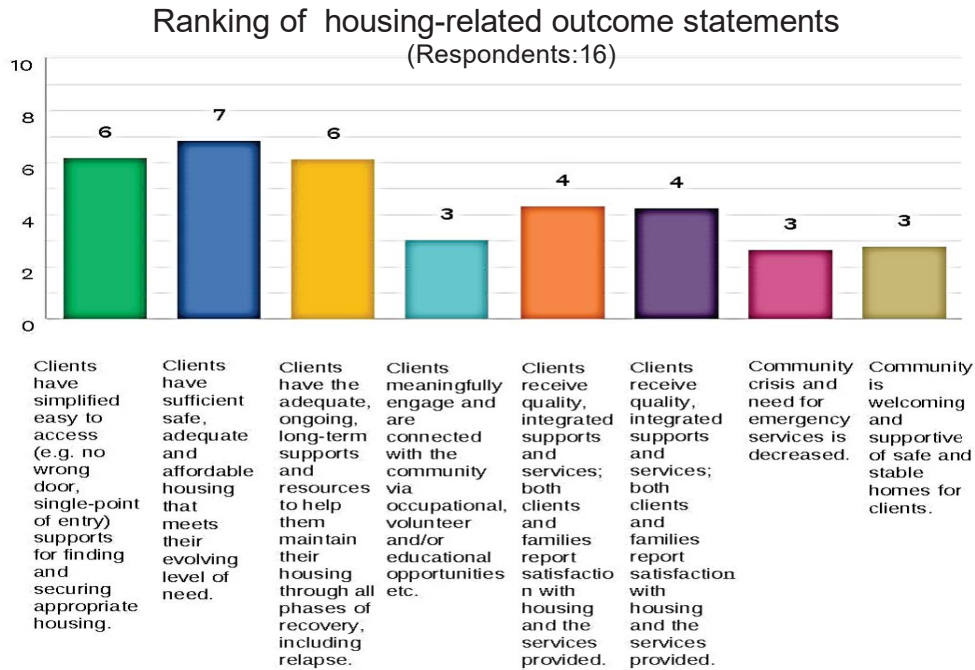
Questions?

2. Outcome Prioritization Results



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Survey Results



3. Best Practices and Funding Recommendations



Best Practices

- Evidence-based Practices
 - Consistently proven effective through rigorous research, replicated across several cases and can be adapted in other contexts.
- Best Practices
 - Effective and efficient methods that are mutually agreed upon as a standard way of operating. Highly regarded for results. Not necessarily subject to rigorous research
- Promising/Emerging Practices
 - Hold promise based on some evidence of effectiveness, not research-based because it is new and not sufficient evidence.



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Outcome #1: Clients have simplified, easy to access (e.g. no wrong door, single-point of entry) supports for finding and securing appropriate housing.

- Best Practices
 - Community Partnering
 - Case manager and peer staff to assist SMI when accessing community services
 - Ongoing support and education to community service partners to increase SMI utilization
 - Consumer knowledge about housing resources
 - Housing navigators and locator services



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Outcome #1: Funding Recommendation

- One Time Funding
 - Fund the development of an online BHRS Housing Portal
- Ongoing Funding
 - Fund housing locator and peer navigator services
 - Fund Mental Health Worker for Homeless Outreach Team
 - Fund mental health support and education for community agencies that provide homeless or housing oriented service to BHRS population



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Discussion –

- What other best or emerging practices would improve access?
- Do the funding recommendations resonate?

Outcome #2: Clients have sufficient, safe, adequate and affordable housing that meets their evolving level of need

- Best Practices
 - Permanent Supportive Housing
 - Collaborative investment in developing affordable supportive housing
 - Range of supportive and supported housing



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Outcome #2: Funding Recommendations

- One-time Funding
 - Fund development of Supportive Housing Units through DoH
 - Fund Transitional Housing and supports for SMI population
 - Special populations: TAY, SMI women with children, criminal justice involved
 - Coordinate with County efforts to increase transitional housing for homeless population
 - Fund match for state funds to increase number of board and care beds
 - Dependent on how state structures release of funds
- Ongoing Funding
 - Fund supportive services for new units developed
 - Fund incentives and supports for existing Board and Care



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- 
- A photograph of a person with dark hair, wearing a patterned jacket, speaking into a microphone. The image is overlaid with a teal tint. The text is white and positioned over the image.
- Discussion – What other best or emerging practices would increase housing?
 - Do the funding recommendations resonate?

Outcome #3: Clients have the adequate, ongoing, long-term supports and resources to help them maintain their housing through all phases of recovery, including relapse.

- Best Practice:
 - Collaborative, Integrated Outreach, Case Management and Treatment Teams with Housing Supports focus



Outcome #3: Funding Recommendations

- Ongoing funding
 - Increase FSP Housing funds
 - Increase BHRS flex funds for housing related expenses
 - Fund housing support services for independent living
 - Fund outreach and field service teams to include ongoing and long term supports focused on housing retention
 - Increase FSP slots



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- 
- Discussion – What other best or emerging practices would provide ongoing housing supports?
 - Do the funding recommendations resonate?

Best Practices References

- Outcome #1
 - Current Psychiatry Reports (March 29, 2019)
 - [Community Interventions to Promote Mental Health and Social Equity](#) - Community Partners in Care
 - [Housing Navigator Toolkit](#)
 - Housing Counseling
 - www.resource.hud.org
 - www.hudexchange.info/resources/housingsearchtool/
- Outcome #2
 - [SAMSHA Permanent Supportive Housing Evidence-Based Practices Toolkit](#)
 - [Corporation for Supportive Housing](#) (CSH)
- Outcome #3
 - [SAMHSA National Registry of Evidence Based Practice](#)
 - [National Alliance on Mental Illness](#) (NAMI)
 - [National Council for Behavioral Health](#)

4. Next Steps



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Prioritizing Recommendations

- Email with updated recommendations, measurable output and estimated costs for input
- Host one more optional meeting on Thursday, May 20th at 10am to review the final recommendations
- Online survey to rank the recommendations



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Recommendations & Public Comment

- The recommendations will be submitted with the MHSA Annual Update, draft will be posted by May 28th.
- **30-Day Public Comment @ the [MHSARC Meetings](#):**
 - June 2nd: Vote to open 30-day public comment period
 - July 7th: Public Hearing and Vote to close public comment and to recommend the Annual Update for approval by the BoS
- Public Comments may provided verbally at the meeting or in writing to: mhsa@smcgov.org

THANK YOU!

Judy Davila

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Doris Estremera

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www.smchealth.org/MHSA

Meeting Feedback:

www.surveymonkey.com/r/HousingTaskforce



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Housing Initiative Taskforce Meeting #3
MHSARC Older Adult Committee Meeting – 5/5/21

Question & Answer

- 1. MHSA legislation requires that funding used for housing developments serve 1) individual with serious mental illness and 2) individuals that are homeless or at-risk of homelessness. Is there flexibility with defining “at-risk of homelessness” for San Mateo County?**

A: Yes, there is flexibility, and this will be decided for San Mateo County once we are ready to roll-out implementation of new MHSA-funded housing. Currently, there are three definitions (attached) that have been used by different housing programs including the San Mateo County Office of Homeless, the MHSA Housing Program, and the No Place Like Home.

- 2. Department of Housing already has a housing service available would it make sense to work with the existing program rather than duplicate services?**

A: Yes, this is a Guiding Principle to build off of what is already available and not build anything new. The DoH is funding a housing portal and we will see if there is a way to build off of it.

- 3. Is the housing portal going to integrate all the other housing portals or a separate point of entry? Does it address the easy access, one point of entry outcome?**

A: This would not be a stand-alone portal, it will be for any individual with serious mental illness to be able to get information on all housing availability.

- 4. Will this portal require that someone have a diagnosis to be able to receive services?**

A: No, the priority will be to build off of current portals available via the DoH and to be supported by housing navigators that are familiar with the nuances of different eligibilities and supports for individuals with mental health challenges.

- 5. I had success using the housing portal to locate housing but was given 5 days to get the unit and no moving support or support to get paperwork together. Will there be support for individuals to maintain their housing?**

A: Peer navigator services is a funding recommendation for the ongoing MHSA budget that could support clients after identifying housing.

6. Will these housing navigators be embedded into existing teams that are already doing some of this work to expand and improve vs. separate team?

A: These are the types of considerations we would like input on to inform the design of the services so that it is most effective.

7. What will be the outcome of the portal for a client, what will that person get?

A: It would be a starting point to gather information and be linked to resources and housing navigators to get clear instructions on the processes for what is available and how to apply. A client and a case manager can go through the information together and develop next steps as a joint effort but, having one place to go to for individuals with mental health challenges, is currently not available. It will need to be a collaborative effort with Department of Housing.

8. How is this portal envisioned? Is it interactive, question and answer forms?

A: Other than a basic concept, the portal is not designed yet. This will be part of the planning process; which can take a look at what could be included and other models.

9. Regarding mental health supportive housing has any thought been given to surveying existing tenants for satisfaction?

A: Currently, we have a statewide Multi-County Full Service Partnership Project looking into the standards, quality and outcome reporting to make recommendations for FSP improvements. This process is being informed by FSP clients and family members via focus groups and interviews. A Progress Report of this project can be found here, https://www.thirdsectorcap.org/wp-content/uploads/2021/03/Multi-County-FSP-INN-Progress-Report_March-2021.pdf

10. Is there an “easy” process for providers of clients who have “graduated” from FSP, to re-enter, to re-engage in some or all of the services?

A: Referral to and participation in FSP is based on an individual's level of functioning in the community at the time of referral. They would start at the highest level of service. As their functioning improves and their service needs lessen, they would step down into a lower level of care provided by the FSP. If they reach a level of independence that would make them eligible for "graduation" their care and case management would be provided by the regional clinic. Should there be a need to return to an FSP level of care, the case manager would make a new referral. Timing of re-enrollment would depend on the availability of FSP slots. However, some of the services might be available through other means without the FSP. The individual should work with the case manager to secure the needed services.

11. When clients are no longer in FSP what are the menu of services that these clients have access to? How can we address this gap? What is the safety net and intentional ongoing support after making progress and graduate?

A: Right now, if a client step-down from FSP they are supported by the regional clinics unless they qualify for a specialty program like OASIS for older adults that are homebound. It depends on the client's individual situation, what they qualify for and what they are interested in. Most of the time they move into a wellness tier within FSP where they continue to stay in the program so that they are monitored before they're fully exited.

There is a recognition that stable housing is a contributor to an FSP participant's progress so separating a client from housing without supports is detrimental.

MHSA Housing Initiative Taskforce

Definitions of At-Risk of Homelessness

MHSA legislation requires that funding used for housing developments serve 1) individual with serious mental illness and 2) individuals that are homeless or at-risk of homelessness. There is flexibility with how we define “at-risk of homelessness” locally this will be decided for San Mateo County once we are ready to roll-out implementation of new MHSA-funded housing. Following are three definitions for at-risk of homelessness currently used by different housing programs:

1. San Mateo County Office of Homelessness

Mckinney- Vento Act CFR 578.3 - At risk of homelessness.

(1) An individual or family who:

(i) Has an annual income below 30 percent of median family income for the area, as determined by HUD;

(ii) Does not have sufficient resources or support networks, *e.g.*, family, friends, faith-based or other social networks, immediately [available](#) to prevent them from moving to an [emergency shelter](#) or another place described in paragraph (1) of the “Homeless” definition in this section; and

(iii) Meets one of the following conditions:

(A) Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

(B) Is living in the home of another because of economic hardship;

(C) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days of the date of application for assistance;

(D) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, [State](#), or local government programs for low-income individuals;

(E) Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons, or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

(F) Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

(G) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan

2. MHSA Housing Program

At risk of homelessness includes the following:

- transition-age youth as defined in Welfare and Institutions Code Section 5847(c), and in Title 9, California Code of Regulations, Section 3200.80) exiting the child welfare or juvenile justice systems
- individuals discharged from:
 - hospital, including acute psychiatric hospitals, psychiatric health facilities (PHF);
 - skilled nursing facilities (SNF) with a certified special treatment program (STP) for the mentally disordered;
 - mental health rehabilitation centers (MHRC)
 - crisis and transitional residential settings; and
 - city and county jails.
- Individuals temporarily placed in a Residential Care Facility upon discharge from one of the above.
- Individuals who have been assessed and are receiving services at the County Mental Health Department, and who have been deemed to be at imminent risk of homelessness, as certified by the County Mental Health Director

3. No Place Like Home (NPLH)

“At-Risk of Chronic Homelessness” for this Program means an adult or older adult with a Serious Mental Disorder or Seriously Emotionally Disturbed Children or Adolescents who meet one or more of the criteria below. All persons qualifying under this definition must be prioritized for available housing by using a standardized assessment tool that ensures that those with the greatest need for Permanent Supportive Housing and the most barriers to housing retention are prioritized for the Assisted Units available to persons At Risk of Chronic Homelessness pursuant to the terms of the Project regulatory agreement. Qualification under this definition can be done in accordance with established protocols of the Coordinated Entry System, or other alternate system used to prioritize those with the greatest needs among those At-Risk of Chronic Homelessness for referral to available Assisted Units, that meet the requirements of these Guidelines, including but not limited to, Section 206 (Occupancy and Income Requirements), and Section 211 (Tenant Selection).

Persons qualifying under this definition are persons who are at high-risk of long-term or intermittent homelessness, including:

(1) Pursuant to Welfare and Institutions Code Section 5849.2, persons exiting institutionalized settings, such as jail or prison, hospitals, institutes of mental disease, nursing facilities, or long-term residential substance use disorder treatment, who were Homeless prior to admission to the institutional setting;

(2) Transition-Age Youth experiencing homelessness or with significant barriers to housing stability, including, but not limited to, one or more evictions or episodes of homelessness, and a history of foster care or involvement with the juvenile justice system; and others as set forth below;

(3) Persons, including Transition-Age Youth, who, prior to entering into one of the facilities or types of institutional care listed herein, had a history of being Homeless as defined under this subsection (f)(3): a state hospital, hospital behavioral health unit, hospital emergency room, institute for mental disease, psychiatric health facility, mental health rehabilitation center, skilled nursing facility, developmental center, residential treatment program, residential care facility, community crisis center, board and care facility, prison, parole, jail or juvenile detention facility, or foster care. Having a history of being Homeless means, at a minimum, one or more episodes of homelessness in the 12 months prior to entering one of the facilities or types of institutional care listed herein.

The CES (as defined in Section 101(n)), or other local system used to prioritize persons At-Risk of Chronic Homelessness for available Assisted Units may impose longer time periods to satisfy the requirement that persons under this paragraph must have a history of being Homeless.

(4) The limitations in subsection (w)(a)(iii) pertaining to the definition of “Homeless” shall not apply to persons At-Risk of Chronic Homelessness, meaning that as long as the requirements in subsections (f)(1) - (3) above are met:

- i. Persons who have resided in one or more of the settings described above in subsection (f)(1) or (f)(3) for any length of time may qualify as Homeless upon exit from the facility, regardless of the amount of time spent in such facility; and
- ii. Homeless Persons who, in the 12 months prior to entry into any of the facilities or types of institutional care listed above, have resided at least once in any kind of publicly or privately operated temporary housing, including congregate shelters, transitional, interim, or bridge housing, or hotels or motels, may qualify as At-Risk of Chronic Homelessness.

Housing Initiative Taskforce

Funding Recommendations Review – 5/20/21

(Additional comments provided by Taskforce participants via email and during the meeting are in green)

Outcome	Funding Recommendations	One-Time Funding Amount	Ongoing Funding Amount	Measurable Output
Clients have simplified, easy to access (e.g. no wrong door, single-point of entry) supports for finding and securing appropriate housing.	1. Development of an online BHRS Housing webpage with comprehensive one-stop housing information (including data dashboard for unmet need) for clients and staff	\$100,000 (ongoing management in #2 and ongoing supports in #11)		Need to establish baseline <ul style="list-style-type: none"> Increase in website engagement Improvement in housing data reporting for clients
	2. Housing locator contract to oversee: <ul style="list-style-type: none"> Maintenance of BHRS Housing website services with real-time housing availability information Linkages to BHRS case managers Landlord engagement Community mental health 101 education to housing agencies Three housing locator positions (mental health counselors), three peer navigators + admin 		\$ 575,000	Need to establish baseline <ul style="list-style-type: none"> 20% increase in clients securing and maintaining housing Process outcomes: # of clients served; # of landlords engaged; # of community education conducted
	3. Mental health workers for Homeless Outreach Teams (two clinicians)			\$325,000
Clients have sufficient, safe, adequate and affordable housing	4. Establishment of an ongoing Housing Fund with Department of Housing for the development of Supportive Housing Units for clients	\$5,000,000 Year 1 \$5,000,000 Year 2		<ul style="list-style-type: none"> At least 40% increase (24 units) in MHSA funded units in six yrs.

that meets their evolving level of need				If Project Based Vouchers (PBV) are not available, we can expect ~20-25 units. If PBV is available then could expect ~40-50.
	5. Transitional housing supports and training to adequately serve SMI population, including special populations		\$100,000	Need to establish baseline <ul style="list-style-type: none"> 20% increase in SMI special populations using transitional housing
	6. Supportive services for new housing units developed		\$375,000/year for 25 units (FY 23-24)*	Need to establish baseline <ul style="list-style-type: none"> 90% of tenants remained housed
	7. Incentives and supports for licensed Board and Cares to improve quality of services		\$50,000	Need to establish baseline <ul style="list-style-type: none"> Improvement in client and family satisfaction, independent living skills development and other skills
Clients have the adequate, ongoing, long-term supports and resources to help them maintain their housing through all phases of recovery, including relapse.	8. Increase Full Service Partnerships (FSP) slots for children/youth and transition-age youth		\$607,835 10 Children/Youth and TAY FSP slots	Need to establish baseline <ul style="list-style-type: none"> Increase in families and TAY clients securing, and maintaining stable housing
	9. Increase FSP housing funds		\$258,662 (\$8,097/client)	Need to establish baseline <ul style="list-style-type: none"> Increase in clients maintained in stable housing
	10. Flexible funds for housing related expenses (moving costs, deposits, first month rent)		\$100,000 +/- (from annual Housing Program interest and payments)*	Need to establish baseline <ul style="list-style-type: none"> 20% increase in use of housing-related supports
	11. Outreach and field-based services to support ongoing and long-term housing retention; a team of Occupational Therapist and Peer Counselor with co-occurring capacity to support independent living skills development and recovery		\$500,000	Need to establish base line <ul style="list-style-type: none"> 20% percent increase in clients participating in independent living skills development Increase in clients maintaining their recovery plan
	TOTALS for FY 21/22 to 22-23	\$10,100,000	\$2,416,497	

*Item #6 (supportive services) is not included in the total budget amount for FY 21/22 to 22/23 because implementation will happen in future years; item #10 (housing-related flex funds) is also not included in the total budget amount because we are able to use funds from the return on MHSA housing investments.

Housing Initiative Taskforce Meeting #3

MHSARC Older Adult Committee Meeting – 5/5/21

Participant Comments and Considerations for Funding Recommendations

- **Development of an online BHRS Housing Webpage**
 - I am concerned that we are creating a BHRS-specific portal that will not be integrated.
 - I don't think we need another housing portal necessarily; when we do find the housing there is no support to get the paperwork together and moving support
 - There needs to be a Q&A or other resources available with the portal for next steps (to check name on the waitlist, confirm next steps); to get help moving and the process to navigate finding housing, next steps after identifying housing and getting ongoing supports. The online websites are difficult to navigate and cause anxiety for clients.
 - The audience for the portal will likely be the counselors and case managers; the ongoing funding makes sense to be for field-based support for moving, what to do and helping with the transition
 - It is a great starting point in collaboration with the DoH; there needs to be back-end support because of all the nuances with housing. It needs to be supported by someone that is well-versed on all housing and eligibility requirements so that they can direct clients, case managers, clinicians and others to the right resources.
 - The webpage should be as easy to navigate by clients and case managers. The current DoH webpage is difficult to navigate; if we build off it, we need to make it more intuitive.
 - The housing portal portion of the DoH webpage is not available yet; it is intended to have information on housing availability
 - There needs to be a specific area of focus for BHRS population. The vendor that works with DoH has expertise in doing this in Alameda County in collaboration w/DoH and BHRS.
 - Housing authority vetted and used to provide weekly lists of landlords that had vacancies and that accepted vouchers; most helpful tool in real-time
 - Currently landlords send an email to BHRS; we need to figure out how to disseminate that information
 - Staff allocated to the housing locator should be dedicated to doing this
- **Housing locator services and peer navigator services**
 - The peer navigator covered in the ongoing funding is essential. Individuals with serious mental health challenges may not have the capacity to independently navigate the system
 - It seems like peer navigator would need to be embedded in a team. They would be the subject matter expert re: housing, other team members re: services, the client the expert on what they want their living situation to be, what they value, what they see as their needs
 - My experience as a Mom has been that many times, more often than not, discharge planners, conservators, social workers et al have actually not known what housing / supportive housing was available. Not that there was a lack of resources, just that they were not aware. The Moms typically have to research this and very often know more about what is possible or available than the professionals. We can aspire to true collaboration and coordination in the system.

- I am so frustrated doing everything right for my health and welfare, but I hit roadblocks in finding the next step to access help for housing. I was never able to acquire a case manager in program because of my age
- I too fall through the cracks for being too young for older adult housing yet still need support to move before I am too old to lift my own furniture
- Though possibly not realistic, if the County had a way to pay for moving services that would be amazing and helpful. The vast majority of people who are low income and need to move just cannot do it themselves or pay for someone else to do it. This has been a big hurdle for our clients. I've suggested that clients plan on saving towards moving costs but not many have the means or have the ability for the first/last month's rent and security deposit that I am aware of.
- Housing locator position should be dedicated keeping the website information real-time on availability from the Housing Authority
- HSA and Whole Person Care (HPSM) has a housing locator that we can learn from
- Housing navigators need to be hands-on (not just handing a flyer or making a recommendation and locating a unit); they need to help fill out forms, getting documentation ready, do a site visit of the unit/apartment.
 - We need be very specific about all the activities we expect the housing locators and navigators to do so there is no question
- For the initial on-boarding for someone that is homeless, they will need assistance in applying for benefits.
 - Access to benefits is addressed by a BHRS Unit to support SSI applications and insurance enrollment, they are located in different regional clinics.
 - Homeless clients are stressed about paying their 30% contribution to the units and this impacts their recovery; SSI supports this.
 - This should be supported by the housing locators and peer navigators in collaboration with BHRS
- **Mental health support and education for community agencies that provide homeless or housing-oriented services to BHRS population.**
 - DoH can provide technical assistance and do housing trainings and modules for agencies and staff providing case management and service delivery.
- **Transitional Housing and supports for SMI population**
 - For transitional housing for special populations, the fact that SMI/AOD beds require clearance for the purpose of drug MediCal has resulted in beds being empty or unused. Need to look at this.
- **Incentives and supports for existing Board and Care**
 - I want to see us refer to "licensed" board and cares. We need to call out that board and cares be licensed to improve the quality of services.
 - I am underwhelmed with quality of currently available board and care settings. What can we do about funding level and quality is current and future settings?
 - It seems like the rules on what services you get depend on the setting the client is in. So, being in board and care wouldn't allow you to receive the services needed to support more independent living skills. Board and cares could be part of a step for an individual to move to a permanent home and live more independently vs. being the final stop.

- Improved and robust oversight of Board and Cares as well as other group settings needed
- Room and Board - I believe room and boards are needed as there are limited beds available in licensed board and care facilities. I agree the quality of care needs to improve and may be achieved with increased monitoring of quality control. I also like to suggest that board and cares, room and boards and shelters provide independent living skills instructions so when clients do get housing they are prepared to live independently. A Housing Wrap group mandatory for clients seeking housing may be helpful.
- There is a gap in service for those clients that need minimal levels of medical care. They get refused in higher level of care like nursing home facilities, but board and cares are afraid to take them on because they need more support (diabetes medication adjustments, etc.). Need an in between housing solution for these folks.
 - WPC has a model to living independently with supportive services; could be replicated for SMI folks in this situation
- I have thrived when don't have to deal with roommates. With roommates it's distracting when there are various levels of healing, it's distracting when roommates still want to abuse substances or not ready to move on. Clients need to be protected... trauma-informed care is important to support those that are ready. Please require developers to commit to more units for the independent minded folks who are behaving and meeting best practices and assisting the county as peer support workers.
- **Development of Supportive Housing Units through DoH**
 - How can we engage communities to support these housing development projects? My community fights against workforce housing etc... without community support developers will not even try to build.
 - DoH has supported the development of Waverly Place and value the model where 100% of the units are targeted to the BHRS population. DoH also funds set aside units in affordable housing throughout the County. DoH has required 5% of units set aside for homeless and an additional 10% for low-income; we are now creating added incentives to increase these percentages. DoH has also funded housing for TAY population. DoH knows how to fund affordable services; BHRS knows the services that support clients to maintain housing. It's important that developers understand the needs and that we continue collaboration for these service plans.
 - The Bay Area is expensive, is \$10M enough to get us 24 units? All affordable housing units are funded with many revenue sources. \$10M will absolutely get us 24 units because it is an incentive for developers who are already developing housing, to make units available for BHRS population.
 - Project-based vouchers are federally funded, what amount does this provide to housing developments? The voucher monies go to the units vs. individuals (mainstream and housing choice vouchers). The Housing Authority determines the amount based on size and location of the development, amenities and covers the amount that clients are unable to pay. This funding may be stagnant for a few years so, we do not know what amounts will be available to subsidize.
- **Increase FSP slots and housing funds**

- The funding for housing supports for FSP clients should stay with the client if they progress onto more Independent Living - currently they are attached to the program, if the client moves to another program because they are progressing in their recovery, they lose their housing subsidy.
 - FSP participants can stay in a step-down model with services and keep their housing. There are some clients that do graduate from FSP, based on their choice; FSPs must do all that they can to keep them housed.
 - Attach the vouchers to the clients otherwise you give FSP a financial incentive for people not to heal.
 - In my perfect world, everyone would have access to the FSP services at any time that they may have the need. The way that it is structured creates a funding silo where you are designated as receiving these services and then are not.
 - A youth in FSP services may leave and what happens to them? If they don't have a case manager and FSP services how do we support them. We need to address this.
- **BHRS flex funds for housing related expenses (moving costs, deposits, first month rent)**
 - These should be added to the locator services – welcome packages, moving cost, deposits, first month rent support.
 - Funds for moving costs can make the difference between smooth transition from one place to another where they would otherwise have to become homeless in between. We should not use this on deposits and first month's rent; instead partner w/CBO's that have this funding but it's so difficult to access; it takes days/weeks/months before funding is available and clients lose funds. Can the County support this process?
 - In the meantime, it would be nice to have funds available for the deposits and first months' rent until things get sorted out through the CBO's to fund this.
 - Yes, some clients will not be eligible for CBO's so there still needs to be a pool of funding
- **Housing support services for long-term housing retention and independent living**
 - Independent daily living skills via occupational therapy should be a part of all our supported housing and provided ongoing.
 - Occupational Therapy should be a position in charge of this team because they have the skills, have been underused, and we have good programs locally for recruitment. Improving daily living skills is one of the most successful approaches to support housing retention.
 - I agree, completely agree. Occupational therapists have done wonderful work for current MHA sites.
 - To support clients to maintain housing through all phases of recovery; one of the biggest obstacle clients face when have SU issue is being able to seek inpatient or residential treatment. There used to be more on-demand residential units for clients to give them a period of sobriety and support. So many fail because they can't escape the routine around SU. We need to improve access to residential treatment.
- **Additional Comments:**
 - I am concerned with the nutrition in all of our client's housing; can we set a standard. Currently the nutrition is sub-standard.

APPENDIX 4. COASTSIDE NEEDS ASSESSMENT SUMMARY AND INFOGRAPHIC

COASTSIDE NEEDS ASSESSMENT SUMMARY

EVIDENCE BASED RECOMMENDATIONS

- Community-Defined Solutions for Latino Mental Health Care Disparities by California Reducing Disparities Project
- Mexican/Mexican American Adolescents and keepin' it REAL: Evidence-Based Substance Use Prevention Program

BARRIERS TO ACCESS: INDIVIDUAL, COMMUNITY, AND SOCIETAL BARRIERS TO CARE

- **Key Finding 1:** Negative perceptions of mental health care
 - Concerns: stigma, culture, masculinity, exposure to violence, lack of information
- **Key Finding 2:** Underutilization of mental health services are due to gaps in culturally and linguistically appropriate services
 - Shortage of bilingual bicultural mental health workers
 - Shortage of academic and school based mental health programs
 - Structural barriers to care
- **Key Finding 3:** Social and economic factors
 - Living conditions
 - Inadequate transportation
 - Social exclusion

STRATEGIES TO IMPROVE ACCESS TO EXISTING SERVICES

- **Key Finding 4:** Identified community and cultural assets that promote mental health
 - Individual and community resiliency
 - Protective factors: Familismo (the value of family), Respeto (respect for community members), Personalismo (value of personal relationships with people and institutions)
 - Family involvement
 - Church and religious leaders
 - Role models and mentors
 - Community Platicas

STRATEGIC DIRECTIONS FOR REDUCING DISPARITIES

- Academic and school-based mental health programs
 - Focus on adolescents and impact of failing to diagnose mental health issues in a timely manner
- Community-based organizations and co-location of services
 - Increase collaboration among agencies by coordinating and maximizing community resources
- Community media
 - Use mainstream Latino media to raise awareness
- Culturally and linguistically appropriate treatment
 - Provide high quality care and treatment
- Workforce development
 - Develop and sustain culturally competent mental health workforce

- Community Capacity Building and Outreach and Engagement
 - Strengthening outreach and engagement
 - Building behavioral leadership in the Latino Community
 - Defining behavioral health outcomes at the community level in terms that matter to Latinos
 - Building local capacity aimed at reducing disparities and improving outcomes

COASTSIDE NEEDS ASSESSMENT RESULTS

OVERVIEW

- 12 Sites
- 210 Total Participants
 - 173 North County Participants
 - 37 South County Participants
 - 22 Youth
 - 188 Adults

SOCIAL AND RECREATION ACTIVITIES

- Physical Activities
 - Group Exercise: Zumba, dance
 - Recreation: parks, playgrounds, nature activities, beach activities
 - Sports: volleyball, basketball, gymnastics, swim, soccer
- Creative/Enrichment
 - Music: Mariachi, composing, learning to play instruments
 - Arts/Crafts: sewing, embroidery, painting, crochet, drawing, sculpture
 - Cooking Classes: nutrition and cooking classes
- Mindfulness
 - Kids yoga/meditation, mommy and me yoga, meditation, stress reduction
- Social Activities
 - Bowling, movie theatre, free activities, developmentally appropriate activities for children

EDUCATION AND PREVENTION

- Parenting Classes
 - Developmental Milestones
 - Family Dynamics
 - Communication
- Wellness and Physical Health Classes
 - Stress Reduction
 - Nutrition Classes
 - Health
- Mental/Behavioral Health classes
 - Bullying
 - Substance use
 - Mental Health Education
- Awareness of Special Needs

- Enrichment Classes
 - Technology
 - Financial
 - Language Attainment
 - Higher Education
 - Cultural Classes
 - Misc
 - Safety
 - Disaster preparedness
-

BARRIERS

- Transportation
 - Geographical Isolation
 - Not consistent or reliable
 - Youth cannot access higher education
 - Accessibility
 - Increase awareness of services
 - Easier way to access resources and learn about new programs
 - Close to communities
 - Use comprehensive communication strategy
 - Economic
 - Activities should be free or low cost
 - Financial assistance needed
-

PROGRAM REQUIREMENTS

- Consistency
 - Commitment from community members and providers
 - Following through with the promise of services/programs/classes
- Staff Values
 - Patient and approachable
 - Trust, respect, accountability
 - Committed to listening without judgement
- Incentives
 - Rewarded for attending (especially youth)
 - Offer dinner
- Participant Engagement
 - Community members need to participate in decision making
 - Should not degrade Latinos
 - Services should be equal
- Linguistically and Culturally Competent
 - Services need to be in Spanish
 - Spanish speaking staff
 - Staff needs to understand Latino culture

PHYSICAL SPACE

- Recreation
 - Parks with soccer fields, basketball courts
 - Place for our children to exercise
 - Place for socialization
- Community Engagement
 - Multicultural center
 - Space to create community
 - Local building
 - Easily accessible
 - Community space for parties
- Community Hub
 - Access to kitchen to prepare afterschool snacks/foods
 - Cultural center
 - Immigration services
 - Mental health services
 - Recreational activities

SCHOOL SERVICES

- Staff training to meet needs of students
 - Lack of support from teachers
 - Positive interactions with students
 - Special training categories for staff/teachers/aids
- School district performance
 - Lack of consistency from school
 - ELD stressors for youth
 - IEPs not being given/used
 - Lack of funding
 - More counseling
- Support from school for special needs students
 - Help to better serve students with ADHD
 - Behavioral assessments
- Curriculum
 - Social/emotional development
 - Access to technology

TREATMENT

- Mental/Behavioral Health
 - Individual
- Mental/Behavioral Health
 - Couple/Marriage/Family
 - Addiction/Family therapy
- Substance Use

- Help with drinking alcohol
- Rehabilitation for alcohol
- Drug rehabilitation for youth/young adults

PREFERRED TIME OF DAY

- Evening 5pm-9pm

COASTSIDE COMMUNITY NEEDS ASSESSMENT

What does this support?

In collaboration with the Latino community on the Coast (including providers, mental health consumers and families, educators and youth) the findings resulting from this assessment will inform the Multicultural Wellness Program in addressing behavioral health gaps and providing culturally and linguistically appropriate services

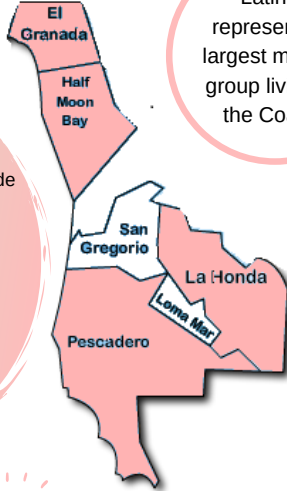
About Our Respondents

210 Participants

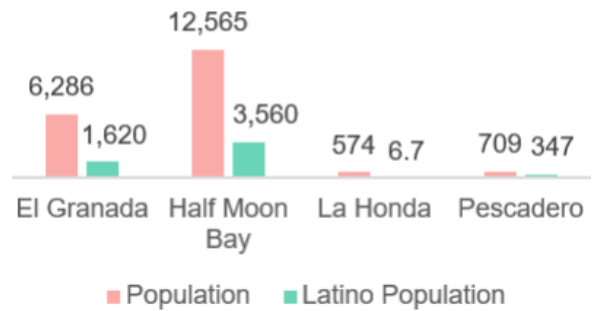
188 Adult
22 Youth

12 Sites

- Coastside Hope
- La Costa Adult School
- Boys and Girls Club of the Coastside
- Our Lady of Pillar Church
- Alas
- Parents of Special Needs Group
- Moonridge Apartments
- Caregiver Connection
- Senior Exercise Class
- La Sala Group
- Zumba in Pescadero
- Pescadero Youth Group



Latinos represent the largest minority group living on the Coast



"During traumatic events people come together"



Strengths

These strengths were identified as being fundamental to the well-being and resilience of the community members

Barriers

These barriers were identified by the community which reduced accessibility and use of behavioral health services

FAITH

"I am thankful to God that he has allowed me to be here"

"Seeing my family happy is what propels me to wake up every morning"



FAMILY

ACCESSIBILITY

- Awareness of service
- Culturally and linguistically appropriate services

"My three year old daughter saw her father get deported and after that shock she stopped talking. She was so talkative before. they thought they might be able to help us but they said this case was not severe enough to help. It is frustrating as a mother to see your children suffer. It feels as though we are not wanted here"

TRANSPORTATION

- Geographic Isolation
- Inconsistent and unreliable

She asked many times for bus transportation to and from the school, but she was told there isn't money for it.

CULTURE

"Mariachi class must continue to occur because daughter likes it and it makes her happy"

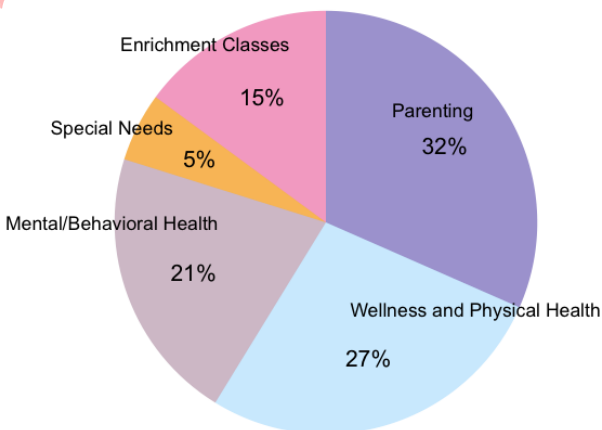
ECONOMIC

- Low wage work
- Limited financial stability

"I pay for classes that should be free"

Consistent **NEEDS** were raised by community members across all sites in achieving and maintaining well-being

Education and Prevention Classes



Treatment

- Availability and consistency of treatment offered in **SPANISH**

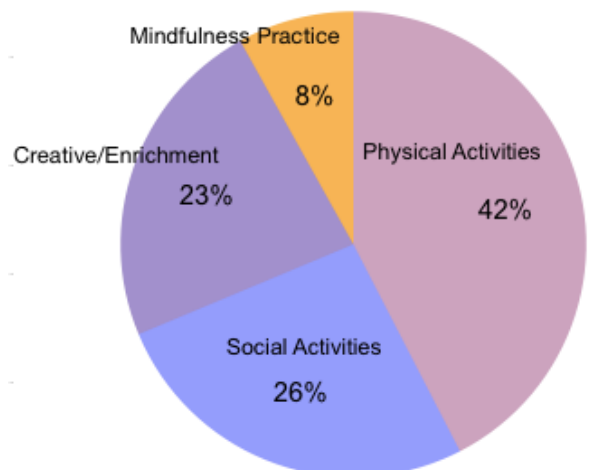
Individual Behavioral Therapy

Marriage and Family Therapy

Substance Use

"I need help with drinking (alcohol) less/not as much"

Social and Recreation Activities



School Services

- There was a high request for improvement of: staff training, increase of resources, support from school for special needs

33.5% of 3rd graders within Cabrillo-La Honda Pescadero Districts are falling below reading proficiency level



"My son needs reading and writing support, but tutoring services begin at 4th grade"

APPENDIX 5. YOUTH S.O.S. TEAM SCOPE OF WORK

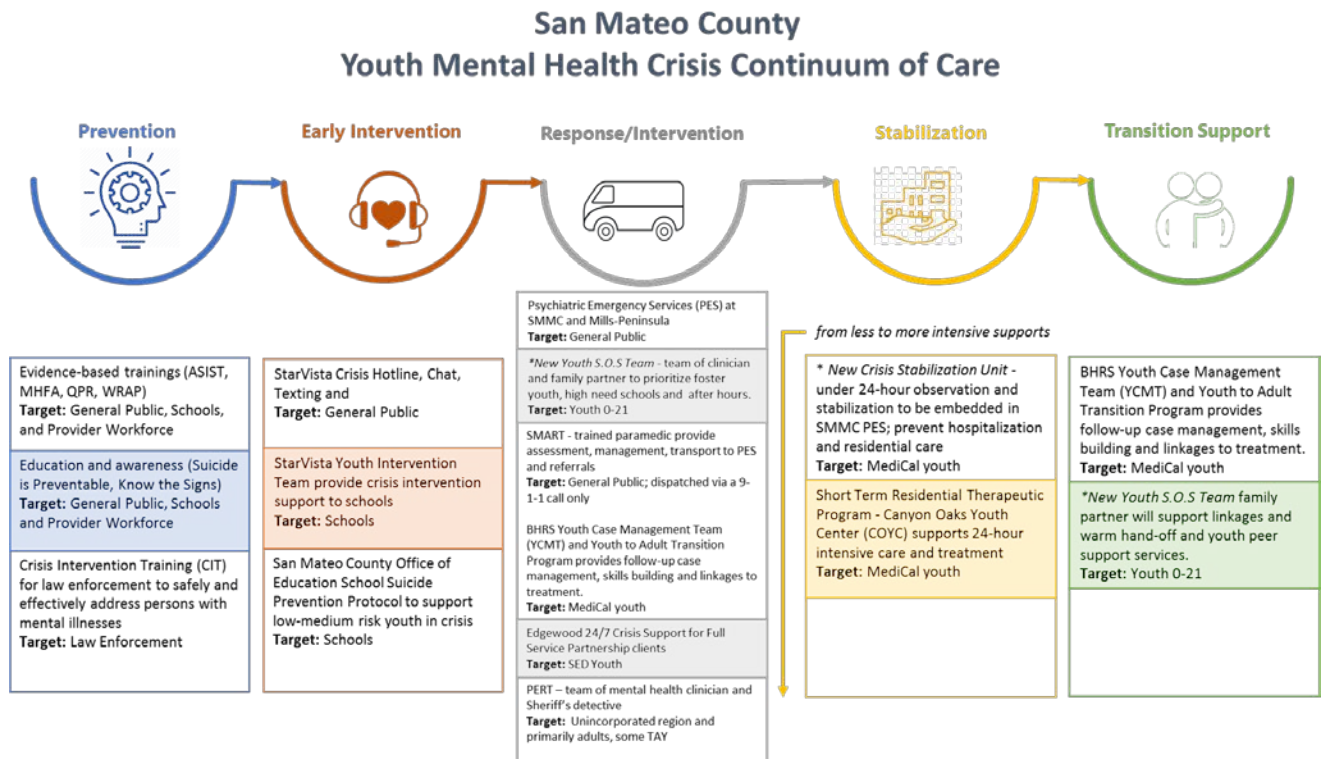


SAN MATEO COUNTY - YOUTH S.O.S. TEAM

BACKGROUND

As part of the Mental Health Services Act (MHSA) Three-Year planning process, stakeholders recommended the convening of a Taskforce of Prevention and Early Intervention (PEI) experts, leaders, clients/consumers and family, and community members to develop specific strategic and programmatic recommendations for children 0-21. Taskforce participants reviewed data, prioritized across issues, and recommended the expansion of mobile behavioral health crisis support for youth in the community and including evidence-based crisis prevention efforts such as training of youth, parents and school staff on identifying signs of mental health or substance use-related issues, reducing stigma and supporting youth behavioral health and knowledge of available local resources. Starting in October 2019, the Youth Committee of the Mental Health and Substance Use Commission (MHSARC) met monthly to plan an integrated youth crisis strategy.

San Mateo County Behavioral Health and Recovery Services (BHRS) continues to seek out resources and opportunities to develop a comprehensive Youth Crisis Continuum of Care, depicted below and attached, that integrates essential elements of behavioral health prevention, early intervention, response, stabilization and transition supports for youth in crisis.





Additionally, the Family Urgent Response System (FURS); established by Senate Bill 80 and amended by Assembly Bill 79 requires counties to develop and implement a Mobile Response System for foster youth and their caregivers. San Mateo County BHRS and Human Services Agency (HSA) partners opted to implement a coordinated effort for both youth crisis supports, and the FURS foster youth response needs via the Youth S.O.S. Team.

SCOPE OF WORK

A) Service Description

The Youth Stabilization, Opportunity, & Support (S.O.S.) Team is designed to respond within 24 hours in the community to any location where youth may be in crisis, provide 24/7 immediate in-person response to current and former youth in foster care, and community awareness and education about behavioral health crisis, suicide prevention and response services. The Youth S.O.S. Team will incorporate trauma-informed, cultural responsiveness and best practice approaches for safety assessment and crisis intervention, brief counseling, family supports, linkages and warm hand-offs, and transition clients to the most appropriate level of care as determined by clinical assessment. The contracting agency will:

1. Respond to youth ages 0-25 years old experiencing a mental health or substance use-related crisis and their families/caregivers in San Mateo County, regardless of insurance;
2. Serve as the Family Urgent Response System (FURS) system of support for children and youth in foster care to provide 24/7 immediate trauma-informed in-person response and support during situations of instability¹, which is defined more broadly than mental health or a substance use-related crisis.
3. Provide behavioral health crisis prevention activities for youth.

The expected outcomes of the Youth S.O.S. Team include:

1. Decreased youth psychiatric emergency service visits;
2. Decreased hospitalization for self-inflicted injury and/or behavioral health issues;
3. Decreased emergency calls to law enforcement for youth in crisis;
4. Increased linkages for children or youth and their caregivers to services;
5. Improved capacity of youth and family/caregivers to recognize the need for intervention and ability to seek services when needed.

¹ Instability is defined broadly to include situations involving tension and conflict and does not require the child/youth to be the presenting problem or require a mental health crisis nor meet any clinical criteria to receive phone or in-person support.



Additionally, for children and youth in foster care, expected outcomes include:

6. Decreased placement in out-of-home facilities;
7. Improved child and youth and family outcomes;
8. Improved retention of current foster caregivers;
9. Maintained current living situations for children and youth in foster care;
10. Improved trust and relationship between the child or youth and their caregiver;
11. Improved stability for youth in foster care, including youth in extended foster care.

B) Target Community

The Youth S.O.S. Team will prioritize current and former foster youth, schools with limited resources and/or complex cases and non-school related community response for youth in crisis. The contracting agency will have expertise and/or capacity to provide trauma-informed services for high risk children and youth in the child welfare field or other similar experience. The contracting agency will provide cultural and language appropriate services for marginalized ethnic, linguistic and cultural communities in San Mateo County; specifically lesbian, gay, bisexual, transgender, and queer (LGBTQ+) youth, given their disproportionate experiences with adverse childhood events such as abuse, foster care and unstable housing, homelessness and mental health disparities including depression, anxiety, and suicidal crisis.

C) Service Approach

The Youth S.O.S. Team will incorporate trauma-informed, culturally responsive services.

A trauma-informed approach shall be incorporated when serving youth with mental health and/or substance use-related issues and their families; safety, trustworthiness and transparency, peer support, collaboration, empowerment and cultural issues. Specifically, a trauma-informed approach that is culturally responsive for lesbian, gay, bisexual, transgender, and queer (LGBTQ+) youth would include attention to hate crimes, the coming out process, familial rejection and abuse related to LGBTQ+ identity and would have standardized follow-up practices to these reports. Supportive services will be provided in the least intrusive and most family friendly manner to avoid triggering further trauma to the child or youth. Current and former foster care youth have expressed that they often feel like existing resources to address situations of instability make the youth's behavior the focal point of the discussion rather than exploring how all the members of the family contribute to the tension. The Youth S.O.S. Team will remove blame, facilitate discussion between the youth and the family, identify ways to reduce the immediate tension, and determine a plan to utilize local resources to further strengthen the family long-term.



SAN MATEO COUNTY HEALTH

BEHAVIORAL HEALTH & RECOVERY SERVICES

Culturally responsive services are sensitive to the diverse cultural identity, are delivered by bilingual/bicultural staff and/or are available in the primary language of clients and use the natural supports provided by the client's culture and community. Services shall be designed to reach diverse communities including adequate levels of staff who can communicate in the languages spoken by the communities they serve and that are reflective of their communities. As required of all BHRS contract agencies, a Cultural Competence Plan will include strategies for communicating with families in other languages if/when staff who speak the language are not available to respond and practices that are inclusive of diverse communities, including LGBTQ+ youth. For example, verbal and written communication like S.O.S. brochures, website, and intake assessment language should be inclusive of people with same gender partners and consideration should be made for privacy of publicly undisclosed LGBTQ identities (e.g., if a youth has not disclosed LGBTQ identity at home or school, crisis care staff should not disclose this identity unless essential for care).

D) Program Components

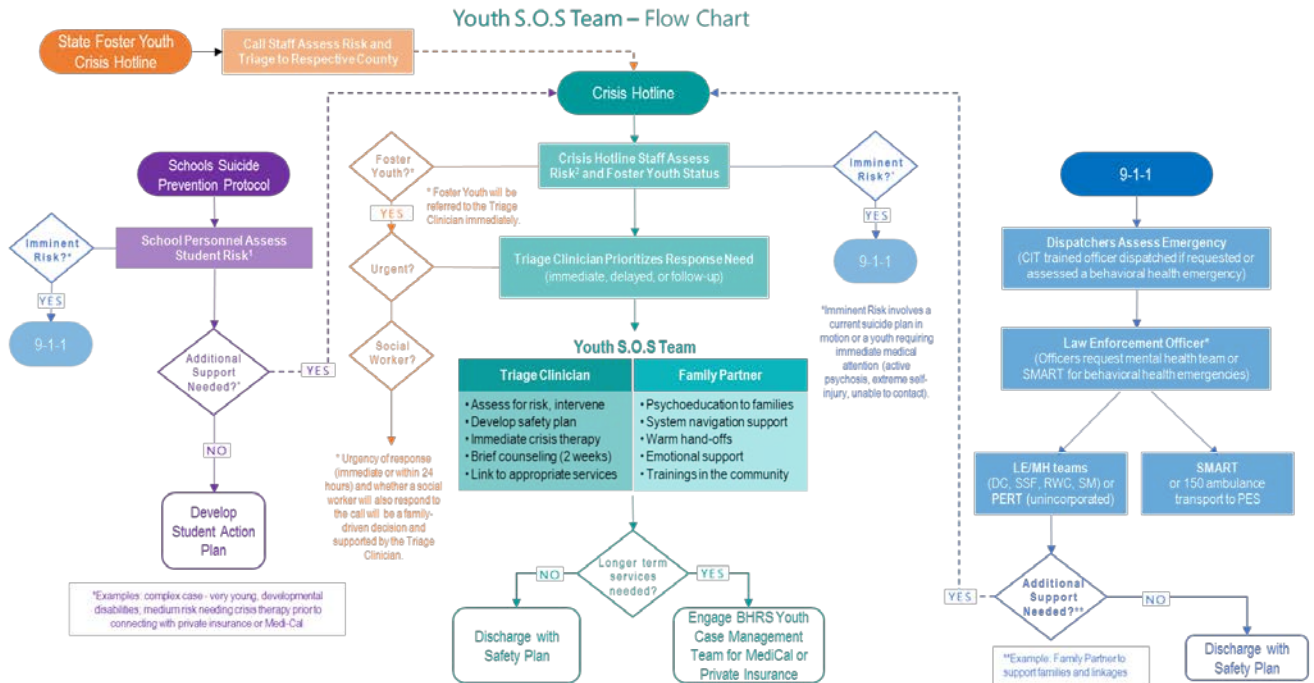
1. COVID-19 Planning Considerations: The program will incorporate COVID-19 policies and protocols including but, not limited to the procurement and use of appropriate personal, protective equipment (PPE) when responding in the community, including home-based responses.
 - (a) Telehealth services would be made available if deemed appropriate.
2. Collaboration with San Mateo County Human Services Agency and Behavioral Health Services: While foster children, youth, and caregivers are encouraged to contact any current provider, social worker, or probation officer for support during situations of instability, there is no requirement that they do so before receiving a Youth S.O.S. response. There may be times when those professionals are not available or cannot be quickly reached or when a child, youth, or caregiver may have chosen to reach out to the FURS statewide hotline because they wanted support from someone else. Moreover, the Youth S.O.S. Team can be a resource for social workers or probation officers who may need immediate help in supporting their families and children or youth during situations of instability. When responding to a child, youth, or caregiver, the Youth S.O.S. Team can support them and provide warm hand-offs to their existing providers and/or culturally responsive resources to support them in future situations of instability. All former and current foster youth response will require a notification to child welfare and probation. Whether a social worker will also respond to the call will be primarily a family-driven decision and supported by the Triage Clinician on the Youth S.O.S. Team. In coordination with the San Mateo County Human Services Agency (HSA), Children and Family Services,



policies will be developed for instances where a social worker response is necessary, including but not limited to, after-hour response for foster care youth.

3. **Crisis Hotline:** The program must use an existing Crisis Hotline, available 24 hours per day and 7 days per week, to respond to all crisis calls from the general public and community partner requests for the Youth S.O.S. Team. Protocols will be developed for screening, assessing safety status and dispatching the Youth S.O.S. Team by hotline volunteers and clinician on staff. Protocols shall also determine the priority of the call and timeline for response including whether the caller is a current or former foster youth and the level of risk.

Aside from the 24/7 phone-based hotline, other youth-friendly and preferred modes of receiving crisis intervention and supports will be provided including, maintaining and operate a website, teen peer-to-peer chatroom and social media support, and texting supports.



1. School personnel are trained to assess low, moderate, high risk and take appropriate actions as per the San Mateo County Office of Education Schools Suicide Prevention Protocol 2019-2020.
2. Crisis hotline staff and volunteers use the iCarol tool to assess risk levels.

Updated: 2/5/2021

4. **Other Access Points:** The Youth S.O.S. Team Flow Chart above, and attached, depicts the various access points for children and youth in crisis in San Mateo County. All access points may result in a referral to the Youth S.O.S. While the



SAN MATEO COUNTY HEALTH

BEHAVIORAL HEALTH & RECOVERY SERVICES

ultimate goal is to reduce and prevent law enforcement contacts and psychiatric emergency services visits, at all points of access if danger to self or others is assessed, it would require a 9-1-1 call or welfare check involving law enforcement. Currently, “imminent risk” is used to assess whether to involve law enforcement; imminent risk definition involves a current suicide plan in action, a youth requiring immediate medical attention (active psychosis, extreme self-injury including active engagement and/or infections or medical repercussions, current and extreme intoxication), and/or unable to make contact with the youth in contact or they are non-responsive when they have previously disclosed suicidal intent.

- (a) The FURS Statewide Hotline will handoff all San Mateo County calls needing an in-person mobile response to the Crisis Hotline for the Youth S.O.S. Team response. Statewide Hotline staff will be trained to make determinations of calls that require a high-level emergency response and will take the appropriate action to connect the caller to the necessary services. However, even in situations that are psychiatric in nature and could benefit from a mental health intervention, a referral to the Youth S.O.S. Team may be sent as a secondary response. A warm hand-off will be facilitated by FURS Statewide Hotline staff to avoid a second triage before in-person support is provided via a three-way call with the caregiver, child or youth, and the Youth S.O.S. Team staff. The FURS Statewide Hotline staff will share information gathered during the call, including information on whether an urgent or non-urgent response is needed and any identified risk or safety concerns.
- (b) San Mateo County Office of Education will continue training school personnel on the San Mateo County Suicide Prevention Protocol, which provides prevention and intervention guidelines to help school personnel assess suicide risk and develop appropriate action plans for low-level risk students and/or request additional support if needed. School personnel may refer to the Youth S.O.S. Team if a student is very young, has developmental disabilities or other complex situation where they may need support. If student meets moderate to high-level risk and is not requiring medical attention or in imminent risk, Youth S.O.S. Team may be referred for immediate response to the school location. If a student requires transport to psychiatric emergency services and parents are not able to transport the youth, school personnel will contact 9-1-1 and request a CIT trained officer and SMART vehicle transport. School



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personnel may also refer to the Youth S.O.S. Team for support and follow-up.

- (c) Law enforcement will have access to the Youth S.O.S. Team via the Law Enforcement/Mental Health partnerships launching in Daly City, South San Francisco, Redwood City and San Mateo and the Psychiatric Emergency Response Team, which serves unincorporated San Mateo County. Behavioral Health and Recovery Services (BHRS) will continue to work with law enforcement partners to make a connection to the Youth S.O.S. Team earlier in the Flow Chart, either by 9-1-1 dispatch personnel and/or Law Enforcement Officers responding. This may include the development of protocols so that behavioral health crisis callers to 9-1-1 can be transferred without disruption to the Youth S.O.S. Team. Currently, BHRS provides CIT training and awareness and communication efforts regarding the Youth S.O.S. Team availability.
 - (d) Other Referrals: If other agencies and/or programs (Child Welfare, Probation, and other community programs) requires an assessment or a safety plan to be developed, they may contact the Youth S.O.S. Team via the crisis hotline. The Youth S.O.S. Team will collaborate with the agency/program to stabilize the behavioral health crisis. Youth S.O.S. Team will do an assessment, develop a safety plan and follow-up plan with the youth and family.
5. Hours of Operation: The Crisis Hotline will be available 24 hours per day and 7 days per week. Youth S.O.S. Team response will be available, at minimum, Monday through Friday, 9am to 9pm and Saturday through Sunday, 11am to 11pm. A Triage Clinician will be available on-call after-hours for assessment and next-day deployment scheduling as needed. If there is no need to dispatch first responders, the reason for call and eligibility for the Youth S.O.S. Team will be assessed. If caller is requesting mobile crisis services and meets age eligibility, the Youth S.O.S. Team may be dispatched. A Youth S.O.S. Team Triage Therapist will further assess the caller/situation and based on location/case load and request will prioritize caller and dispatch accordingly. Responses may include;
- (a) Immediate Response (within 1 hour) to location by Youth S.O.S. Team
 - (b) Delayed Response (within 4 hours)
 - (c) Follow Up Appointment Response (within 24 hours)

For former and current foster youth, in-person response 24/7 will be made available. All foster youth calls will be considered “urgent” unless the caller



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specifically indicates that they do not want the response to be immediate. The purpose is to provide a child or youth and their caregiver with support at the time they identify they need it. This means that situations not traditionally considered emergencies will still require an urgent Youth S.O.S. Team response. Response times and explanations of the extenuating circumstances should be documented when the response cannot occur within one hour. Youth S.O.S. Team response will include:

- (a) Immediate response (within 1 hour) to location by Youth S.O.S. Team
 - (b) If extenuating circumstances prevent in-person support within 1 hour, response shall not exceed 3 hours
 - (c) Non-urgent response (within 24 hours)
6. Staffing: Youth S.O.S. Team staff must be available 24-hours a day to respond to crisis calls. The Youth S.O.S. Team response will include capacity of two response teams that will overlap during a 12-hour response time each day and will primarily be made up of a Triage Clinician and a Family Partner to help improve families' level of comfort and trust and support linkages and warm hand-offs. Additional staff may be designated on-call if additional response is required. Given the challenges with hiring for 24 hours on-call coverage, after-hours response for foster care youth may be coordinated with the San Mateo County Human Services Agency (HSA), Children and Family Services who currently have a pool of Social Workers on-call rotations and could provide the connection necessary for foster care youth. At a minimum, two team members will respond in the community in order to have one team member who can meet individually with the caregiver while another team member meets with the child or youth. A youth peer partner should be available during call shifts to support youth as needed.

Policies will be developed for when more than two people should go in-person (including a youth peer partner for example), exceptions when only one person may be needed and staffing during times of peak activity for Youth S.O.S. Team requests.

For current and former youth in foster care, in-person response 24/7 will be made available. All foster youth calls will be considered urgent unless the caller specifically indicates that they do not want the response to be immediate. In-person response will include situations of instability (as defined previously) that



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include, but are not limited to, mental health and or substance use-related crises.

Specifically, the Youth S.O.S. Team will consist of the following staffing:

- (a) *Supervisor:* will supervise all team members and be responsible for the programmatic (administrative and clinical) oversight for the Youth S.O.S. Team. The supervisor will be responsible to ensure compliance of all programmatic operations and to participate in any county mandated activities.
- (b) *Triage Therapists:* will have a minimum of 3-5 years working with high risk children and youth who have experienced trauma and/or in the child welfare field or similar experience. The Triage Therapist will be familiar with San Mateo County system resources and be responsible for responding to triage calls at schools, in homes or in the community. Will assess the individual for risk and based on clinical judgement take appropriate steps to ensure safety of the client. This may include working with CIT trained law enforcement and SMART to transport the youth to further evaluation and possibly hospitalization. Therapist will work with client and family/caregiver to develop a safety plan, link client to appropriate outside resources including ongoing behavioral health treatment as needed. Therapist will continue to meet with client for 8-12 weeks, when appropriate, and ensure a warm hand-off.

Not all calls to the hotline will result in dispatch of the Youth S.O.S. Team as some callers may receive the support they need over the phone. When the Youth S.O.S. Team response is not needed or desired, the Triage Clinician and hotline staff as appropriate can still help with connecting the caller to other local resources they may need and be available to assess a mental health crisis over the phone and make recommendations regarding need for immediate actions (such as Law Enforcement response) or help stabilize the situation over the phone and schedule the Youth S.O.S. Team for a follow up assessment within the next 24 hours.

For former and current foster youth, the Triage Therapist will be available, along with trained hotline staff, to provide the caregivers, and/or youth with immediate over-the-phone support in deescalating and addressing situations of instability, resolving conflicts, and assessing risk and safety. The



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required response will depend on the individualized circumstances of each call and the desires and needs of the caregiver or youth after receiving phone support.

- (c) *Family Partners:* Family Partners will accompany the Triage Therapists on Youth S.O.S. Team response. Family Partners will be trained individuals with lived experience as a parent of a child receiving behavioral health services and/or as a foster parent and preferably members of the community who speak a threshold language other than English (Spanish, Cantonese, Mandarin, Tagalog). The role of the Family Partner is to provide the family members or caretakers of the youth with psychoeducation about behavioral health issues, suicide risk, self-harming behavior, support and resources while the Triage Therapist assesses the youth.

The Family Partner will continue to work with the parents or caregivers after the initial crisis to provide continued support and help with navigation of behavioral health systems, insurance and school supports for ongoing support to the family and youth. The Family Partner will, if necessary, assist the family in understanding the process of a 5150 and hospitalization, along with helping the family access ongoing treatment supports if needed. Family Partners will be able to offer emotional support the parents/caregivers, if wanted, during this difficult time.

- i) As part of Youth S.O.S. Team's required services, the family partners will engage in prevention and education activities and Question, Persuade, Refer (QPR) trainings for parents countywide. These may include specialized parent education nights at local community centers, schools/districts, Parent Teacher Association/Organization events. They will also deliver training and educational presentations to schools, youth agencies and community members on how to access Youth S.O.S. Team and QPR trainings.
- (d) *Youth Peer Partner:* The Peer Partners will be young adults (21-28 years old) who have any of the following experiences:
- i) Lived experiences (self or a family member), as a LGBTQ, consumer of behavioral health services and/or foster youth.
- ii) Experience as a peer educator, health educator, advisor, youth leader, student worker or youth commissioner.



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- iii) Interested in pursuing a career in behavioral health, social work, public health or criminal justice.

Youth Peer Partners will be the main team members to provide community education and training. They will offer presentations to classrooms for youth around suicide prevention, facilitating QPR for students, faculty, community members and parents alongside of the Family Partner, Triage Therapist or Supervisor. Youth Peer Partners will attend collaborative meetings to conduct outreach with youth and family/caregivers regarding how to access the Youth S.O.S. Team Services. Youth Peer Partners will be available during call shifts to support youth as needed.

- (e) *Interns:* In order to provide all necessary services, interns may be used to support the behavioral health clinicians. In addition to supporting the Youth S.O.S. Team activities, interns can co-provide clinical services with the clinicians.

- 7. Community Education and Prevention Activities: Youth S.O.S. Team staff will be trained in these evidence-based trainings;
 - (a) Question, Persuade, Refer (QPR);
 - (b) Youth Mental Health First Aid (YMHFA);
 - (c) Applied Suicide Intervention Skills Training (ASIST).

At least two staff will complete the train-the-trainer training for each evidence-based training listed above and work with BHRS crisis coordination staff to provide the trainings to current and future Youth S.O.S. Team staff, schools, providers and communities throughout San Mateo County. The Youth S.O.S. Team staff will also conduct psychoeducational sessions and community awareness and education about mental health and substance use-related crisis, suicide prevention and response services as needed for school/communities impacted by a behavioral health crisis including participation in the San Mateo County Suicide Prevention Committee, which meets monthly and provides oversight and direction to suicide prevention efforts in San Mateo County.

- 8. Staff Training Requirements: The contracting agency will develop an onboarding and ongoing training plan provided by trainers with experience on the topic. Youth and caregivers should be incorporated into trainings, when appropriate, and consulted in the development of the training. The training plan should include the crisis care continuum of care, trauma-informed supports, mentoring support, individual supervision, group team meetings, and hands-on



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learning/role-playing opportunities. Additionally, agencies will support peer staff in pursuing credentialing as Certified Peer Specialists, which will be available and provided by BHRS.

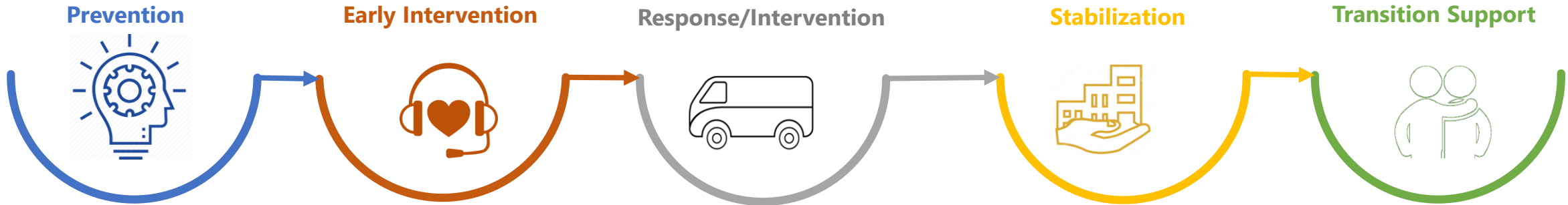
Per statute, FURS response must consist of individuals with specialized training in trauma of children or youth and the foster care system on the mobile response and stabilization team.

Staff must complete twenty (20) hours of training per calendar year. Other training topics can include, but are not limited to, the following:

- (a) HIPPA
- (b) Cultural Humility and Sexual Orientation and Gender Identity reporting
- (c) LGBTQ culturally affirming care
- (d) Suicide Prevention (Mental Health First Aid, QPR, ASIST)
- (e) Wellness and Recovery Action Plan (WRAP)
- (f) Peer support
- (g) NAMI family to family
- (h) Harm Reduction
- (i) Motivational Interviewing

9. Tracking, reporting and evaluation: The contracting agency will support the following activities:
- (a) Document all services provided to clients, consultations, trainings and presentations and submit to BHRS monthly.
 - (b) Collect youth referral outcomes and demographics.
 - (c) Enter data into an online survey portal, which will be provided by BHRS. The data collected will be analyzed by a BHRS independent contractor as part to inform responsive support services.
 - (d) Monthly implementation meetings with BHRS and HSA.
 - (e) Update presentations, as requested, to keep stakeholders informed (i.e. at the Mental Health and Substance Abuse Commission, the MHSA Steering Committee, the San Mateo Board of Supervisors, etc.)
 - (f) Support facilitation of any evaluation activities as determined by BHRS for example, focus groups and/or key interviews to assess the impact of the mobile crisis response services.
 - (g) Submit a year-end report by the fifteenth (15th) of August each fiscal year.

San Mateo County Youth Mental Health Crisis Continuum of Care



Evidence-based trainings (ASIST, MHFA, QPR, WRAP)
Target: General Public, Schools, and Provider Workforce

Education and awareness (Suicide is Preventable, Know the Signs)
Target: General Public, Schools and Provider Workforce

Crisis Intervention Training (CIT) for law enforcement to safely and effectively address persons with mental illnesses
Target: Law Enforcement

StarVista Crisis Hotline, Chat, Texting and
Target: General Public

StarVista Youth Intervention Team provide crisis intervention support to schools
Target: Schools

San Mateo County Office of Education School Suicide Prevention Protocol to support low-medium risk youth in crisis
Target: Schools

Psychiatric Emergency Services (PES) at SMMC and Mills-Peninsula
Target: General Public

**New Youth S.O.S Team* - team of clinician and family partner to prioritize foster youth, high need schools and after hours.
Target: Youth 0-21

SMART - trained paramedic provide assessment, management, transport to PES and referrals
Target: General Public; dispatched via a 9-1-1 call only

BHRS Youth Case Management Team (YCMT) and Youth to Adult Transition Program provides follow-up case management, skills building and linkages to treatment.
Target: MediCal youth

Edgewood 24/7 Crisis Support for Full Service Partnership clients
Target: SED Youth

PERT – team of mental health clinician and Sheriff’s detective
Target: Unincorporated region and primarily adults, some TAY

from less to more intensive supports

** New Crisis Stabilization Unit* - under 24-hour observation and stabilization to be embedded in SMMC PES; prevent hospitalization and residential care
Target: MediCal youth

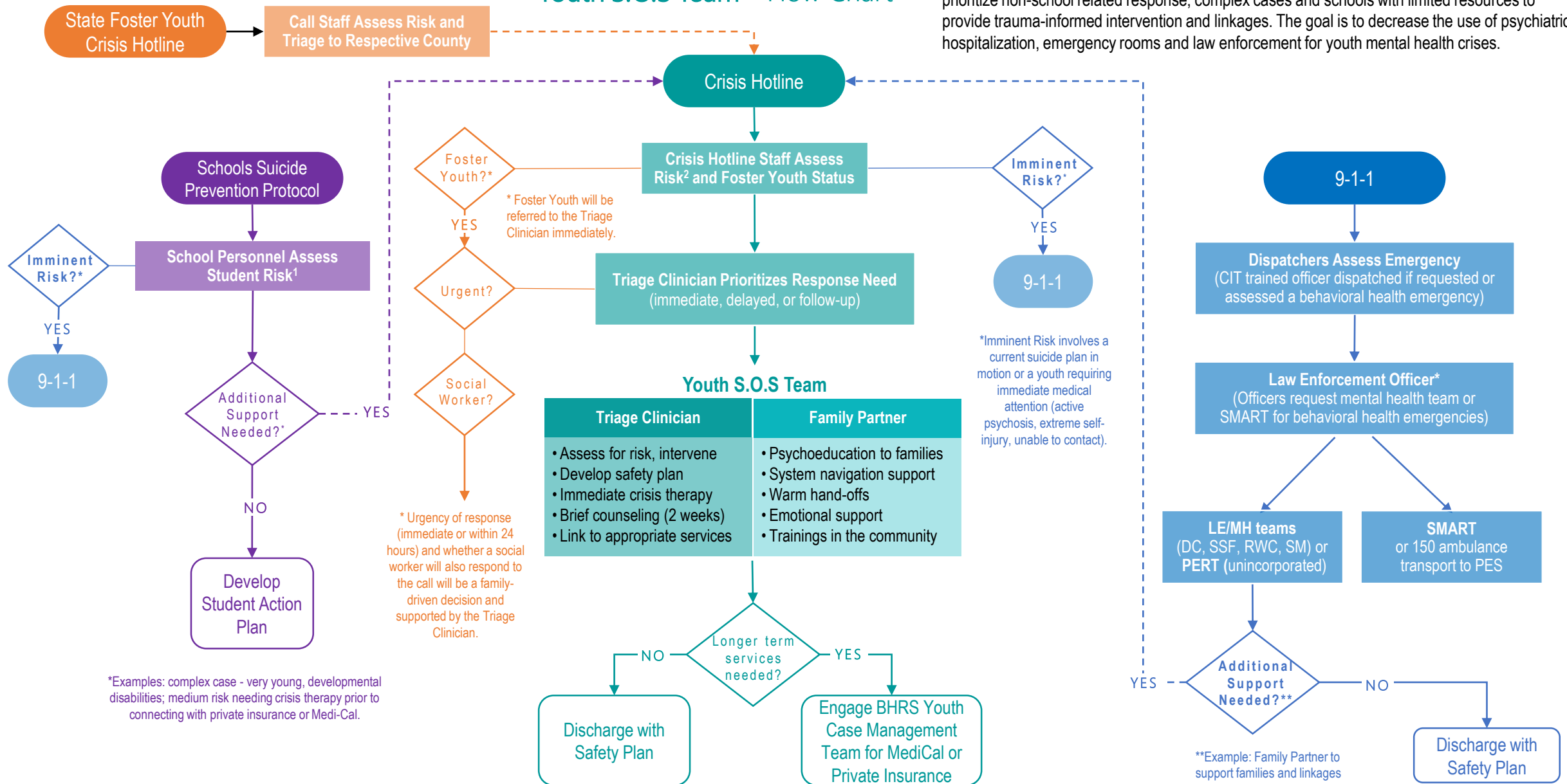
Short Term Residential Therapeutic Program - Canyon Oaks Youth Center (COYC) supports 24-hour intensive care and treatment
Target: MediCal youth

BHRS Youth Case Management Team (YCMT) and Youth to Adult Transition Program provides follow-up case management, skills building and linkages to treatment.
Target: MediCal youth

**New Youth S.O.S Team* family partner will support linkages and warm hand-off and youth peer support services.
Target: Youth 0-21

Youth S.O.S Team – Flow Chart

The Youth S.O.S Team will respond to youth ages 0-21 experiencing a mental health crisis and prioritize non-school related response, complex cases and schools with limited resources to provide trauma-informed intervention and linkages. The goal is to decrease the use of psychiatric hospitalization, emergency rooms and law enforcement for youth mental health crises.



1. School personnel are trained to assess low, moderate, high risk and take appropriate actions as per the San Mateo County Office of Education Schools Suicide Prevention Protocol 2019-2020.
 2. Crisis hotline staff and volunteers use the iCarol tool to assess risk levels.

APPENDIX 6. MHSA FUNDING SUMMARY

**FY 2021/22 Mental Health Services Act Annual Update
Funding Summary**

County: San Mateo

Date: 6/2/21

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2021/22 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	11,384,724	1,080,000	1,522,663	500,000	1,873,004	0
2. Estimated New FY 2021/22 Funding	35,221,952	8,805,488	2,317,234	0	0	0
3. Transfer in FY 2021/22 ^{a/}	0	0	0	969,000	1,311,000	6,972,193
4. Access Local Prudent Reserve in FY 2021/22	0	0	0	0	0	0
5. Estimated Available Funding for FY 2021/22	46,606,676	9,885,488	3,839,897	1,469,000	3,184,004	0
B. Estimated FY 2021/22 MHSA Expenditures	40,406,179	8,743,866	2,386,160	1,264,000	2,011,000	0
G. Estimated FY 2021/22 Unspent Fund Balance	6,200,497	1,141,622	1,453,737	205,000	1,173,004	0

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2021	600,000
2. Contributions to the Local Prudent Reserve in FY 2021/22	6,972,193
3. Distributions from the Local Prudent Reserve in FY 2021/22	0
4. Estimated Local Prudent Reserve Balance on June 30, 2022	7,572,193

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

**FY 2021-22 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding**

County: San Mateo

Date: 6/2/21

	Fiscal Year 2021-22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children and Youth	4,557,164	3,979,164	578,000	0	0	0
2. Transition Age Youth	3,466,017	3,041,017	425,000	0	0	0
3. Adults and Older Adults	5,677,409	4,980,409	697,000	0	0	0
4. Housing Initiative	5,192,045	5,192,045		0	0	0
5. Housing Initiative (One-Time Spend Plan)	100,000	100,000	0	0	0	0
6. FSP/BHRS Clinic Restructure (One-Time Spend Plan)	1,500,000	1,500,000	0	0	0	0
7. Recovery Oriented, Co-Occurring Capacity (One-Time Spend Plan)	430,000	430,000	0	0	0	0
	-		0	0	0	0
	-		0	0	0	0
	-		0	0	0	0
Non-FSP Programs			0	0	0	0
1. Older Adult System of Care	1,403,575	1,186,356	217,219	0	0	0
2. Criminal Justice Integration	902,394	804,895	97,499	0	0	0
3. Co-Occurring Services	1,110,911	993,260	117,651	0	0	0
4. Other System Development	4,278,504	3,450,825	827,679	0	0	0
5. Peer and Family Supports	2,516,589	2,110,397	406,192	0	0	0
6. Primary Care Integration	267,594	267,594		0	0	0
7. Infrastructure Strategies	1,042,791	1,042,791		0	0	0
8. Outreach and Engagement	3,836,121	3,836,121		0	0	0
9. Supported Employment (One-Time Spend Plan)	400,000	400,000		0	0	0
10. COVID-19 Client Supports (One-Time Spend Plan)	548,915	548,915				
11. DoH Supportive Housing Units (One-Time Spend Plan)	5,000,000	5,000,000				
12. Mental Health Surge Needs (One-Time Spend Plan)	425,000	425,000				
	0					
	0					
	0			0	0	0
CSS Administration	942,051	942,051	0	0	0	0
CSS Planning	0	0	0	0	0	0
CSS Evaluation	70,300	70,300	0	0	0	0
CSS MHSA Housing Program Assigned Funds	105,039	105,039	0	0	0	0
Total CSS Program Estimated Expenditures	43,597,080	40,406,179	3,366,240	0	0	0
FSP Programs as Percent of Total	51.8%					

**FY 2021/22 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding**

County: San Mateo

Date: 6/2/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Early Childhood Community Team	442,468	442,468	0	0	0	0
2. Community Interventions for School Age and TAY	685,771	685,771	0	0	0	0
3. Community Outreach, Engagement and Capacity Building	964,628	964,628	0	0	0	0
4. Trauma-Informed Systems	150,000	150,000	0	0	0	0
5. Trauma-Informed Systems (One-Time)	100,000	100,000	0	0	0	0
6. Community MH 101 Education (One-Time)	180,000	180,000	0	0	0	0
7. Post-Covid Supports (One-Time)	451,000	451,000	0	0	0	0
8. Help@Hand Sustainability (One-Time)	300,000	300,000	0	0	0	0
	-		0	0	0	0
PEI Programs - Early Intervention						
1. Early Onset of Psychotic Disorders	879,127	879,127	0	0	0	0
2. Early Crisis Interventions	962,039	962,039	0	0	0	0
3. Primary Care/Behavioral Health Integration	1,070,378	1,070,378	0	0	0	0
4. Crisis Coordination (One-Time)	50,000	50,000	0	0	0	0
	0		0	0	0	0
PEI Programs - Outreach for Increasing Recognition of Early Signs of MI						
1. Mental Health First Aid	71,869	71,869				
2.	0					
PEI Programs - Access and Linkage to Treatment						
1. Outreach Collaboratives	430,818	430,818				
2. Cultural Centers	544,954	544,954				
3. Older Adult Outreach	171,696	171,696				
4. Primary Care-Based Efforts	25,440	25,440				
	0					
PEI Programs - Stigma and Discrimination Reduction	0					
1. Digital Storytelling & Photovoice	125,896	125,896				
2. Mental Health Awareness	76,698	76,698				
PEI Programs - Suicide Prevention	0					
1. Suicide Prevention Initiative	126,698	126,698				
PEI Evaluation - One-Time						
1. School data coordination (one-time)	170,000	170,000				
	0		0	0	0	0
PEI Administration	589,586	589,586	0	0	0	0
PEI Assigned Funds - CalMHSA	174,800	174,800				
Total PEI Program Estimated Expenditures	8,743,866	8,743,866	0	0	0	0

**FY 2021/22 Mental Health Services Act Annual Update
Innovations (INN) Funding**

County: San Mateo

Date: 6/2/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Social Enterprise	767,000	767,000				
2. PIONEERS	330,000	330,000				
3. PEI in Low-Income Housing	330,000	330,000				
4. AB114 - Help@Hand (Tech Suite)	842,305	842,305				
5. Evaluation	116,855	116,855				
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	0					
Total INN Program Estimated Expenditures	2,386,160	2,386,160	0	0	0	0

**FY 2021/22 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding**

County: San Mateo

Date: 6/2/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	100,000	100,000				
2. Training for/by Consumers	60,000	60,000				
3. Behavioral Health Career Pathways	80,000	80,000				
4.	-					
WET (One-Time Spend Plan)	-					
1. Online Training Capacity	60,000	60,000				
2. Workforce Capacity (EMDR, DBT, Self Care)	280,000	280,000				
3. Peer Certification and Training	50,000	50,000				
4. Loan Repayment Match (One-Time)	250,000	250,000				
5. CSIP Stipend Increase (One-Time)	24,000	24,000				
6. Workforce Wellness (One-Time)	100,000	100,000				
	-					
	-					
	-					
	-					
	-					
	-					
	-					
	-					
WET Administration	260,000	260,000				
Total WET Program Estimated Expenditures	1,264,000	1,264,000	0	0	0	0

**FY 2021/22 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding**

County: San Mateo

Date: 6/2/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects (One-Time)						
1. EPA Clinic	700,000	700,000				
2. Cordilleras	500,000	500,000				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
1. Client Devices	330,000	330,000				
2.	0					
CFTN Programs - Technological Needs Projects (One-Time)						
1. Network Adequacy Compliance	100,000	100,000				
2. IT Infrastructure	301,000	301,000				
3. Telepsychitry/health	80,000	80,000				
	0					
	0					
	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	2,011,000	2,011,000	0	0	0	0

APPENDIX 7. ONE-TIME SPEND PLANS

Updated Plan to Spend One-time Funds (with descriptions)

Priority	Item	FY 21/22	FY 22/23	Grand Total	Item Description
System Improvements	Clinic/FSP productivity stop-gap	\$1,500,000	\$0		Temporary “stop gap” to support BHRS revenue reductions... BHRS worked on improved integration of FSP/clinical services and billable services to increase other state/federal revenues for long-term sustainability
	MHSA PEI data-informed improvements	\$80,000	\$0		To support a database development for the San Mateo County Office of Education, Mental Health Student Services Act project, which is currently funded by State MHSA monies. The database will support data-informed decision making for school PEI services.
	Trauma-informed systems (BHRS, HSA, CJ, etc)	\$100,000	\$100,000		To fund trauma-informed system development consultants across county departments that interact with BHRS clients including Human Services Agency, Criminal Justice and others.
	System Improvement Total	\$1,680,000	\$100,000	\$1,780,000	
Technology Supports	Network Adequacy Compliance	\$100,000	\$0		Certification tool and consultant fees to support State requirements for implementation of Medicaid managed care adequacy standards addressing many key service areas including beneficiary rights and protections, quality, care coordination, timely access, among others.
	IT Infrastructure	\$301,000	\$0		Hardware and professional services including, dictation software, automated appointment reminders, treatment submission via Avatar, direct messaging via Avatar, patient portal to help capture e-signatures, licenses, interoperability and upgrades to allow for better user interface with tablets and MacBooks.
	Telepsychiatry/health	\$80,000	\$0		Telepsychiatry equipment and fees to support technology needs across BHRS services.
	Help@Hand (Tech Suite)	\$300,000	\$300,000		Help@Hand is an Innovation funded project. This funding is for sustainability. The Help@Hand advisory committee will focus on sustainability planning during FY 21/22.
	Technology Total	\$781,000	\$300,000	\$1,081,000	
Workforce Training and Community Education	Workforce Capacity Development	\$295,000	\$85,000		Relias online learning system, Psychodiagnostic Assessment, EMDR Implementation, Peer trainings (certification, advocacy and documentation), DBT, eating disorders, self-care/resilience
	Workforce pipeline and retention	\$274,000	\$24,000		Increased rate for cultural competence interns and State OSHPD match for student loan repayment program.
	Crisis Coordination	\$50,000	\$50,000		Regional collaboration and training, crisis resources and materials for community education.
	Supported Employment	\$400,000	\$300,000		Develop the infrastructure needed to leverage Dept of Rehabilitation funding for ongoing supported employment (services to assist clients with obtaining and maintaining employment.

Updated Plan to Spend One-time Funds (with descriptions)

Priority	Item	FY 21/22	FY 22/23	Grand Total	Item Description
Workforce Training and Community Education (continued)	Community Education	\$180,000	\$180,000		MH101, navigating housing/resources, hoarding Board and Care providers (MH 101, Recovery 101, WRAP, co-occurring, etc.)
	Education and Training Total	\$1,199,000	\$639,000	\$1,838,000	
COVID Client Supports	Client activities/needs	\$50,000			For residential sites; card games, apps, food, supports
	Alternative Care Sites	\$83,500			For residential clients that are COVID-19 positive and need to be quarantined
	Hotels for homeless	\$165,415			To address mass jail releases and reduction of shelter beds due to COVID
	Co-occurring detox facility	\$200,000			To address reduced beds due to physical distancing requirements
	COVID Testing/Vaccines for high risk	\$50,000			Regular 2x/week testing at Palm Ave Detox (25 tests/wk) and CYOC as needed; will allow for MediCal billing. Expanded to include vaccination supports.
	COVID Client Supports Total	\$548,915		\$548,915	
Capital Facilities (must be County-owned)	EPA Clinic Renovations	\$700,000			County-owned buildings qualify for MHS Capital Facilities for renovations
	Cordilleras Renovations	\$500,000			
	SSF Clinic Renovations		\$500,000		
	Capital Facility Improvements Total	\$1,200,000	\$500,000	\$1,700,000	
TOTALS		\$5,408,915	\$1,539,000	\$6,947,915	

NEW \$12M* One-Time Plan
For Housing Initiative + Post-COVID Supports and MH Surge
*\$1,080,000 must be spent in prevention and early intervention efforts

Priority	Item	FY 21/22	FY 22/23	Total	Item Description
Housing Initiative Taskforce	BHRS Housing Webpage	\$100,000	\$0		Development of an online BHRS Housing webpage with comprehensive one-stop housing information (including data dashboard for unmet need) for clients and staff use. Will be supported w/ongoing management, housing locator services and peer supports contract.
	Development of Supportive Housing Units	\$5,000,000	\$5,000,000		Establishment of an ongoing Housing Fund with Department of Housing (DoH) for the development of supportive housing units for BHRS clients. Transfer of funds to DoH to include in their application process for affordable housing developers.
	Total Housing	\$5,100,000	\$5,000,000	\$10,100,000	
Post-COVID Supports (Prevention and Early Intervention)	Community mental health and substance use education	\$50,000	\$50,000		Behavioral health 101 campaign for communities who are in need of linkages to behavioral health services - in threshold languages and focused on special populations (i.e. TAY, cultural groups, essential workers). For substance use - a focus on opioid overdose prevention strategies.
	Community wellness and recovery supports	\$50,000	\$50,000		Partner with libraries and other community spaces to provide PTSD training, WRAP, healthy eating, self-care and other wellness topics with linkages to behavioral health services.
	Field and group supports	\$100,000	\$100,000		Increase field and group supports for grief and hoarding (eviction prevention), eating disorders, cultural/spiritual coaching.
	Older adult supports	\$50,000	\$50,000		Partner with Aging & Adult Services and other Older Adult service providers in the community to support older adult identified COVID-related needs (awareness campaign, support groups, peer lead support, resource sharing, digital literacy support, etc.)
	Health Equity Initiative capacity development	\$30,000	\$30,000		Strategic planning facilitation/consultation focused on post-COVID response, strengthening collaboration and improving HEI outcome reporting.
	School mental health supports	\$46,000	\$46,000		Suicide Prevention (Kognito) training for school districts not covered by a Healthcare District and Early Alert text-based system that parents and school staff can access and be connected to resources as needed.
	Racial Equity and Multicultural Organizational Development	\$125,000	\$125,000		Training and consultant to support advancement of racial equity work including implicit bias training, developing culture of trust, inclusive communication and CBO technical assistance. (\$30K for consultant + \$25K for translations + \$20-30K trainer fees)
	Total Prevention	\$451,000	\$451,000	\$902,000	Total Available for Prevention Efforts: \$1,080,000
Mental Health Surge Needs	Workforce Development	\$200,000	\$200,000		Workforce training for BHRS and contractors in eating disorders and other treatments (PTSD, EMDR, trauma-focused CBT, MBSAT/Seeking Safety to support co-occurring SMI/SUD, 3P and other EBPs for justice involved) that are expected to surge as we transition out of shelter-in-place.
	Workforce Wellness	\$100,000	\$100,000		Workforce post-COVID infrastructure consultation and re-entry supports; self-care, provider wellness month continuation, work-life integration, emotional wellness.
	SMI Private Provider Network (SSPN) incentives	\$125,000			The SSPN provides therapy to clients at regional clinics. Incentives can engage providers to SSPN quickly (current waitlist of 38 clients is projected to increase to ~80 clients). This would provide \$5,000 sign-on incentive for a one year contract for 10 slots, for 25 providers.
	Total MH Surge	\$425,000	\$300,000	\$725,000	Total Available for MH Surge Needs: \$820,000
			Grand Total	\$11,727,000	

APPENDIX 8. ONGOING BUDGET INCREASES

Proposed MHSA Ongoing Budget Increases (with descriptions)

\$13.1M increase over two fiscal years

Green = new allocations

Black = BHRS systemic needs

Red = BHRS systemic needs; new MHSA priorities

Purple = one-time programs to ongoing

Item	FY 2021-22 Amount	Item Description
NEW (Housing Initiative Taskforce)	\$2,200,000	FSP increases in both Youth and Adult System of Care. Increasing slots for clients + housing supports
NEW Infrastructure Supports	\$462,500	BHRS administration, contracting, fiscal, planning, evaluation, and implementation to support the State and local requirements associated with MHSA.
FSP Match	\$1,700,000	FSP-related Federal Financial Participation (FFP) match to allow for draw down of Federal Government's share under the Medicaid program.
Housing Supportive Services	\$290,283	Adult /Older Adult Supportive Housing Services for clients in MHSA funded units. Supportive services include comprehensive case management on-site and recovery based education and activities.
Client Flex Funds and Stipends	\$51,000	Flexible Funds for Pathways Court Mental Health clients to fund short-term non-clinical services (i.e. transportation, moving costs, clothes, grooming, food, storage, etc.). Stakeholder stipends support participation of individuals with lived experience in key BHRS activities.
Communication Support	\$75,000	BHRS Communication supports including graphic design, digital communication, web-based and social media, brochure, flyer development, and reports.
OASIS, Criminal Justice and Pre to 3 Position	\$750,000	Child Welfare and Pre-to-Three positions in the BHRS Youth System to support services for high risk children/youth referred through child welfare. Criminal Justice Restoration position to support forensic mental health and jail diversion.
AOD - Youth Residential	\$85,790	Dedicated residential SUD treatment bed with at Advent in a co-occurring STRTP licensed facility which also provide fully co-occurring services.
Adult Resource Management	\$1,037,593	ARM Mental Health Counselor positions that support individuals with SMI or co-occurring disorders in shelters, sobering centers, social detox who are eligible but not connected to ongoing services.
School Based MH Clinicians	\$500,000	School-based programs provide integrated mental health and special education services for adolescents who are at risk of psychiatric hospitalization, more restrictive school placement, residential placement or school failure.
Adult Neurosequential Model of Therapeutics (NMT) Interventions	\$200,000	Application of the BHRS Youth System NMT to the Adult System for assessing trauma so that alternative interventions (educational, enrichment and therapeutic) can be provided in a way that will help best meet the needs of adult clients.
Tech Supports	\$330,000	Tech Supports to provide technology supports (devices and data plans) and digital mental health literacy for peers, clients and family members of clients that would benefit from telehealth and/or other behavioral health services, but do not have the resources.
Pride Center	\$700,000	The San Mateo County Pride Center, a behavioral health coordinated services center, addresses the need for culturally specific programs and mental health services for the LGBTQ+ community.
Health Ambassador Program- Youth	\$250,000	HAP-Y serves as a youth-led initiative where young adults act as mental health ambassadors to promote awareness of mental health, reduce mental health stigma, and increase service access for young people and their communities.
Primary Care Interface	\$1,337,972	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.
TOTAL	\$9,970,138	

Program	FY 2022-23 Amount	Item Description
Whole Person Care (HOPE Program)	\$1,444,188	The five-year Whole Person Care (WPC) initiative is entering its final year of grant funding. The pilot is aimed at improving the access, quality of care and efficiency of services delivered to those individuals with the most complex and often co-occurring conditions. Helping Our Peers Emerge (HOPE) Program assists BHRS adult clients transition from local psychiatric facilities into the community via trained Peer Mentors and Family Partners who provide emotional support, educational services and community resources.
Youth Neurosequential Model of Therapeutics (NMT) Interventions	\$628,318	BHRS Youth System practitioners are trained in the NMT for assessing children for trauma and other history and neural functioning so that interventions (educational, enrichment and therapeutic) can be provided in a way that will best meet the needs of the child.
Youth Mental Health First Aid	\$189,313	Youth Mental Health First Aid is an 8-hour public education training course provided to adults that focuses on how to identify a youth who is struggling with a mental health issue and how to connect that youth with services.
Parent Project	\$160,896	The Parent Project is a free, 12-week course that is offered in English and Spanish to anyone who cares for a child or adolescent. The classes meet for three hours each week. Parents learn parenting skills and get information about resources and other support available in their communities.
Total Wellness	\$750,000	Total Wellness is peer-driven coordinated care to holistically address behavioral health and physical health needs of clients.
TOTAL	\$3,172,715	

APPENDIX 9. FULL SERVICE PARTNERSHIP EVALUATION REPORT



Full Service Partnership (FSP) Outcomes

Findings from 2019-2020 Fiscal Year

Manxi Yang, MPP

Dierdre Gilmore, MA

JUNE 2021

Full Service Partnership (FSP) Outcomes

Findings from 2019-2020 Fiscal Year

June 2021

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Executive Summary

Full Service Partnerships (FSPs) are a set of enhanced, integrated services administered through San Mateo County contracted providers to assist individuals with mental and behavioral health challenges. The American Institutes for Research (AIR) is working with San Mateo County (“the County”) to understand how enrollment in an FSP promotes resilience and improves health outcomes of individuals served.

This report presents outcomes for child, transitional age youth (TAY), adult, and older adult clients (hereafter referred to as “partners”) of the Full Service Partnership (FSP) program in the County using FSP program survey data and Avatar data, the County’s electronic health records (EHR) system. In some cases, the EHR data will have a larger sample size than the survey data, as partners did not always complete the survey tools.

The findings from self-reported outcomes (survey data) suggest that the majority of outcomes improved (27 of 32 outcomes) for all reported age groups. Exhibit 1, below, presents the percent change between the year just prior to enrollment in an FSP and the first year enrolled in an FSP, by age group. Red (and bold) font in the Exhibit indicates percent change that was not favorable (e.g., greater number of detention or incarceration or worse grades for TAY partners; 5 out of 32 outcomes). Percent improvement is the percent change in the percent of partners with any outcomes of interest (e.g., homelessness, incarceration, employment). For example, the number of adult partners experiencing homelessness changed from 45 before FSP enrollment to 34 in the first year following FSP enrollment, a 24% improvement.

Exhibit 1 shows improvements for all age groups for the following self-reported outcomes: homelessness, arrests, mental health emergencies, and physical health emergencies. For children and TAY partners, school suspensions decreased, and the percent of TAY and adult partners with an episode of detention or incarceration decreased as well. Fewer adult and older adult partners reported an active substance use disorder in the year following FSP enrollment. Employment and substance use disorder treatment outcomes also increased for adult partners. Adult partners more frequently reported receiving substance use disorder treatment in the year following their FSP enrollment, which may indicate that the integrated care and case management services offered through FSP connected adult partners with needed care.

Five outcomes showed no improvement for specific age groups. Fewer older adult partners reported substance use disorder treatment in the year following FSP enrollment compared to the year before enrollment. TAY partners reported decreased grade ratings. Child partners reported decreased grade ratings and attendance, and increased detention or incarceration. However, the increase in incarceration is relatively small (28 in the first year with FSP compared to 26 in the year just prior) when compared to the decrease in arrests (56 in the first year with FSP compared to 10 in the year just prior) among child partners.

Moreover, the main finding from the hospitalization outcomes (EHR data) is that, compared to the year before joining an FSP, there are reductions in the percent of partners with any hospitalization, mean hospital days per partner, percent of partners using any psychiatric emergency services (PES), and mean PES event per partner. The only exception is that the mean hospital days for older adults increase by about one day which is likely be attributed to other

medical conditions as both the hospitalization and PES incidence decrease significantly. Also, for all cohorts, the reductions are consistently observed over the years since the inception of the FSP program.

Exhibit 1: Percent Change in Outcomes by Age Group, Year before FSP Compared with First Year with FSP

FSP Outcomes <i>Self-reported Outcomes</i>	Adult (25 to 59 years) N = 111			Older adult (60 years & older) N = 17		
	<i>Yr before</i>	<i>Yr after</i>	<i>change</i>	<i>Yr before</i>	<i>Yr after</i>	<i>change</i>
Homelessness	45	34	-24%	3	1	N/A
Detention or Incarceration	34	21	-38%	3	2	N/A
Employment	0	3	N/A	1	1	N/A
Arrests	22	4	-82%	13	0	-100%
Mental Health Emerg.	83	24	-71%	9	1	N/A
Physical Health Emerg.	48	17	-65%	6	2	N/A
Active S.U. Disorder	58	52	-10%	4	3	N/A
S.U. Treatment	26	32	23%	4	2	N/A
<i>Healthcare Utilization (EHR data)</i>	Adult (25 to 59 years) N = 329			Older adult (60 years & older) N = 53		
	<i>Yr before</i>	<i>Yr after</i>	<i>change</i>	<i>Yr before</i>	<i>Yr after</i>	<i>change</i>
Hospitalization	120	54	-55%	12	9	-25%
Hospital Days per partner	11.9	3.8	-68%	3.6	5.2	45%
PES	178	125	-30%	17	11	-35%
PES Event per partner	1.8	1.0	-42%	1.0	0.5	-49%

FSP Outcomes <i>Self-reported Outcomes</i>	Child (16 years and younger) N = 185			TAY (17 to 25 years) N = 230		
	<i>Yr before</i>	<i>Yr after</i>	<i>change</i>	<i>Yr before</i>	<i>Yr after</i>	<i>change</i>
Homelessness	9	6	-33%	32	29	-9%
Detention or Incarceration	26	28	8%	36	31	-14%
Arrests	56	10	-82%	113	20	-82%
Mental Health Emerg.	72	8	-89%	103	24	-77%
Physical Health Emerg.	15	1	-93%	55	5	-91%
Suspension	42	20	-52%	22	5	-77%
Grade	3.36	3.02	-10%	3.23	3.14	-3%
Attendance	2.20	1.89	-14%	2.36	2.44	3%
<i>Healthcare Utilization (EHR data)</i>	Child (16 years and younger) N = 213			TAY (17 to 25 years) N = 185		
	<i>Yr before</i>	<i>Yr after</i>	<i>change</i>	<i>Yr before</i>	<i>Yr after</i>	<i>change</i>
Hospitalization (N)	10	3	-70%	27	18	-33%
Hospital Days per partner	1.2	0.1	-91%	5.6	2.5	-55%
PES (N)	53	23	-57%	83	53	-36%
PES Event per partner	0.5	0.2	-55%	1.1	0.8	-30%

Hospitalization Outcomes**	Overall Improvement	Range (Partnerships Beginning 2006 – 2018)
<i>Healthcare Use (EHR data, N= 780)</i>		
Partners with Hospitalizations	50%	26% – 77%
Mean Hospital Days	63%	(7%) – 87%
Partners with PES	36%	12% – 56%
Mean PES Events	41%	12% – 69%

Note. The table above indicates the percent change in the percent of partners with any events, comparing the year just prior to FSP with the first year on FSP. Percent change in ratings indicates the change in the average rating for the first year on the program as compared to the year just prior to FSP. Value of N/A means a change is not reported due to insufficient sample size (fewer than 10 observations). Red (and bold) font indicates outcomes that worsened, such as lower school attendance for TAY partners or more days spent in the hospital for older adult partners.

** These outcomes are presented overall for all clients as well as by year of partnership; the range presented is from the lowest to highest percent changes among the calendar years.

This report also includes a separate analysis of the self-reported outcomes for Telecare partners. Telecare changed its electronic healthcare record (EHR) system on December 1, 2018 and was only able to provide the data after the conversion date due to data reliability issues. There are 20 partners in the Telecare survey data who have completed at least a year of the FSP as of June 30, 2020. Due to the small sample size, our analysis combined all age groups for this separate analysis. Exhibit 2 shows improvements for Telecare partners on homelessness, arrests, mental and physical health emergencies, and active substance use disorder. The Telecare partners did not have improvements on incarceration and employment, and less frequently reported substance use disorder treatments.

Exhibit 2: Percent Change in Outcomes among Telecare partners, Year before FSP Compared with First Year with FSP

FSP Outcomes <i>Self-reported Outcomes</i>	Everyone N = 20		
	<i>Yr before</i>	<i>Yr after</i>	<i>change</i>
Homelessness	5	2	-60%
Detention or Incarceration	0	0	N/A
Employment	0	0	N/A
Arrests	5	0	-100%
Mental Health Emerg.	7	2	-71%
Physical Health Emerg.	4	0	-100%
Active S.U. Disorder	13	4	-69%
S.U. Treatment	4	0	-100%

Note. The table above indicates the percent change in the percent of partners with any events, comparing the year just prior to FSP with the first year on FSP. Red (and bold) font indicates outcomes that worsened, i.e. less frequently reported substance use disorder treatment.

Background and Introduction

The Mental Health Services Act (MHSA) was enacted in 2005 and provides a dedicated source of funding to improve the quality of life for individuals living with mental illness. In San Mateo County (the County), a large component of this work is accomplished through Full Service Partnerships (FSP). FSP programs provide individualized integrated services, flexible funding, intensive case management, and 24-hour access to care (“whatever it takes” model) to help support recovery and wellness for persons with serious mental illness (SMI) and their families. In the County there are currently four comprehensive FSP providers: Edgewood Center and Fred Finch Youth Center serving children, youth, and transition age youth; and Caminar and Telecare serving adults and older adults.

The County has partnered with the American Institutes for Research (AIR) to understand how enrollment in the FSP is promoting resiliency and improving health outcomes of the County’s clients living with mental illness. The data used for this report are collected by providers from clients’ (hereafter, “partners”) self-reports (i.e., survey data), and electronic health records obtained through the County’s Avatar system (i.e., EHR data).

This year’s report includes data from all FSP providers but only included Telecare data from December 2018 to June 2020. Telecare changed its electronic healthcare record (EHR) system and is having technical difficulties providing the data prior to the change of the EHR system.

Initial survey data are collected via an intake assessment, called the Partnership Assessment Form (PAF), which includes information on well-being across a variety of measures (e.g., residential setting) at the start of FSP and over the twelve month “lookback” window of the year prior to FSP enrollment. While participating in the FSP, survey data on partners is gathered in two ways. Life changing events are tracked by Key Event Tracking (KET) forms, which are triggered by any key event (e.g., a change in residential setting). Partners are also assessed regularly with Three Month (3M) forms. Changes in partner outcomes are gathered by comparing data on PAF forms to data compiled from KET and 3M forms.

EHR data collected through the County Avatar system contain longitudinal partner-level information on demographics, FSP program participation, hospital stays, and psychiatric emergency services (PES) utilization before and after the enrollment date within the County health system. The Avatar system is limited to individuals who obtain care in the County health system. Hospitalizations outside of the County, or in private hospitals, are not captured.

This report presents changes in partners’ self-reported and hospitalization outcomes in two consecutive years: (1) the baseline year, i.e., the 12 months prior to enrollment in the FSP program, and (2) the first full 12 months of the partner’s FSP participation. Children (aged 16 and younger), transition aged youth (TAY; aged 17 to 25), adults (aged 25 to 59), and older adults (aged 60 and older) were included in the analysis if they had completed at least one full year with the FSP program by June 2020 (the data acquisition date). Trends in EHR data are subsequently presented as an average across all years of the program as well as annually, by year of FSP program enrollment.

We have included several appendices to clarify the methods used and provide more detailed findings. Appendix A presents the self-reported outcomes from FSP survey by race and ethnicity among Caminar partners. Appendix B presents additional detail on residential outcomes. Outcomes for individual FSP providers can be found in Appendix C. Details on our methodology for both the self-reported outcomes and the EHR-based hospitalization outcomes can be found in Appendix D.

Self-reported outcomes

Overview

The following section presents outcomes for: 185 child (aged 16 and younger) FSP partners; 230 TAY (aged 17 - 25) FSP partners; 111 adult (aged 26-59) FSP partners; and, 17 older adult (aged 60 and older) FSP partners. The results compare the first year enrolled in an FSP with the year just prior to FSP enrollment for partners completing at least one year in an FSP program.

Outcomes Assessed. Several outcomes are broken down by age category, as described below. Note that employment, homelessness, and incarceration outcomes are not presented for adults aged 60 or older, as there are insufficient observations in this age group for meaningful interpretation (i.e., there are less than 5 older adult partners total with any of these events).

1. **Partners with any reported homelessness incident:** measured by residential setting indicating homelessness or emergency shelter (PAF and KET).
2. **Partners with any reported detention or incarceration incident:** measured by residential setting indicating Jail or Prison (PAF and KET).
3. **Partners with any reported employment:** measured by employment in past 12 months and date employment change (PAF and KET).¹
4. **Partners with any reported arrests:** measured by arrests in past 12 months and date arrested (PAF and KET).
5. **Partners with any self-reported mental health emergencies:** measured by emergencies in past 12 months and date of mental health emergency (PAF and KET).
6. **Partners with any self-reported physical health emergencies:** measured by emergencies in past 12 months and date of acute medical emergency (PAF and KET).
7. **Partners with any self-reported active substance use disorder:** measured by self-report in past 12 months and captured again in regular updates (PAF and 3M).
8. **Partners in substance use disorder treatment:** measured by self-report in past 12 months and captured again in regular updates (PAF and 3M).²

In addition, we also examine three outcomes specific to child and TAY partners:

1. **Partners with any reported suspensions:** measured by suspensions in past 12 months (PAF) and date suspended (KET).

¹ Employment outcome is not applicable to child and TAY partners.

² If more partners reported receiving substance use disorder treatment in the year following their FSP enrollment, it may indicate that the integrated care and case management services offered through FSP connected partners with needed care.

2. **Average school attendance ranking:** an ordinal ranking (1-5) indicating overall attendance; measured for past 12 months (PAF), at start of FSP (PAF), and over time on FSP (3M).
3. **Average school grade ranking:** an ordinal ranking (1-5) indicating overall grades; measured for past 12 months (PAF), at start of FSP (PAF), and over time on FSP (3M).

Mental and physical health emergencies by living situation. Mental and physical health emergencies are considered in conjunction with residential status for all age groups combined. Specifically, we explore the likelihood of an emergency in relation to whether the partner’s living situation in their first year of FSP participation is “advantageous” (i.e., living with family or foster family, living alone and paying rent, or living in group care or assisted living) or “higher risk” (i.e., homeless, incarcerated, or in a hospitalized setting).

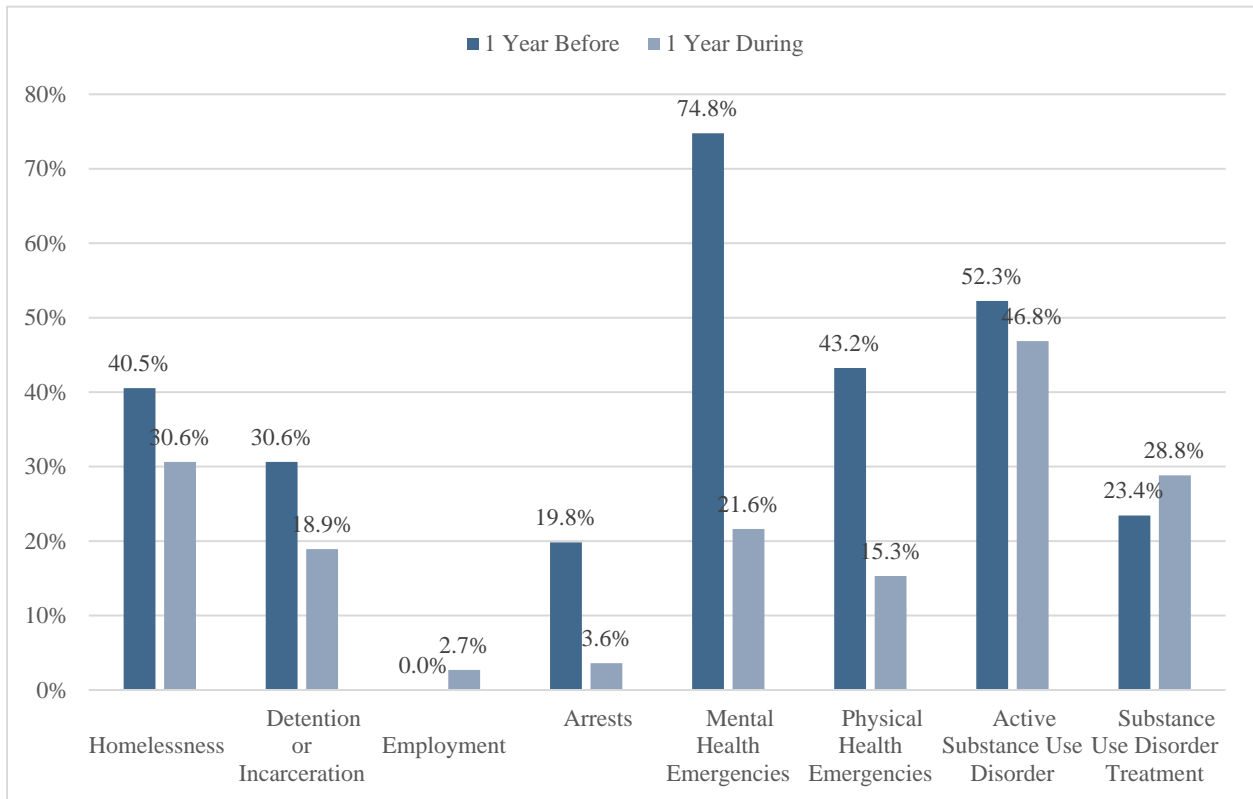
Telecare changed its electronic healthcare record (EHR) system on December 1, 2018 and was only able to provide the data after the conversion date due to data reliability issues. Our previous annual reports include all the partners from Caminar, Edgewood/Fred Finch and Telecare who joined the FSP programs since the program inception. Due to the incompleteness of the Telecare data, we conducted a separate analysis for Telecare. Below we present the findings from the analysis of Caminar and Edgewood/Fred Finch combined data since FSP inception—the main analysis, and the findings from the analysis using Telecare data from December 2018.

Caminar and Edgewood/Fred Finch

Self-Reported Outcomes by Age Group

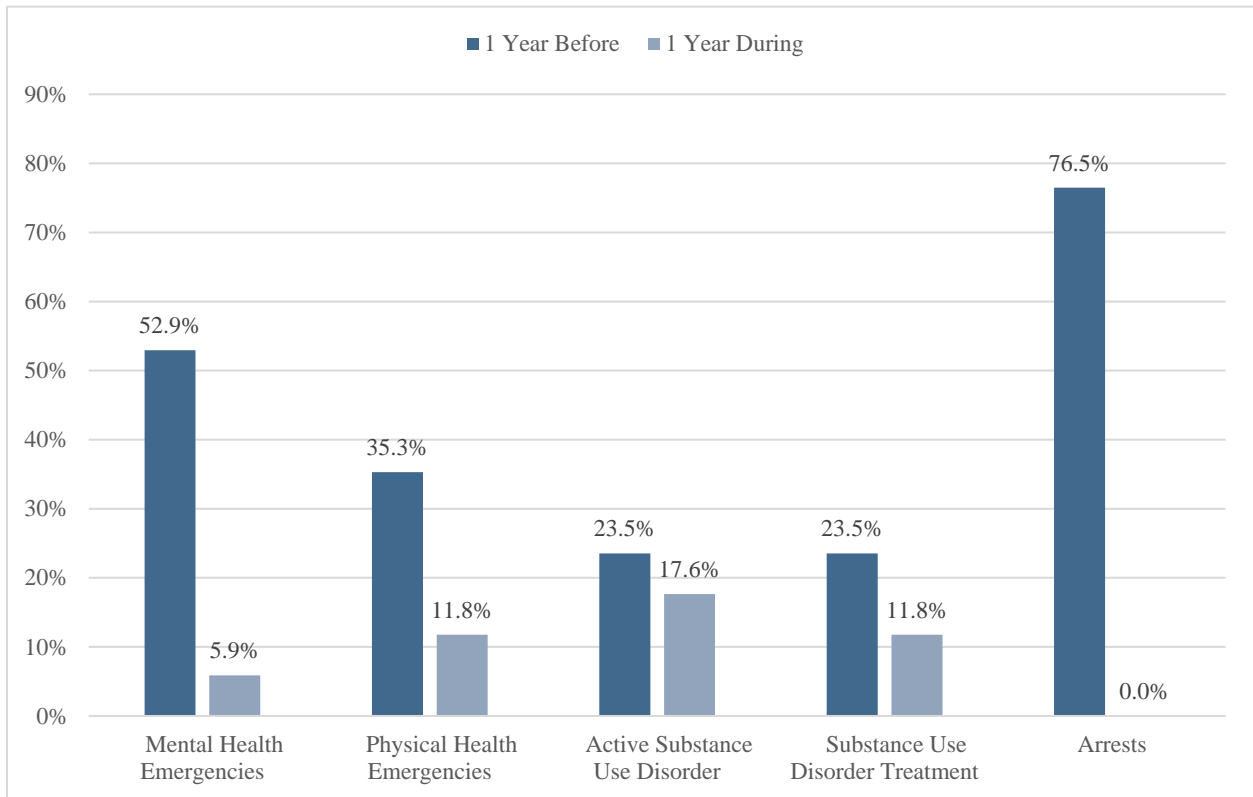
Adults. The comparison of outcomes for adult partners in the year prior to FSP enrollment with the first year in an FSP is shown in Exhibit 3. Homelessness, incarceration, arrests, self-reported mental and physical health emergencies, and substance use problems all decreased. In addition, employment and reported substance use disorder treatment increased. Each of these demonstrates improvements for adult partners in the first year of FSP enrollment.

Exhibit 3: Outcomes for Adult Partners Completing One Year with FSP (n = 111)



Older Adults. Exhibit 4 compares outcomes in the year prior to FSP enrollment with outcomes reported in the first year of FSP enrollment for older adult partners. Similar to adult partners, self-reported mental and physical health emergencies, and substance use disorder, and arrests all decrease. Each of these demonstrates improvement for older adult partners in the first year of FSP enrollment. On the other hand, fewer older adults reported substance use disorder treatment during the first year of FSP enrollment compared to one year before.

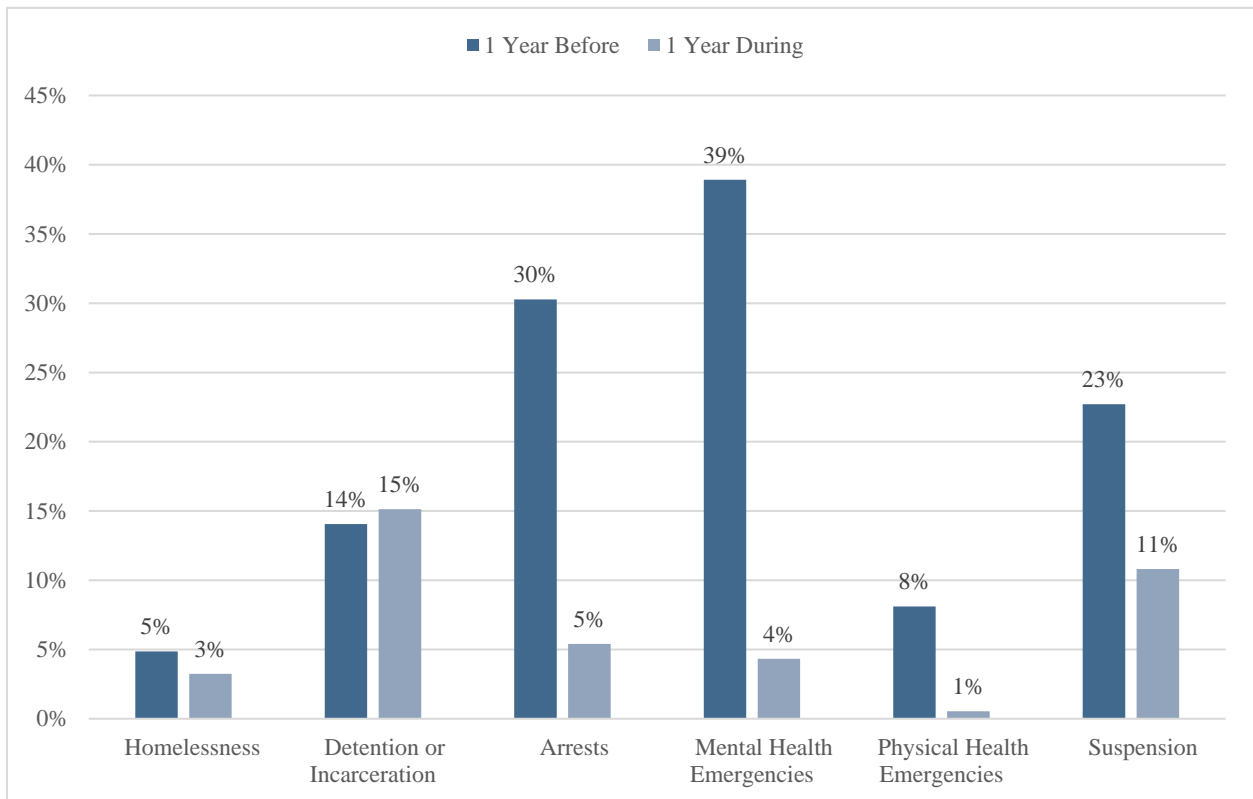
Exhibit 4: Outcomes for Older Adult Partners Completing One Year with FSP (n = 17)



Note: Employment, homelessness, and incarceration outcomes are not presented for older adults, as there are insufficient observations in this age group for meaningful interpretation.

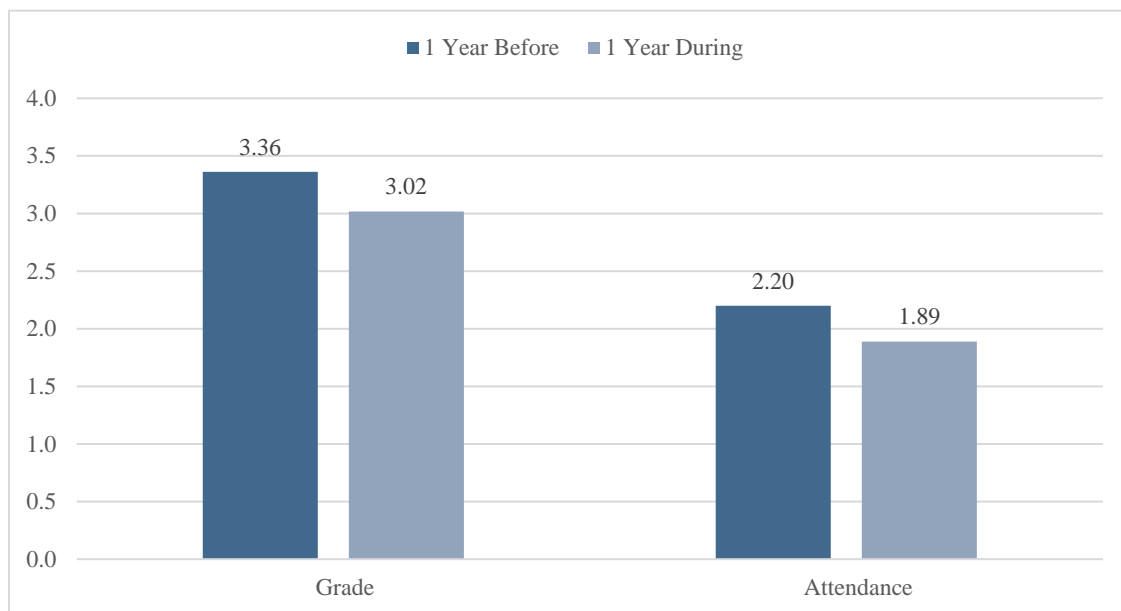
Children. Exhibit 5 below shows the comparison of outcomes in the year prior to FSP enrollment with the first year enrolled in an FSP program for child partners. The findings are essentially the same as those in the last year’s report. All but one self-reported outcome decreased while participating in FSP, showing improvements in homelessness, arrests, suspensions, and mental or physical health emergencies. Detention or incarceration increased slightly for children, however (28 incidents in the first year with FSP compared to 26 incidents in the year prior to FSP enrollment). The magnitude of decline in arrest incidence is much larger (56 in the first year with FSP compared to 10 in the year just prior).

Exhibit 5: Outcomes for Child Partners Completing One Year with FSP (n = 185)



Outcomes on school attendance and grades are presented below in Exhibit 6. As can be seen, attendance and grades for child partners declined modestly. These ratings are on a 1-5 scale, coded such that a higher score is better.

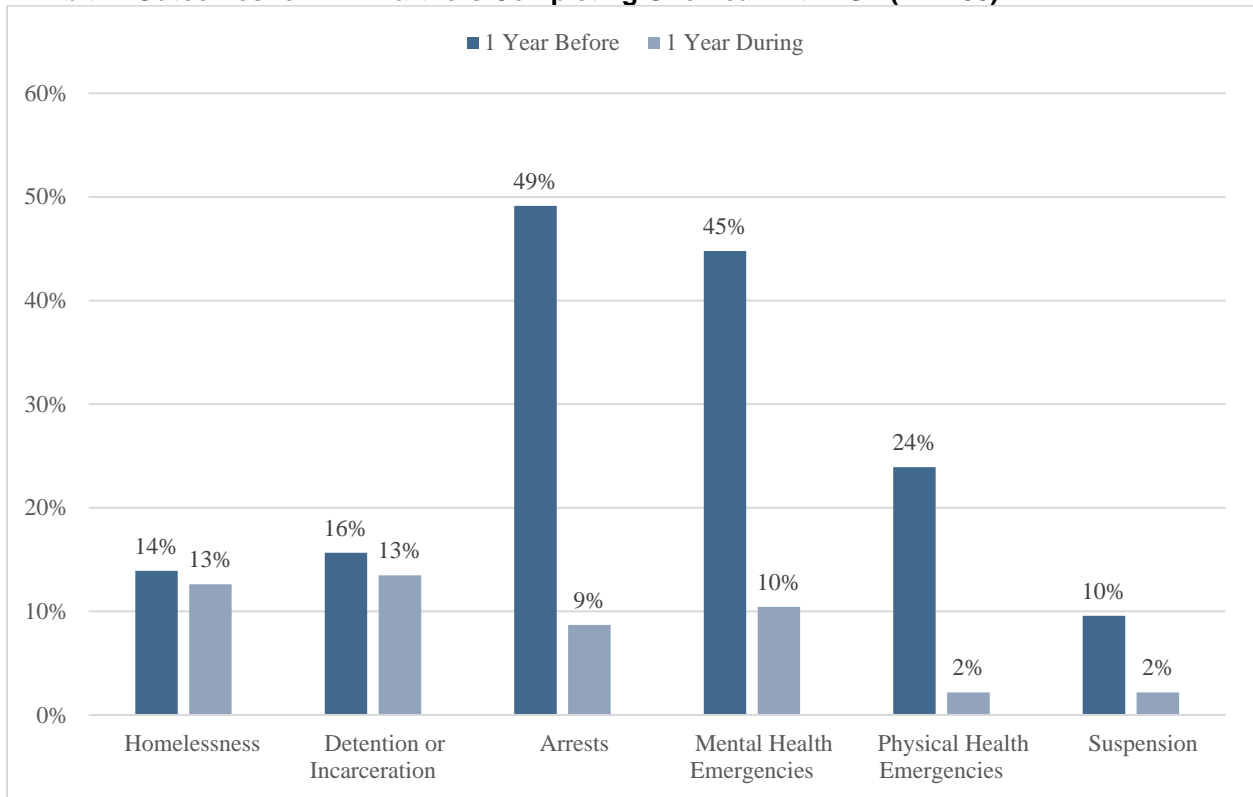
Exhibit 6: School Outcomes for Child Partners Completing One Year with FSP (n = 185)



TAY. Exhibit 7 shows the comparison of outcomes in the year prior to FSP to the first year in the program for TAY partners.³ All self-reported outcomes decreased (an improved status), though the differences for homelessness and incarceration is small. Homelessness decreased from 32 (14%) in the year prior to enrollment to 29 (13%) in the year following enrollment. Incarceration decreased from 36 (16%) in the year prior to enrollment to 31 (13%) in the year following enrollment. Compared to the last year’s report, the magnitudes of decrease are similar and slightly larger.

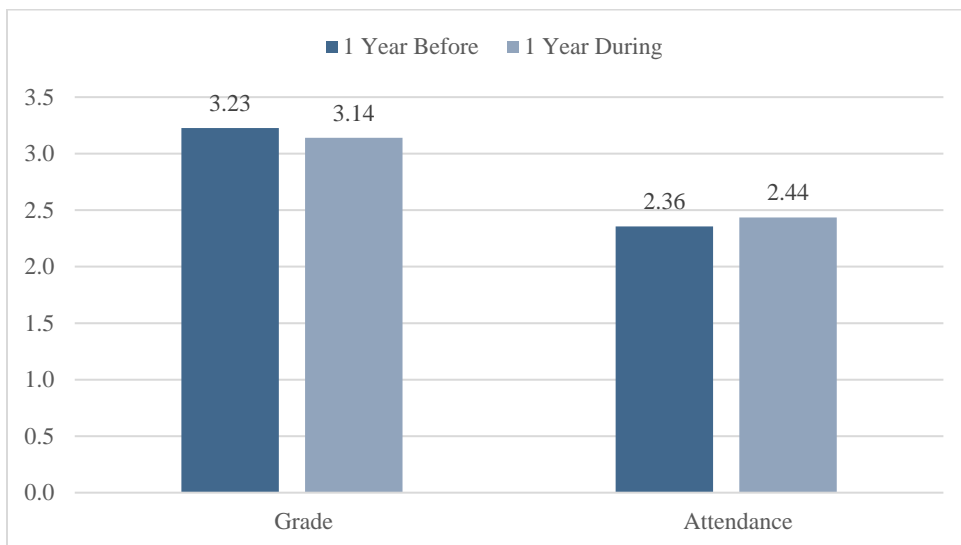
³ The 26 older TAY partners in Caminar are excluded from these outcomes because these providers do not reliably gather TAY specific outcomes. Note that employment as an outcome is not presented for TAY because many of these individuals are in school.

Exhibit 7: Outcomes for TAY Partners Completing One Year with FSP (n = 230)



Outcomes on school attendance and grades are presented in Exhibit 8. Attendance and grades for TAY partners change very little. These ratings are on a 1-5 scale; a higher score is better.

Exhibit 8: School Outcomes for TAY Partners Completing One Year with FSP (n = 230)

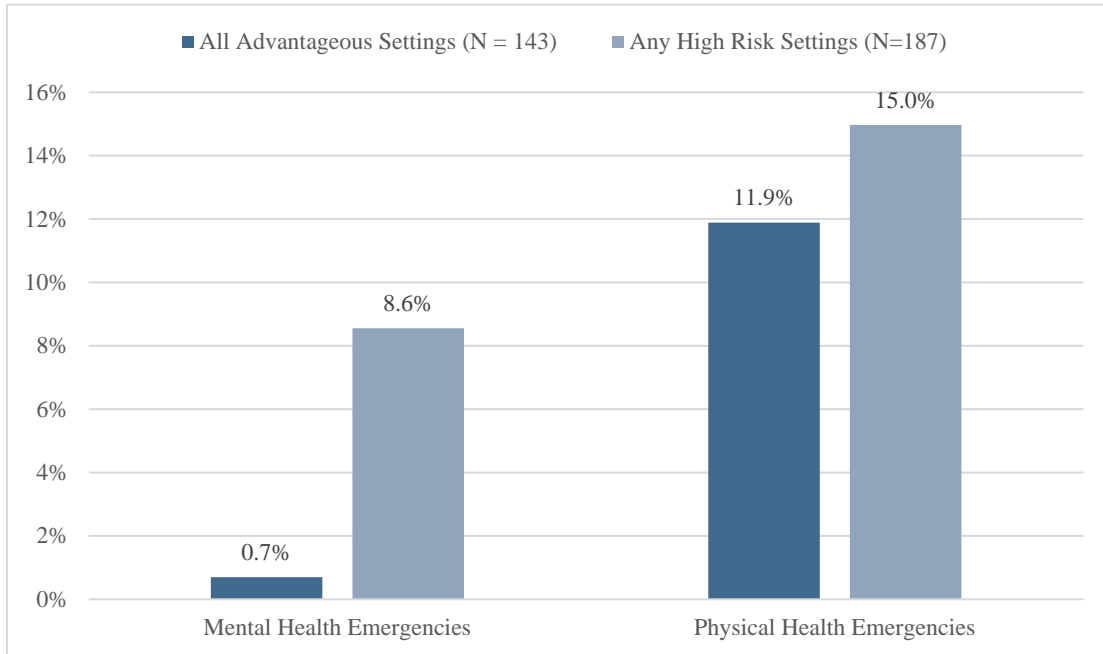


Mental and physical health emergencies by living situation

Exhibit 8 shows the percentage of adult and older adult partners living in advantageous vs higher risk living situations who had a mental or physical health emergency in their first year on FSP.

Advantageous settings are defined as living with family or foster family, living alone and paying rent, or living in group care or assisted living. High risk settings are defined as homelessness, incarceration, or in a hospitalized setting. As shown in the exhibit, both mental and physical health emergencies were more common among individuals who experienced a high-risk residential setting in their first year of FSP participation.

Exhibit 9: Emergency Outcomes as a Function of Residential Setting

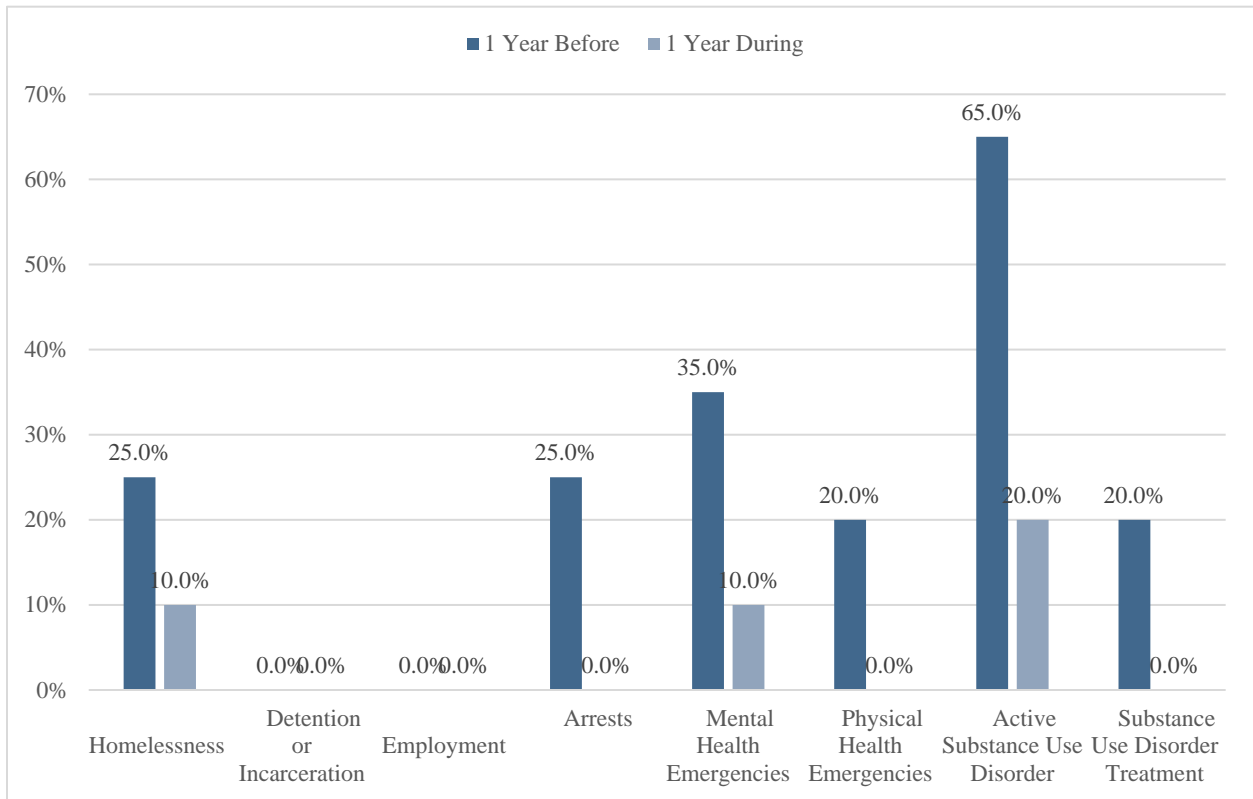


Telecare

Self-Reported Outcomes—All age groups

Because the Telecare data only includes 20 partners who have completed at least one year of FSP as of June 30, 2020, we present the findings for all age groups combined due to small sample size. The comparison of outcomes for all Telecare partners in the year prior to FSP enrollment with the first year in an FSP is shown in Exhibit 10. Homelessness, arrests, self-reported mental and physical health emergencies, and substance use disorders all decreased. Each of these demonstrates improvements for partners in the first year of FSP enrollment. Fewer Telecare partners reported substance use disorder treatments one year during the FSP program compared with one year before enrollment.

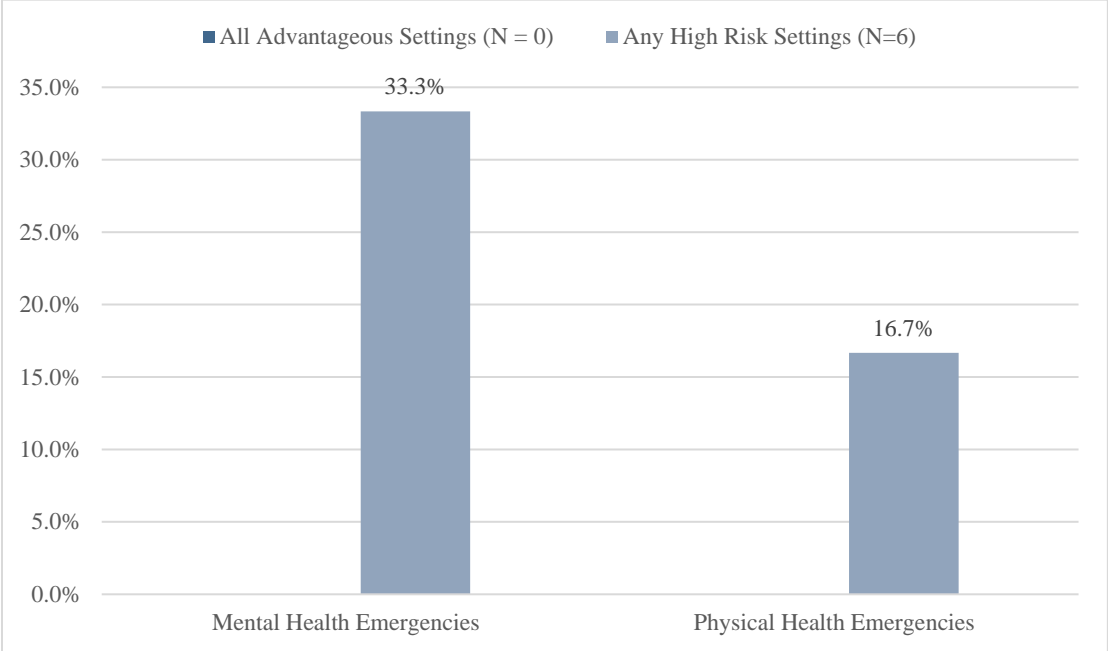
Exhibit 10: Outcomes for Telecare Partners Completing One Year with FSP (n = 20)



Mental and physical health emergencies by living situation

Exhibit 11 shows the percentage of Telecare adult and older adult partners living in advantageous vs higher risk living situations who had a mental or physical health emergency in their first year on FSP. As shown in the exhibit, both mental and physical health emergencies only happened with individuals who experienced a high-risk residential setting in their first year of FSP participation.

Exhibit 11: Emergency Outcomes as a Function of Residential Setting among Telecare Partners



Health Care Utilization Overall and Over Time

Overview

This section describes (1) overall healthcare utilization across all partners, (2) healthcare utilization by age group, and (3) healthcare utilization for partners over time (2006-2020).

Four hospitalization outcomes are presented for the 213 child, 185 TAY, 329 adult, and 53 older adult FSP partners using the Avatar system (EHR):

1. **Partners with any hospitalizations:** measured by any hospital admission in the past 12 months;
2. **Partners with any PES:** measured by any PES event in the past 12 months;
3. **Average length of hospitalization (in days):** the number of days associated with a hospital stay in the past 12 months; and,
4. **Average number of PES event:** the number of PES events in the past 12 months.

Note that the difference in the number of partners across the data sources is due to the difference in age group definition (see Appendix D) and not every partner has a health care record in the County’s EHR system.

Overall Healthcare Utilization Outcomes Across all Partners

We detected statistically significant changes in outcomes from the year before FSP compared to the first year in FSP for all hospitalization outcomes (Exhibit 12). Percent of partners with any hospitalization decreased from 22% before FSP to 11% during FSP. Days in the hospital decreased from 6.92 days before FSP to 2.37 days during FSP. Percent of partners with any psychiatric emergency services (PES) decreased from 42% before FSP to 27% during FSP. The average number of PES events decreased from 1.20 events before FSP to 0.71 events during FSP.

Exhibit 12: FSP Partners Have Significantly Improved Hospitalization Outcomes (n=780)

	Mean	95% Confidence Interval
Percent of Partners with Any Hospitalization*		
1 Year Before	22%	(19% - 25%)
Year 1 During	11%	(9% - 13%)
Mean Number of Hospital Days, per Partner*		
1 Year Before	6.92	(5.48 - 8.36)
Year 1 During	2.37	(1.73 - 3.41)
Percent of Partners with any PES Event*		
1 Year Before	42%	(39% - 46%)
Year 1 During	27%	(24% - 30%)
Mean PES Events, per Partner*		
1 Year Before	1.20	(1.03 - 1.37)
Year 1 During	0.71	(0.58 - 0.84)

*Significance testing was conducted using Chi-square analysis for percentages and t-tests for means; results are statistically significant at the 95% level.

Health Care Utilization for FSP Partners by Age Group

Hospitalization outcomes are presented in Exhibits 13-16, respectively by age group. For all four age groups, the percent of FSP partners with any hospitalization or PES event decreased after joining FSP. The mean number of hospital days experienced by FSP partners also decreased after FSP enrollment for all but the older adult group. The average number of PES events decreased after FSP enrollment for all the age groups.

Exhibit 13: Hospitalization and PES Outcomes for Adult Partners Completing One Year with FSP (n = 313)

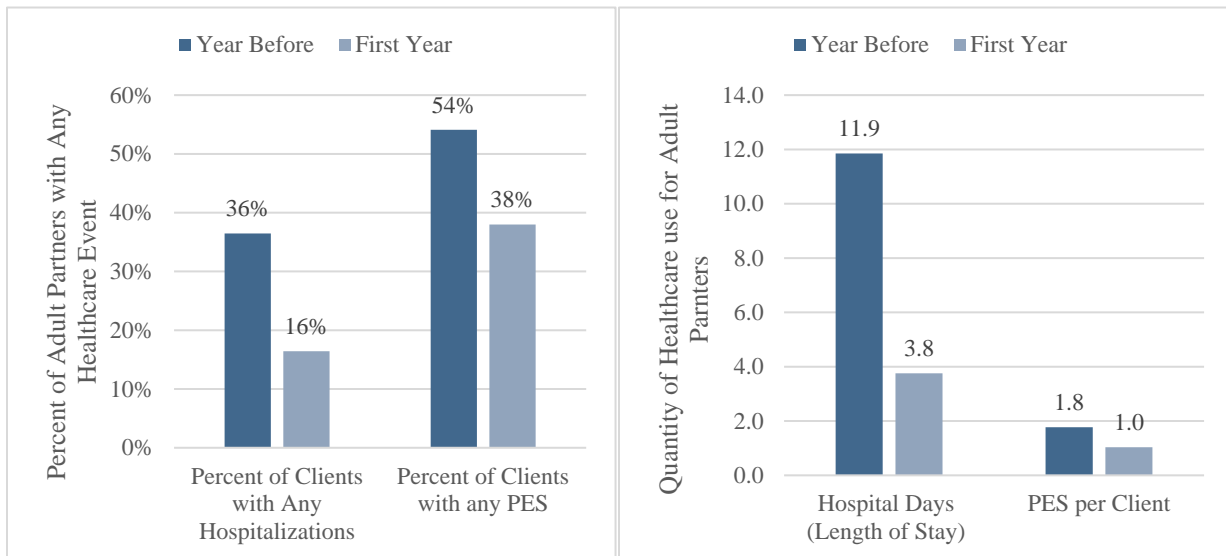


Exhibit 14: Hospitalization and PES Outcomes for Older Adult Partners Completing One Year with FSP (n = 53)

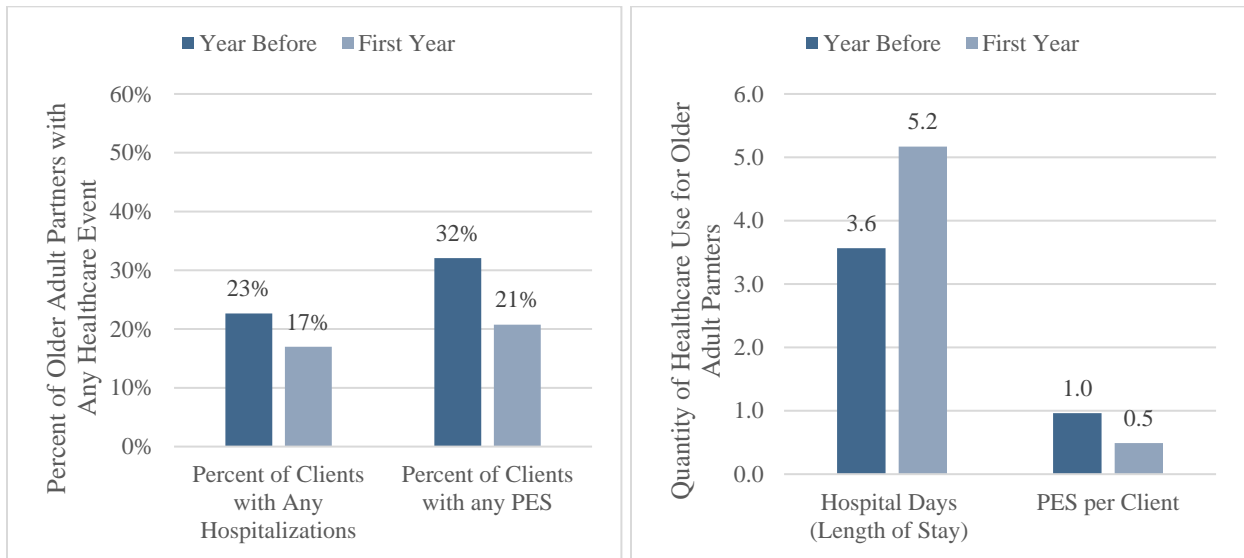


Exhibit 15: Hospitalization and PES Outcomes for Child Partners Completing One Year with FSP (n = 213)

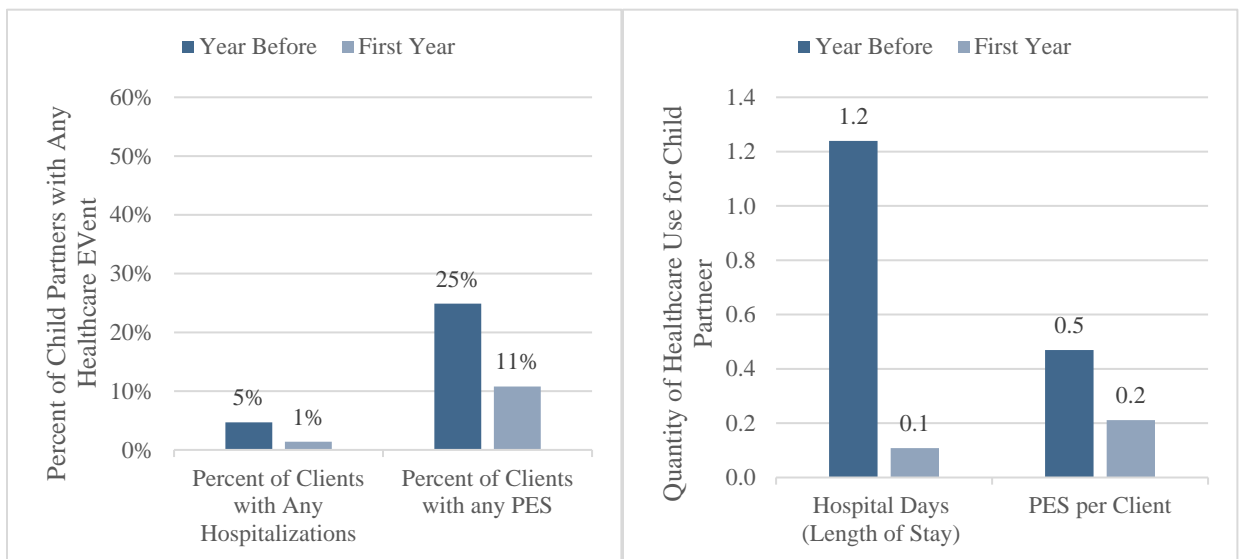
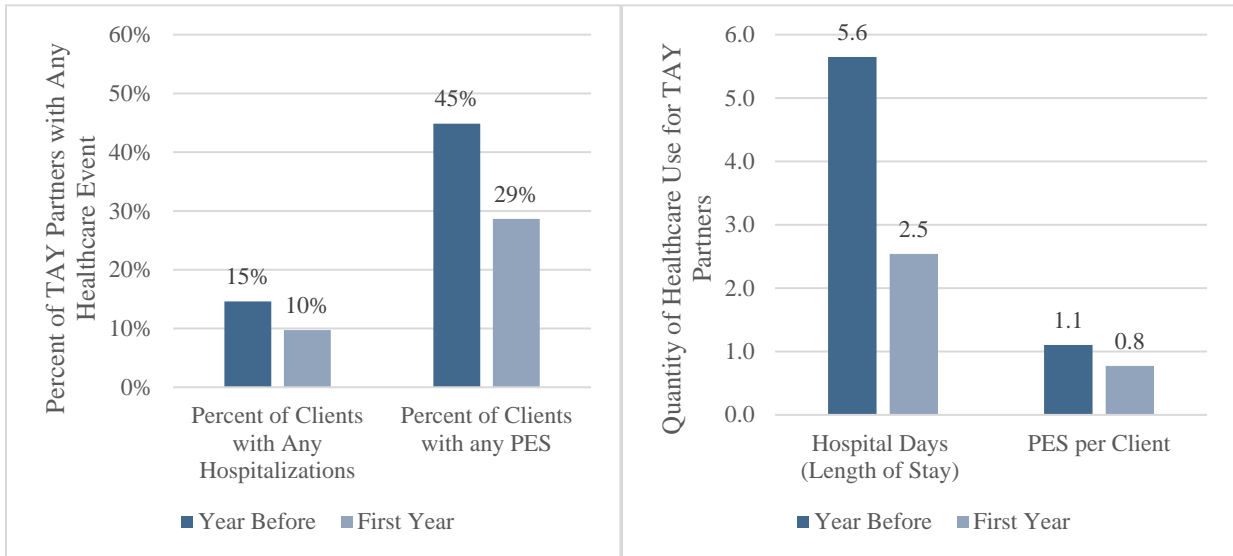


Exhibit 16: Hospitalization and PES Outcomes for TAY Partners Completing One Year with FSP (n = 185)



Health Care Utilization for FSP Partners over Time

Exhibits 17-20 show the four hospitalization outcomes, stratified by enrollment year. As can be seen in Exhibit 17, the percent of partners with any hospitalization decreased after joining an FSP program for all enrollment year cohorts.

Exhibit 17: Percent of Partners with Any Hospitalization by FSP enrollment year.

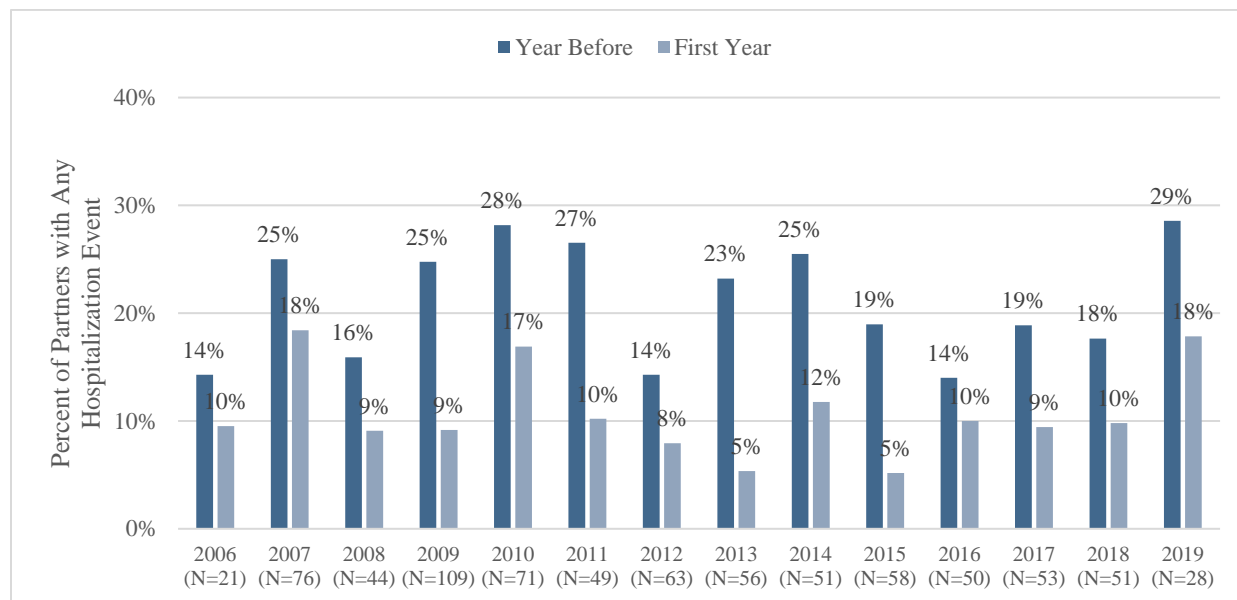


Exhibit 18 displays the mean hospital days per partner by enrollment year. With the exception of 2006 and 2007 cohorts, most partners experienced decreases in the mean number of hospital days regardless of when they enrolled in the program.

Exhibit 18: Mean Number of Hospital Days by FSP Enrollment Year

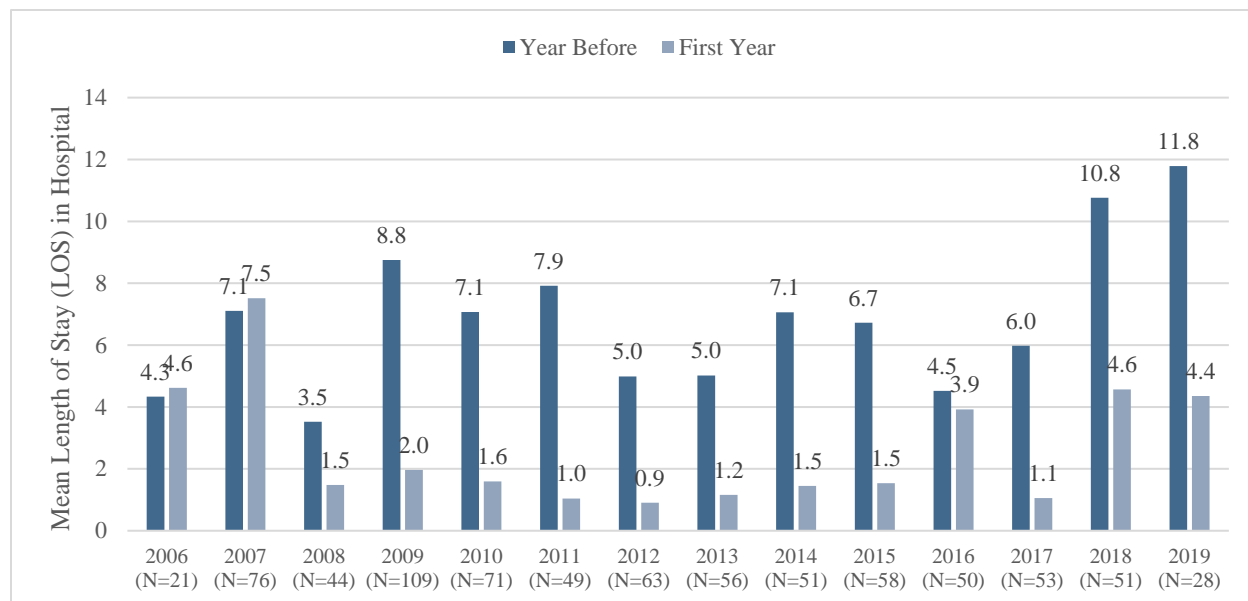
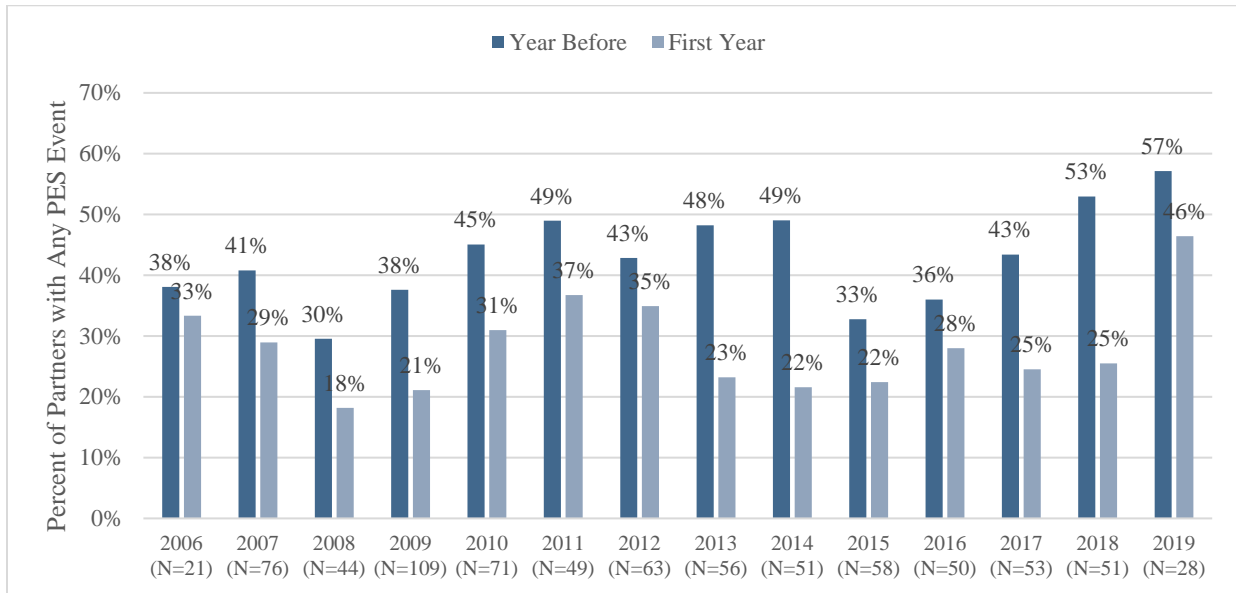


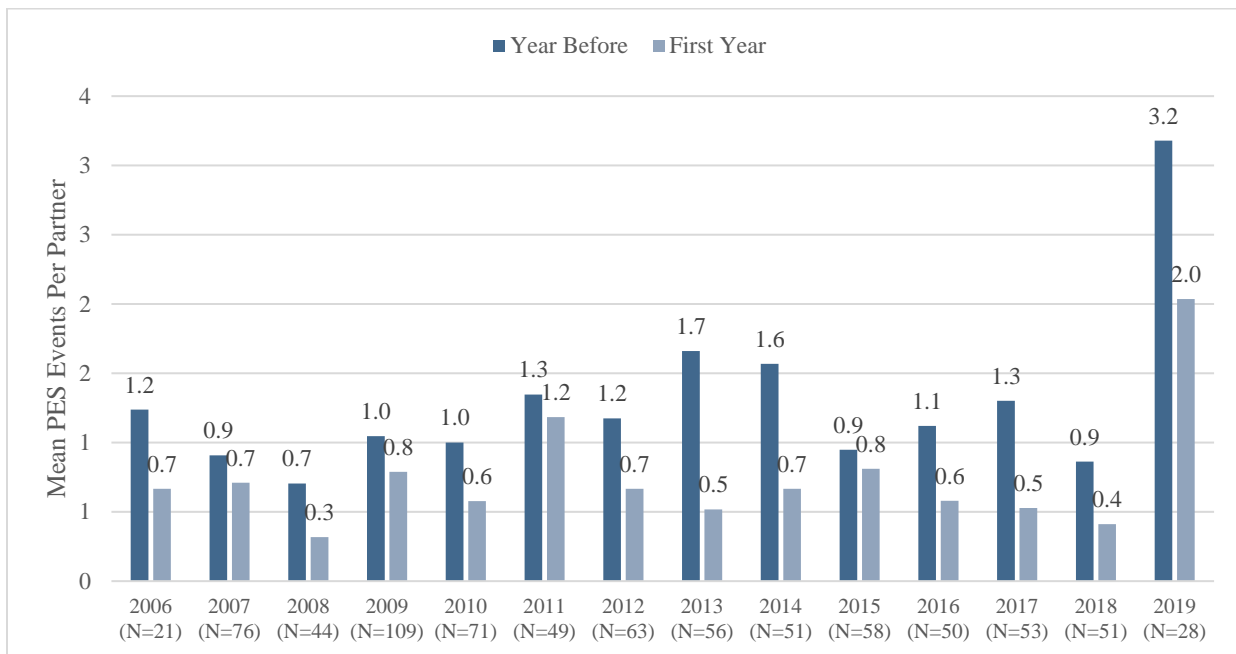
Exhibit 19 displays the percent of partners with any PES event by the year they began FSP. All cohorts experienced a decline in the likelihood of a PES event.

Exhibit 19: Percent of Partners with any PES Event by FSP Enrollment Year



Finally, exhibit 20 displays the mean PES events per partner by FSP enrollment year. Again, all cohorts experienced a reduction in PES events.

Exhibit 20: Mean PES Events by FSP Enrollment Year



Appendix A: Self-Reported Outcomes by Race and Ethnicity among Caminar Partners

In this section, we present the self-reported outcomes by race and ethnicity using the FSP program survey data from Caminar. The survey data from Caminar contains the most complete information on race and ethnicity among all FSP providers in the County. Among 154 partners from Caminar, the race and ethnicity data are available for 138 of them, where 69 reported as White, 15 Black, 19 Asian, Native Hawaiian or Other Pacific Islander (AAPI), 14 Hispanic, and 21 of other races.

The findings from the self-reported outcomes suggest that the majority of outcomes improved (30 of 40 outcomes) for all reported race and ethnicity groups. Exhibit A1, below, presents the percent change between the year just prior to enrollment in an FSP and the first year enrolled in an FSP, by race and ethnicity. Red (and bold) font in the Exhibit indicates percent change that was not favorable.

Exhibit A1 shows improvements for all race and ethnicity groups for the following self-reported outcomes: mental health emergencies, and physical health emergencies. Partners from all race and ethnicity groups except for the AAPI more or as frequently reported receiving substance use disorder treatment in the year following their enrollment of the FSP program, which may indicate that the integrated care and case management services offered through FSP connected partners with needed care. Among all race and ethnicity groups, partners who self-identified as White had improvements with all outcomes. Black partners had improvements on 6 out of 8 outcomes, while they had no change on employment and substance use disorder treatment. Hispanic partners had improvements on 7 out of 8 outcomes, but they more frequently reported active problems with substance use in their first year with FSP than in the year prior to joining the program. AAPI partners improved on 4 out of 8 outcomes (the fewest among the five race and ethnicity groups), while they did not improve on homelessness and incarceration, had more arrests, and less frequently reported substance use disorder treatment. Partners of other races improved on 5 outcomes, they did not improve on homelessness, employment, or having an active problem with substance use in their first year with FSP than in the year prior to joining the program.

Exhibit A1: Percent Change in Outcomes by Race and Ethnicity, Year before FSP Compared with First Year with FSP, among Caminar Partners

FSP Outcomes <i>Self-reported Outcomes</i>	White N = 69			Black N = 15		
	<i>Yr before</i>	<i>Yr after</i>	<i>change</i>	<i>Yr before</i>	<i>Yr after</i>	<i>change</i>
Homelessness	26	16	-38%	8	6	-25.0%
Detention or Incarceration	16	9	-44%	6	4	-33.3%
Employment	0	1	N/A	0	0	N/A
Arrests	11	1	-91%	3	0	-100.0%
Mental Health Emerg.	50	11	-78%	11	2	-82%
Physical Health Emerg.	27	8	-70%	8	3	-63%
Active S.U. Disorder	33	31	-6%	8	6	-25%
S.U. Treatment	15	16	7%	3	3	0%
FSP Outcomes	Hispanic			AAPI		

Self-reported Outcomes	N = 14			N = 19		
	<i>Yr before</i>	<i>Yr after</i>	<i>change</i>	<i>Yr before</i>	<i>Yr after</i>	<i>change</i>
Homelessness	6	5	-17%	5	5	0%
Detention or Incarceration	6	3	-50%	3	3	0%
Employment	0	1	N/A	0	1	N/A
Arrests	4	1	-75%	0	1	N/A
Mental Health Emerg.	12	3	-75%	14	6	-57%
Physical Health Emerg.	6	2	-67%	7	3	-57%
Active S.U. Disorder	8	9	13%	9	4	-56%
S.U. Treatment	4	7	75%	4	0	-100%
FSP Outcomes	Other Races					
Self-reported Outcomes	N =21					
	<i>Yr before</i>	<i>Yr after</i>	<i>change</i>			
Homelessness	2	2	0%			
Detention or Incarceration	5	2	-60%			
Employment	0	0	N/A			
Arrests	3	0	-100%			
Mental Health Emerg.	14	2	-86%			
Physical Health Emerg.	8	3	-63%			
Active S.U. Disorder	9	9	0%			
S.U. Treatment	5	8	60%			

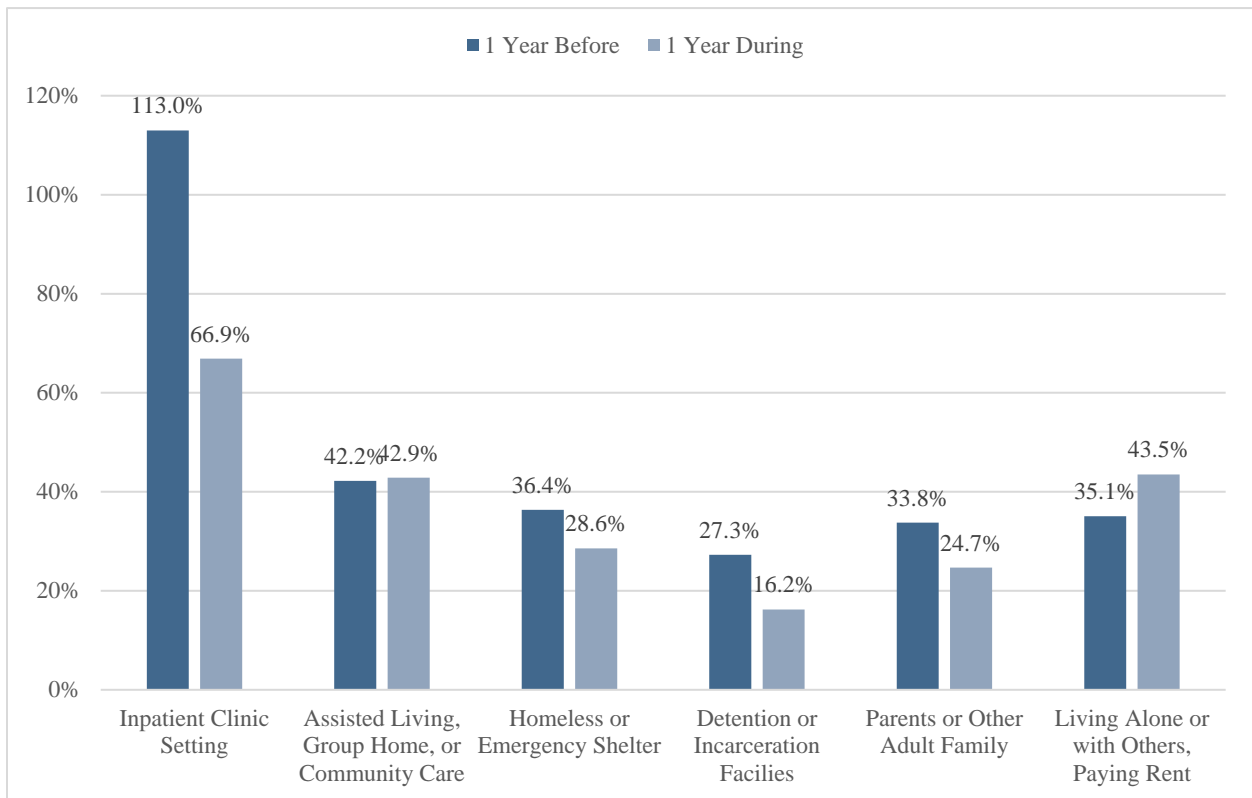
Note. The table above indicates the percent change in the percent of partners with any events, comparing the year just prior to FSP with the first year on FSP. Red (and bold) font indicates outcomes that worsened, such as more active substance use disorder for Hispanic partners or more arrests for AAPI partners.

Appendix B: Additional Detail on Residential Outcomes

For residential setting outcomes, we present all the categories of living situations and compare the percentages of any partners spending any time in various residential settings the year prior to FSP and in the first year of FSP participation. A list of all residential settings and how they are categorized, is presented in Appendix D with the methodological approach.

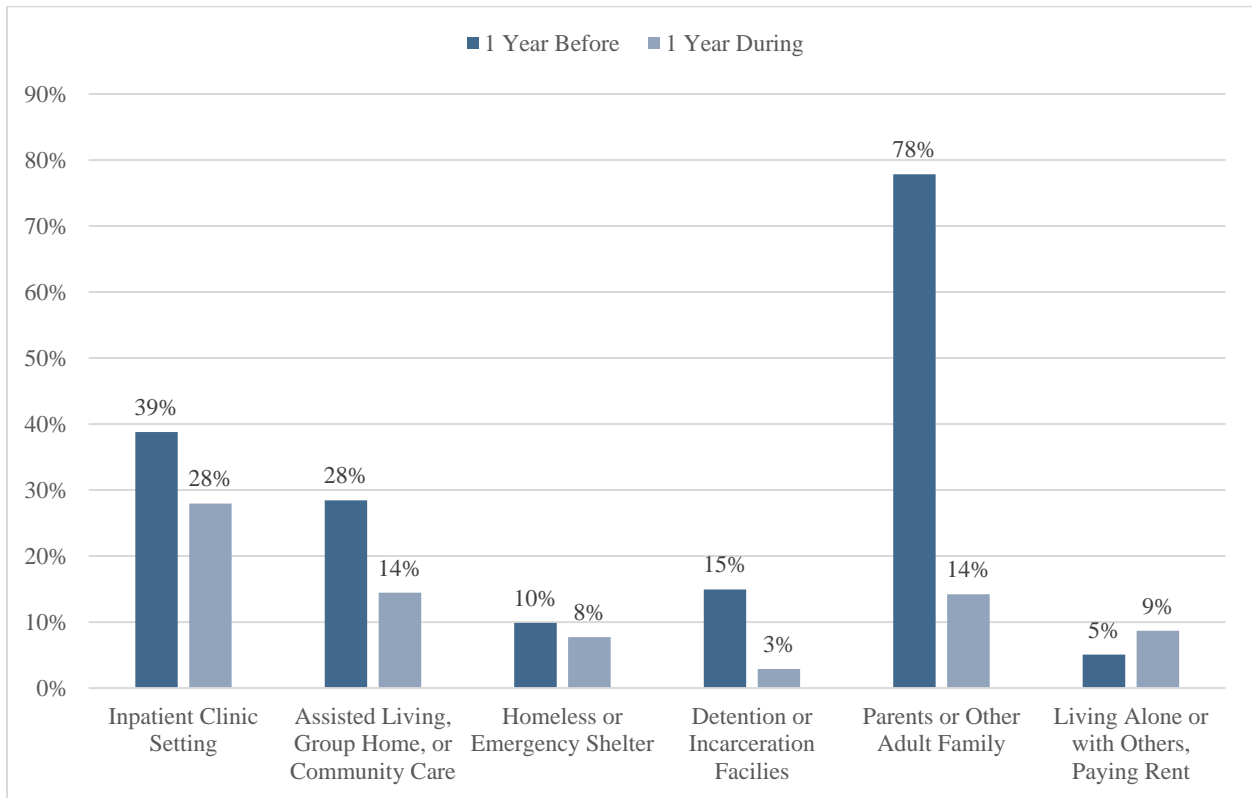
As can be seen in Exhibit B1, the percent of clients reporting any time in an inpatient clinic, homeless, incarcerated, or living with parents decreases. In contrast, the percent of clients reported any time in assisted living, group home, or community care environment, and those who reported living alone or with others, paying rent increases.

Exhibit B1: Any Time in Residential Settings – Adult and Older Clients from Caminar Completing 1 Year in the FSP Program (n = 154)



Note. Residential settings are not mutually exclusive, so percents may exceed 100.

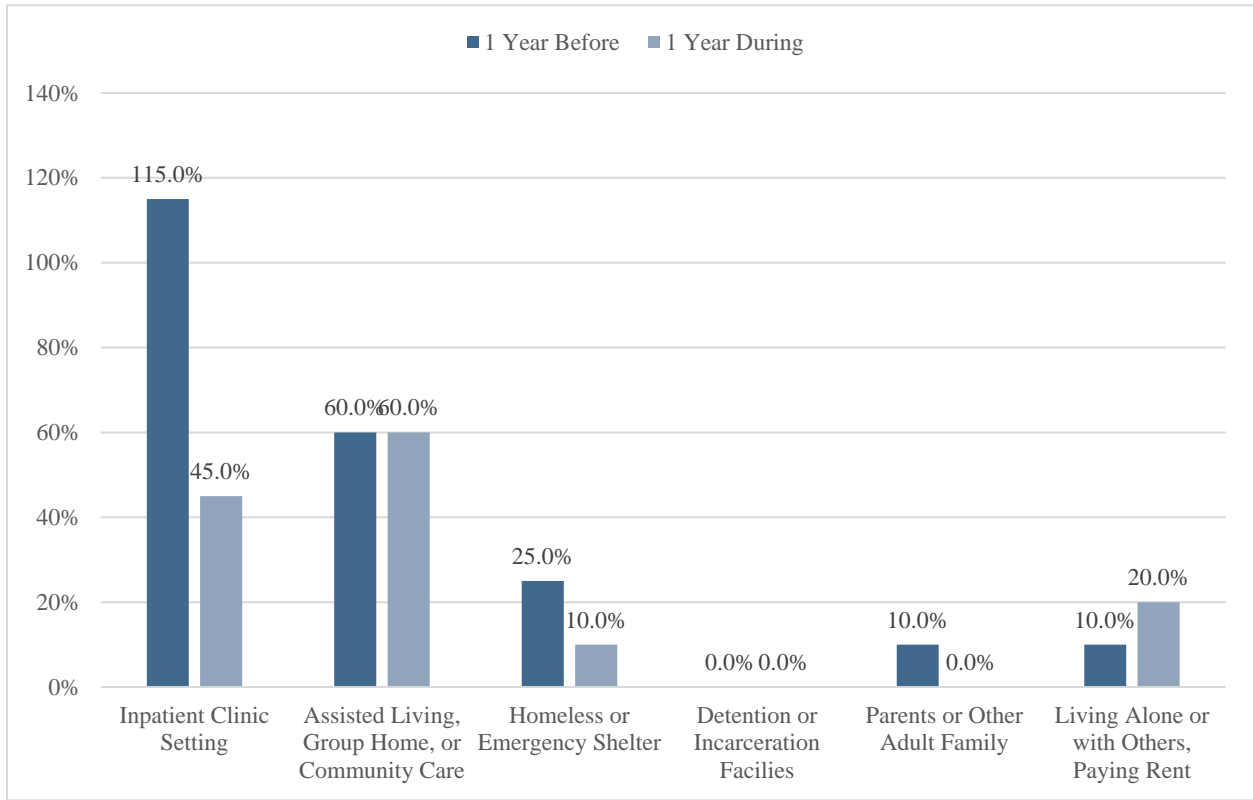
Exhibit B2: Any Time in Residential Settings – Child and TAY Clients from Edgewood/ Fred Finch Completing 1 Year in the FSP Program (n = 415)



Telecare

As shown in Exhibit B3, the percent of Telecare clients reporting any time in an inpatient clinic, homeless, or living with parents decreases. In contrast, the percent of clients who reported living alone or with others, paying rent increases.

Exhibit B3: Any Time in Residential Settings – Telecare Clients Completing 1 Year in the FSP Program (n = 20)



Note. Residential settings are not mutually exclusive, so percents may exceed 100.

Appendix C: Additional Detail on Outcomes by FSP Providers

This section provides more detail on the results presented in the main report. No outcomes are presented for any group of partners with 10 or fewer individuals.

Exhibit C1-C3, presents the percent of partners with any events the year just prior to FSP enrollment and the first year in an FSP, as well as the percent improvement for each FSP provider. Percent improvement is the percent change in the percent of partners with any events.

As can be seen in Exhibit C1, there are improvements comparing the year prior to FSP to the first year during FSP for Caminar on all the available self-reported outcomes.

Exhibit C1. Percent of Caminar Partners with Outcome Events by Year and Percent Change in Prevalence of Outcome Events (Year before FSP vs. the first year of FSP participation)

Survey Outcomes, Caminar	1 Year Before	Year 1 During	Change (%)
Homelessness	36.4%	28.6%	-21.4%
Detention or Incarceration	27.3%	16.2%	-40.5%
Arrests	26.6%	3.2%	-87.8%
Mental Health Emergencies	72.7%	18.2%	-75.5%
Physical Health Emergencies	40.3%	12.3%	-69.4%
Employment	0.6%	2.6%	300%
Active Substance Use Disorder	48.7%	43.5%	-10.7%
Substance Use Disorder Treatment	21.4%	25.3%	18.2%

As can be seen in Exhibit C2, there are improvements comparing the year prior to FSP to the first year during FSP for Telecare on most available self-reported outcomes, except for detention or incarceration, employment, and substance use disorder treatment. The percent difference with any detention or incarceration and employment is reported as N/A because the percent of partners with detention or incarceration and employment did not change (from 0% to 0%). Thus, the denominator is 0.

Exhibit C2. Percent of Telecare Partners with Outcome Events by Year and Percent Change in Prevalence of Outcome Events (Year before FSP vs. the first year of FSP participation)

Survey Outcomes, Telecare	1 Year Before	Year 1 During	Change (%)
Homelessness	25.0%	10.0%	-60.0%
Detention or Incarceration	0.0%	0.0%	N/A
Arrests	25.0%	0.0%	-100.0%
Mental Health Emergencies	35.0%	10.0%	-71.4%
Physical Health Emergencies	20.0%	0.0%	-100.0%
Employment	0.0%	0.0%	N/A
Active Substance Use Disorder	65.0%	20.0%	-69.2%

Substance Use Disorder Treatment	20.0%	0.0%	-100.0%
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Red (bold) font indicates outcomes that worsened, such as less frequently reported substance use disorder treatment.

Exhibit C3 shows improvement in many outcomes except for grade and attendance.

Exhibit C3. Percent of Edgewood Partners with Outcome Events by Year and Percent Change in Prevalence of Outcome Events (Year before FSP vs. the first year of FSP participation)

Survey Outcomes, Edgewood	1 Year Before	Year 1 During	Change (%)
Homelessness	9.9%	8.4%	-14.6%
Detention or Incarceration	14.9%	14.2%	-4.8%
Arrests	40.7%	7.2%	-82.2%
Mental Health Emergencies	42.2%	7.7%	-81.7%
Physical Health Emergencies	16.9%	1.4%	-91.4%
Suspension	15.4%	6.0%	-82.1%
Grade	3.36	3.06	-9.0%
Attendance	2.25	2.08	-7.5%

Appendix D: Methods

Methodology for FSP Survey Data Analysis

The FSP survey data are collected by providers via discussions with partners and should thus be viewed as self-report. Among the providers included in these analyses (Fred Finch/Edgewood, Caminar, and Telecare), 589 partners completed a full year with FSP since program inception.

In general, three datasets are obtained for this report: one from Caminar, one from Telecare and one from Edgewood. All providers provide their datasets in a Microsoft Excel format. In 2018, Telecare changed their data system for the FSP survey in which the data structure and variable names were different from before. Due to data reliability issues, Telecare only provided the data after their data system change—data from December 2018 onward. Therefore, the main analysis of this report includes all Caminar and Edgewood partners, and a separate analysis is included for Telecare data since December 2018.

Edgewood/Fred Finch serve child partners and transitional age youth (TAY) partners. Caminar and Telecare serve primarily adult and older adult partners, and a small number of older TAY clients. Exhibit D1 below describes the age group of partners completing at least one full year of FSP by provider. For Telecare, this data includes December 2018 through June 2020.

Exhibit D1: Summary of Partners One Full Year of FSP

Age Group	Edgewood/ Fred Finch	Caminar	Telecare	Total*
Child (aged 16 and younger)	185	--	--	185
TAY (aged 17 – 25)	230	26	1	257
Adult (aged 26 -59)	--	111	16	127
Older Adult (aged 60+)	--	17	3	20
Total	415	154	20	589

*Telecare partners were not reported in the survey outcomes by age group, a separate analysis was conducted for Telecare partners all age groups combined due to small sample size.

A master assessment file with FSP start and end dates and length of FSP tenure was created at the client level. Note that for clients who stopped and then reestablished their FSPs, we only kept the record corresponding with their most recent participation in an FSP (using Global ID), as indicated in the State’s documentation.

Partner type (child, TAY, adult, and older adult) is determined by the Partnership Assessment Form (PAF) data.

- For Caminar and Edgewood/Fred Finch, this was done by selecting records with specific Age Group codes, i.e.:
 - Caminar: selected records with Age Group codes of “7” (TAY partner, aged 17 to 25), “4” (adult partner, aged 25 to 59), and “10” (older adult partner, aged 60 and older).

- Edgewood/Fred Finch: selected records with Age Group codes of “1” (child partner, aged 16 and younger) and “4” (TAY partner, aged 17 to 25).
- In both cases, this was confirmed using the data file’s continuous *Age* variable.
- For Telecare data, partners were given an age appropriate PAF. Records with specific *Form Type* codes were retained in the analysis (i.e., Form Types “TAY_PAF”, “Adult_PAF” and “OA_PAF”).

Partnership date and *end date* were determined as follows: Partnership date was determined using enrollment start date. End date was determined by the reported date of the partnership status change in the Key Event Tracking (KET) form to “discontinued.” For clients still enrolled at the time of data acquisition, we assigned an end date of June 30, 2020.

All data management and analysis was conducted in Stata. All code is available upon request. Additional details on the methodology for each outcome are presented below.

Residential Setting

1. Residential settings were grouped into categories as described in the table below (Exhibit D2).
2. The baseline data were populated using the variable *PastTwelveDays* (Caminar and Edgewood) or *res_past12m_days_int* (Telecare) collected by the PAF. Individuals without any reported locations were assigned to the “Don’t Know” category.
3. The partner’s first residential status once they joined FSP is determined by the *Current* (Caminar and Edgewood) or *res_curr_dsr* (Telecare), collected by the PAF. Individuals without any reported current residence were assigned to the “Don’t Know” category. Some individuals had more than one first residence location. In this case, if there was one residence with a later date (as indicated by the variable, *DateResidentialChange* (Caminar and Edgewood) or *main_resident_date* (Telecare)), this residence was considered to be the first residential setting. If the residences were marked with the same date, both were considered as part of the partner’s first year in an FSP.
4. Additional residential settings for the first year were found using the KET data, inclusive of all residence types listed with a corresponding date of residential change (*DateResidentialChange* (Caminar and Edgewood) or *main_resident_date* (Telecare)) occurring within one year of the FSP partnership start date. If no residential data were captured subsequent to the PAF by a KET, it was assumed that the individual remained in their original residential setting.

Exhibit D2: Residential Setting Categories and Corresponding Classification Values used to Derive Them

Category	Telecare, Caminar, Edgewood, and Fred Finch Setting Value ⁴
With family or parents	
With parents	1
With other family	2
Alone	
Apartment alone or with spouse	3
Single occupancy (must hold lease)	19
Foster home	
Foster home with relative	4
Foster home with non-relative	5
Homeless or Emergency Shelter	
Emergency shelter	6
Homeless	7
Assisted living, group home, or community care	
Individual placement	20
Assisted living facility	28
Congregate placement	21
Community care	22
Group home (Level 0-11)	11
Group home (Level 12-14)	12
Community treatment	13
Residential treatment	14
Inpatient Facility	
Acute medical	8
Psychiatric hospital (other than state)	9
Psychiatric hospital (state)	10
Nursing facility, physical	23
Nursing facility, psychiatric	24
Long-term care	25
Incarcerated	
Juvenile Hall	15
Division of Juvenile Justice	16
Jail	27
Prison	26
Other / Don't Know	
Don't know	18
Other	17

⁴ Setting names determined by the following guide:
https://mhdatapublic.blob.core.windows.net/fsp/DCR%20Data%20Dictionary_2011-09-15.pdf

Employment

Employment outcomes were generated for adults only. Therefore, Edgewood and Fred Finch data were excluded.

1. The baseline data were populated using the PAF data. An individual was considered as having had any employment if there was a non-zero, non-blank value for one of the following variables (note that variable names differ slightly by dataset):
 - a. Any competitive employment in past twelve months (any competitive employment; any competitive employment for any average number of hours per week; any average wage for competitive employment)
 - b. Any other employment in past twelve months (any other employment; any other employment for any average number of hours per week; any average wage for any other employment)
2. Ongoing employment was populated using any dates of employment change (variable names vary slightly by file) noted in the KET file within the first year of membership in FSP (as determined by the partnership start date). An employment change was coded if the new employment status code corresponding to the employment change date indicated competitive employment or other employment. If the KET contained no information on employment, the original employment was presumed to sustain throughout FSP membership.

Arrests

1. The baseline arrest data were populated using the variable *ArrestsPast12* (Caminar and Edgewood) or *lgl_arrest_p12_times* (Telecare) collected by the PAF. If the variable was blank, the partner was assumed to have zero arrests in the year prior to FSP.
2. Ongoing arrests were populated using any dates of arrest (variable names vary slightly by file) noted in the KET file within the first year of membership in FSP (as determined by the partnership date). If the KET contained no information on arrests, the partner was assumed to have had no arrests in the first year in an FSP.

Mental and Physical Health Emergencies

1. The baseline utilization of emergency services was populated using the PAF's variables for mental health emergencies (*MenRelated* (Caminar and Edgewood) or *emr_mental_p12* (Telecare)) and physical health emergencies (*PhysRelated* (Caminar and Edgewood) or *emr_physical_p12* (Telecare)), respectively. If either of these fields were blank, the partner was assumed to have had zero emergencies of that type in the year prior to FSP.
2. Ongoing emergencies were populated using the variable indicating the date of emergency (variable names vary slightly by file) in the KET file, as long as the date is within the first year with FSP as determined by the partnership date. The type of emergency was

indicated by *EmergencyType* (Caminar and Edgewood) or *main_emergency_int_dsr* (Telecare) (“1”=physical; “2”=mental). We assumed that no information on emergencies in the KET indicated that no emergencies had occurred in the first year on FSP.

Substance Use Disorder

1. Baseline data on substance use disorder were populated using variables in the PAF for active substance use disorder (*ActiveProblem* (Caminar and Edgewood) or *sub_co_mh_sa_probl_past* (Telecare)) and participation in substance use disorder treatment and recovery services (*AbuseServices* (Caminar and Edgewood) or *sub_sa_services_now* (Telecare)). If these fields were blank, the partner was assumed to have had no substance use disorder nor received substance use disorder treatment and recovery services in the year prior to FSP.
2. Ongoing substance use disorder data were populated using the 3M data variables of the same name. Any record of an active substance use disorder or participation a substance use disorder treatment during the first year of FSP was recorded. If there were no observations in the variables of interest, clients were assumed to have no ongoing substance use disorder or participation in substance use disorder treatment.

Methodology for Avatar Data Analysis

Hospitalization outcomes were derived from electronic health records (EHR) data obtained through the Avatar system. Using EHR data avoids some of the reliability shortcomings of self-reported information, but presents several challenges as well. The Avatar system is limited to individuals who obtain care in the County hospital system. Hospitalizations outside of the County, or in private hospitals, are not captured. The hospitalization outcomes include 780 partners who were both (1) included in the Avatar system and (2) completed one full year or more in a FSP program by the June 2020 data acquisition date. Thus, individuals included in the EHR analysis had to have started with the FSP between July 2006 (the program’s inception) and June 2019.

All data management and analysis were conducted in Stata. Code is available upon request.

To count instances of psychiatric hospitalizations and PES admissions, we relied on the Avatar *view_episode_summary_admit* table. Exhibit D3 shows the corresponding program codes. Additionally, FSP episodes were identified through the Avatar *episode_history* table.

Exhibit D3: Program codes among clients ever in the FSP

Program code	Program value
Psychiatric Hospitalizations	
410200	ZZ410200 PENINSULA HOSPITAL INPT-MSO I/A
410205	410205 PENINSULA HOSPITAL INPATIENT
410700	410700 SMMC INPATIENT
921005	921005 NONCONTRACT INPATIENT
926605	926605 JOHN MUIR MED. CTR INPT MAN CARE
Psychiatric Emergency Services	
410702	Z410702 SMMC PES -termed 10/31/14
410703	410703 PRE CONV SMMC PES~INACTIVE
41CZ00	41CZ00 SAN MATEO MEDICAL CENTER - PES

Notes: Data represent all utilization from FSP clients for these codes, as pulled from Avatar on August 19, 2019.

Partner type (child, TAY, adult, and older adult) was determined by the partner’s age on the start date of the FSP program, as derived from the *c_date_of_birth* variable from the *view_episode_summary_admit* table and the *FSP_admit_dt* variable from the *episode_history* table.

As we have discussed in the previous year’s report, the distribution of partners by age group is different between the Avatar data and the FSP Survey data. This is likely due to the different ways age group was determined. For the survey data, AIR determined age group by whether the partner was evaluated using the child, TAY, adult, or older adult FSP survey forms. For the Avatar data, AIR assigned individuals to an age group based upon the date they joined FSP and their reported date of birth.

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APPENDIX 10. CONTRACTOR'S ASSOCIATION GRANT FUNDING PROGRAM



NEEDS ADDRESSED BY FUNDING

CONTRACTOR	Amount Requestd	Amount Granted	Amount Spent	Improved capacity to provide integrated models for addressing trauma and co-occurring disorders	Improved capacity to incorporate evidence-based practices into day-to-day resources	Improved cultural competency	Improved capacity to collaborate, partner and share resources and information with other Association Members	% of Funding Recipients' staff who provide direct services participated in training that developed new skills in the areas of trauma, co-occurring disorders and/or cultural awareness	How grant was spent
Art Unity Movement	6292.19	6292.19	7511.62	No	No	No	Yes	75%	Speaker fee, Assistant, Travel, Site Rental, Food & Beverage, Workshop Materials; staff achieved overall better work satisfaction & well-being; adapted Dynamic Alignment tools to use with the people served to be incorporated into staff practice with clients; all goals met
Caminar	6292.19	6292.19	7500.00	Yes	Yes	Yes	Yes	100%	12/04/20: Methidemic and Personality Disorders (trainers- Caminar staff at no cost); 02/12/20: Dynamic Alignment Training- 2 trainers @ 1,250.00 each for a total of 2,500.00; 06/17/20: Housing in the New Normal (trainer provided training at no cost); 06/04-07/01/20: Transformative Communication during challenging times series at a cost of \$2,500.00; 07/17-24/20: Becoming Culturally Responsive at a cost of \$2,500.00
Children's Health Council	6292.19	6292.19	6292.19	Yes	Yes	Yes	No	75%	Speaker fee, Travel, Staff time/Training
Daly City Youth Health Center	6292.19	6292.19	6292.19	Yes	Yes	Yes	Yes	100%	ICA Notes SSubscription, Yellow Schedule, Staff Trainings, Materials/Resources, Travel
Edgewood	6292.19	6292.19	6292.19	Yes	No	Yes	No	75%	Training Coordinator, QA Specialist, Food/Beverage, Travel time; new trainings: Addressing Social Determinants of Health for LGBTQ People, and Advocacy for Diverse Communities, Growing Up Trans
El Centro de Libertad	6292.19	6292.19	6292.19	Yes	No	Yes	No	75%	Evidence based practices; Best Practice for Co-Occuring Disorder, Culturally & Linguistically appropriate Services
Fred Finch Youth Center	6292.19	6292.19	6464.13	No	Yes	Yes	Yes	75%	Trainings: Evidence Based Topic & training that helped staff to better communicate with Partner staff within the program; learned communication skills; Currently all staff are taking Minimizing Disruptions in Care Through the Use of Behavioral Telehealth. The aim of this 11-week webinar series is to consolidate learning from the quick transition to behavioral telehealth services in response to COVID 19
Free At Last	6292.19	6292.19	6292.19	No	No	Yes	No	75%	Conference trining facilities, training preparations, food & beverage, 8 part-time staff time/benefits
Health Right 360	6292.19	6292.19	6275.97	Yes	Yes	Yes	No	75%	Training fees, food & beverage for trainings, Materials/Curriculum; staff expanded their understanding, knowledge and awareness on Cultural Humility through training, workshop and materials
Horizon/Palm Ave Detox	6292.19	6292.19	6292.19	Yes	Yes	Yes	No	75%	Training materials, staff time; Staff meetings consist of 12-15 staff Solution Focused Short Term Therapy, Emotional Intelligence, Mindfulness, Positive Relationships, The Schience of Self Acceptance
Mental Health Association	6292.19	6292.19	6292.19	Yes	No	Yes	No	75%	Conference fees, Travel & Parking reimbursement, Staff time; Trainigs: Sexual Harassment, SOGI, Cultural Humility, Housing Firt
Service League	6292.19	6292.19	6292.19	Yes	Yes	Yes	No	75%	Trainings, materials, staff time; Cultural Competency Working w/LBGTQIA Clients, Understanding Cultural Stigma of Addiction & Mental Health, Cultural Competency Trauma Treatment & Care for PTSD, Cultural Competency Basics of Borderline Personality Disorder, Cultural Competency Eating Disorders & Treatment for Women, Cultural Competency Treatment for Bi-Polar Disorder
Sitike	6292.19	6292.19	2100.00	Yes	No	Yes	No	75%	Prepaid Rental facilities, Subject Matter Expert/Trainers
Star Vista	6292.19	6292.19	6292.19	No	No	Yes	No	75%	Trainings, training materials, food & beverage, Travel time for staff in training, Speaker fee & Travel: The trainings focused on Sexual Orientation / Gender Identity and Expression (SOGIE), each 2 hours, as well as cultural humility and culturally responsive care.
The Latino Commission	6292.19	6292.19	9212.19	Yes	Yes	Yes	No	75%	Training conference including food & beverage, Staff covered homes 3 days, Travel time, Hotel, 2 group dinners; workshops addressed Cultural Competency, Integration of Mental & Behavioral Health, Substance Abuse & Recovery, Violence & Criminal Justice, Mindfulness, Indigenous TEachings, LGBTQ issues & Evidence Based Practice
YMCA Youth Service Bureaus	6292.19	6292.19	3200.00	No	Yes	Yes	No	75%	Trainers, trainer travel, provided more than 150 additional students with mentalhealth services, Afinity & Accountability group consultant

APPENDIX 11. OUTREACH COLLABORATIVES EVALUATION REPORTS



San Mateo County Behavioral Health and Recovery Services (SMC BHRS) Provider Outreach Annual Report FY 2019-2020

**Quy Nhi Cap, MPH;
Lee Nethercott, BA**

JAN 2021

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) Provider Outreach Annual Report FY 2019-2020

JANUARY 2021

**Quy Nhi Cap, MPH;
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Executive Summary

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), to provide funding to Counties for mental health services by imposing a 1% tax on personal income in excess of \$1 million. The Community Services and Supports (CSS) component of MHSA was created to provide direct services to individuals with severe mental illness and included Outreach and Engagement activities.

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) funds the North County Outreach Collaborative (NCOC) and the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) to provide outreach and engagement activities throughout San Mateo County.

This report summarizes self-reported outreach data from the attendee at the collaborative and provider-specific level across individual and group outreach events that occurred in fiscal year (FY) 2019-2020 (July 1, 2019 through June 30, 2020). We also present historical data since FY 2014-2015 to show how outreach has changed over time.

To note, on March 13, 2020, San Mateo experienced a regional stay-at-home order due to the COVID-19 pandemic. Data, from March to June 2020, reflect outreach and engagement activities during the pandemic.

Total Attendance

For FY 2019-2020, SMC BHRS providers reported a total of 13,023 attendees at all outreach events. This number increased significantly from last year where there were 5,417 outreach attendees. The increase is mainly observed in the NCOC collaborative. In 2019-2020, the total number of NCOC increased significantly due to COVID-19 pandemic. The COVID-19 regional stay-at-home order was issued March 13 and services provided from March to June 2020 showed an increase in outreach. Of these, 813 attendees were reached through individual outreach events and 12,210 attendees were reached across 252 group outreach events. There were 12,506 NCOC attendees and 517 EPAPMHO attendees.

Demographics of outreach attendees

NCOC

NCOC's most common age group among outreach attendees was adults (44%). Over half of the attendees were female (62%). The four largest racial/ethnic groups were Mexican (18%), White (16%), Hawaiian (12%), and Filipino (9%). There is a positive shift in the number of Mexican attendees attending outreach events. The percentage of Mexican attendees attending outreach events increased from 8% to 18% over the last two years. Of those reporting special population status (i.e., homeless, at risk for homelessness, vision impaired, hearing impaired, veterans), 52% had other disabilities.

EPAPMHO

EPAPMHO outreach attendees were largely adults (57%). Over half of the attendees were female (58%). The greatest proportion of attendees were Hawaiian (31%), followed by Mexican (23%). The percentage of Hawaiian attendees significantly increased from 2.3% to 31% over the last two years. Of those reporting special population status, 35% were at risk of being homeless and 30% were homeless.

Outreach event characteristics

NCOC

NCOC individual outreach events lasted from 5 to 120 minutes and lasted on average 32 minutes in FY 2019-2020. Outreach events took place primarily over the phone, or at health primary clinics and unspecified field locations. Most individual outreach events were in English (72%).

NCOC group outreach events lasted from 1 to 240 minutes and were on average 110 minutes in length in FY 2019-2020. Of the 246 group outreach events, most were conducted in other community locations and at home. Other community locations included places such as Boys and Girls club, community centers, Daly City Youth Health Center, health fairs, fair grounds, malls, and public parks. Most were conducted in English (99%).

NCOC individual outreach events resulted in mental health referrals (67%) and substance abuse referrals (17%) in FY 2019-2020. Providers made 1102 referrals to 327 NCOC individual outreach attendees. Of the different referral types, the top four types of referrals made for attendees were in *other* category (22%), food (20%), legal (16%) and financial services (13%). *Other* referrals that were reported included obtaining referrals for advocacy resources, clothing assistance, and utility assistance.

EPAPMHO

EPAPMHO individual outreach events lasted from 10 to 60 minutes and were an average of 31 minutes in FY 2019-2020. Outreach events took place primarily over the phone or in health primary clinics, unspecified field locations, other locations, and offices. Over half were held in English (51%).

EPAPMHO group outreach events lasted from 15 to 90 minutes and were on average 55 minutes. Group outreach events primarily occurred in other community locations homes, other locations, and schools. Other community locations included places such as Boys and Girls club, community centers, Daly City Youth Health Center, health fairs, fair grounds, malls, and public parks. Sixty-two percent were conducted in Spanish.

EPAPMHO individual outreach events resulted in mental health referrals (28%) and substance abuse referrals (37%) in FY 2019-2020. Providers made 563 referrals to 311 attendees. Of the

different referral types, the top three types of referrals made for attendees were for medical care (34%), housing (32%), and food (11%).

Recommendations

Recommendations based on FY 2019-2020 data fall under two umbrellas: those aimed at enhancing outreach and those to improve data collection.

Continue to conduct outreach in languages other than English. This past reporting year showed an increase in outreach to diverse populations. The Hawaiian attendees at these outreach events increased over the last two years in the NCOC from 2% to 31%. Outreach to residents speaking another language increased from 21% (942 activities) to 30% (1,066 outreach activities). Outreach conducted were in multiple languages (<1% in Tagalog, 2% in Samoan, 2% in Tongan, 5% in Cantonese, 6% in Mandarin, and 13% in Spanish). However, certain languages that are preferred such as Samoan (preferred: 14%) have limited outreach (used: 2%). By increasing the number of languages offered, this will help ensure individuals who do not speak English are able to access services.

Make other/unspecified categories clearer. Outreach staff have made an effort to provide better data collection and minimize missing data. For example, the reported percentage of outreach in “Other Community Location” decreased for individual outreach in the EPAPMHO over the last two years from 3% to 0%. A next step will be to further work at revising certain variables such as the number of participants who access social services. In this year’s finding, the percentage of individuals who reported being referred to “other social services” made up 22% of referrals for the NCOC collaborative for FY 2019-2020. This percentage remained the same compared to last year. This speaks to the need to expand upon the categories for this question.

Introduction

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), to provide funding to Counties for mental health services by imposing a 1% tax on personal income in excess of \$1 million. Activities funded by MHSA are grouped into components, and the Community Services and Supports (CSS) component was created to provide direct services to individuals with severe mental illness. CSS is allotted 80% of MHSA funding for services focused on recovery and resilience while providing clients and families an integrated service experience. CSS has three service categories: 1) Full Service Partnerships; 2) General System Development Funds; and 3) Outreach and Engagement.

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) MHSA Outreach and Engagement strategy increases access and improves linkages to behavioral health services for underserved communities. Strategies include community outreach collaboratives, pre-crisis response, and primary care-based efforts. SMC BHRS has seen a consistent increase in representation of underserved communities in its system since the strategies were deployed.

In particular, community outreach collaboratives funded by MHSA include the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO), which targets at-risk youth, transition-age youth and underserved adults (Latino, African American, Pacific Islander, and Lesbian, Gay, Bisexual, Transgender, and Questioning [LGBTQ]) in East Palo Alto, and the North County Outreach Collaborative (NCOC), which targets rural and/or ethnic communities (Chinese, Filipino, Latino, Pacific Islander, and LGBTQ) in the North County region including Pacifica. These collaboratives provide advocacy, systems change, resident engagement, expansion of local resources, education and outreach to decrease stigma related to mental illness and substance abuse. They work to increase awareness of, and access and linkages to, culturally and linguistically competent behavioral health, Medi-Cal and other public health services, and social services. They participate in a referral process to ensure those in need receive appropriate services. Finally, they promote and facilitate resident input into the development of MHSA funded services and other BHRS program initiatives.

Providers reported fiscal year (FY) 2019-2020 (July 1, 2019 through June 30, 2020) outreach data using an electronic form first implemented in quarter four (Q4) of FY 2014-2015. The information collected is self-reported by the attendee. AIR created this form based on interviews with San Mateo County staff and focus groups with providers. This collective effort sought to improve the data collection process so that SMC BHRS and its providers could better understand the reach of their outreach efforts. After data are entered, AIR cleans the data and calculates aggregated counts and percentages to describe outreach activities. Please see Appendix I for information about calculations.

This report focuses on EPAPMHO and NCOC's outreach events that occurred during FY 2019-2020 and outreach event attendees. We also present historical data from FY 2014-2015, FY 2015-2016, FY 2016-2017, FY 2017-2018, and FY 2018-2019 to show how outreach has changed over time. Counts of attendees do not necessarily represent unique individuals because a

person may have been part of more than one outreach event, taken part in both individual and group outreach events, and/or interacted with different providers. Provider summaries are also available to help SMC BHRS and its providers better understand each individual provider’s outreach efforts. Please refer to Appendix A to I.

Overall Outreach

During FY 2019-2020, SMC BHRS outreach providers reported a total of 13,023 attendees at outreach events—813 attendees reached through individual outreach events and 12,210 attendees reached across 252 group outreach events. Each individual outreach event occurs with a single attendee. Group outreach events include multiple attendees. The count of attendees is not necessarily unique because a person may have been a part of multiple individual or group outreach events.

Table 1 shows outreach attendees, by collaborative, provider, and event type (i.e., individual or group) for FY 2019-2020.

Table 1. Outreach Attendees, by Collaborative, Provider, and Event Type, FY 2019-2020

Provider Organization	Number of Individual Outreach Attendees	Number of Attendees at Group Outreach Events	Total Attendees Reported Across All Events
North County Outreach Collaborative (NCOC)			
Asian American Recovery Services	304	594	898
Daly City Peninsula Partnership Collaborative	0	5999	5999
Daly City Youth Health Center	23	2689	2712
Pacifica Collaborative	18	2453	2471
Star Vista	118	308	426
Total (NCOC)	463	12,043	12,506
East Palo Alto Partnership for Mental Health Outreach (EPAPMHO)			
Anamatangi Polynesian voices*	73	167	240
El Concilio	81	0	81
Free at Last	196	0	196
Total (EPAPMHO)	350	167	517
Total (NCOC and EPAPMHO)	813	12,210	13,023

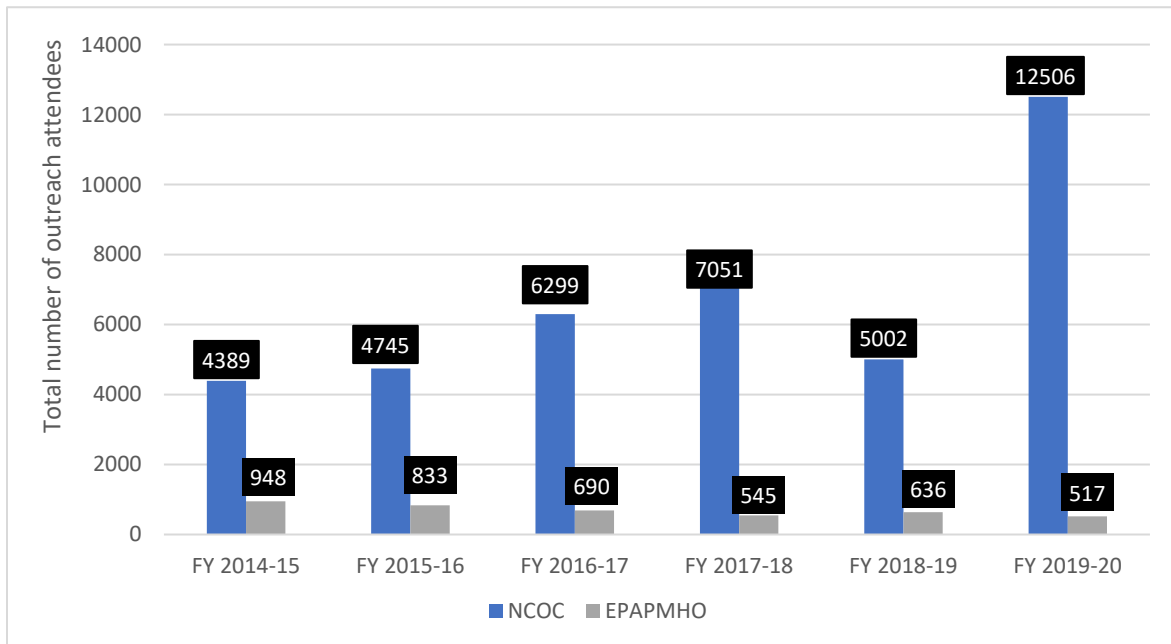
*Note: Multicultural Counseling and Education Services of the Bay Area (MCESBA) changed their name to Anamatangi Polynesian voices.

It is expected that the NCOC would serve a much larger proportion of the Outreach Collaborative effort as it serves the entire north region of San Mateo County (estimated population 140,149) including the cities of Colma, Daly City, and Pacifica, which is five times the population of the city of East Palo Alto, served by the EPAPMHO. The north region also spans a

much wider geographical area, making group events (vs. individual outreach) such as community wide fairs much more feasible and relevant. In contrast, East Palo Alto spans 2.5 square miles making an individual approach to outreach more achievable.

The total number of NCOC outreach attendees showed an increase over time from 2018-2020, with FY 2018-2019 being the exception. In 2019-2020, the total number of NCOC increased significantly due to COVID-19 pandemic. The COVID-19 regional stay-at-home order was issued March 16 and services provided from March to June 2020 showed an increase in outreach. Daly City Peninsula Partnership Collaborative and Daly City Youth Health Center also both do food distribution and outreach and these services were highly used during COVID-19 pandemic. The total number of EPAPMHO outreach attendees decreased in FY 2014-2018 but then increased again from FY 2018-2019 to decrease again in FY 2019-2020 (**Figure 1**).

Figure 1. Total Outreach Attendees by Collaborative, FY 2014-2020



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

Figures 2a and 2b presents the top five race/ethnicity groups served by individual or group outreach in each year for FY 2014-2015, FY 2015-2016, FY 2016-2017, FY 2017-2018, FY 2018-2019, and FY 2019-2020 within each collaborative. A table with the entire breakdown of race/ethnicity groups from FY 2014 to FY 2020 is presented later in the Appendix J.

Figure 2a. Percentage of Race/Ethnicity Groups Served by NCOC, FY 2014-2015 to FY 2019-2020

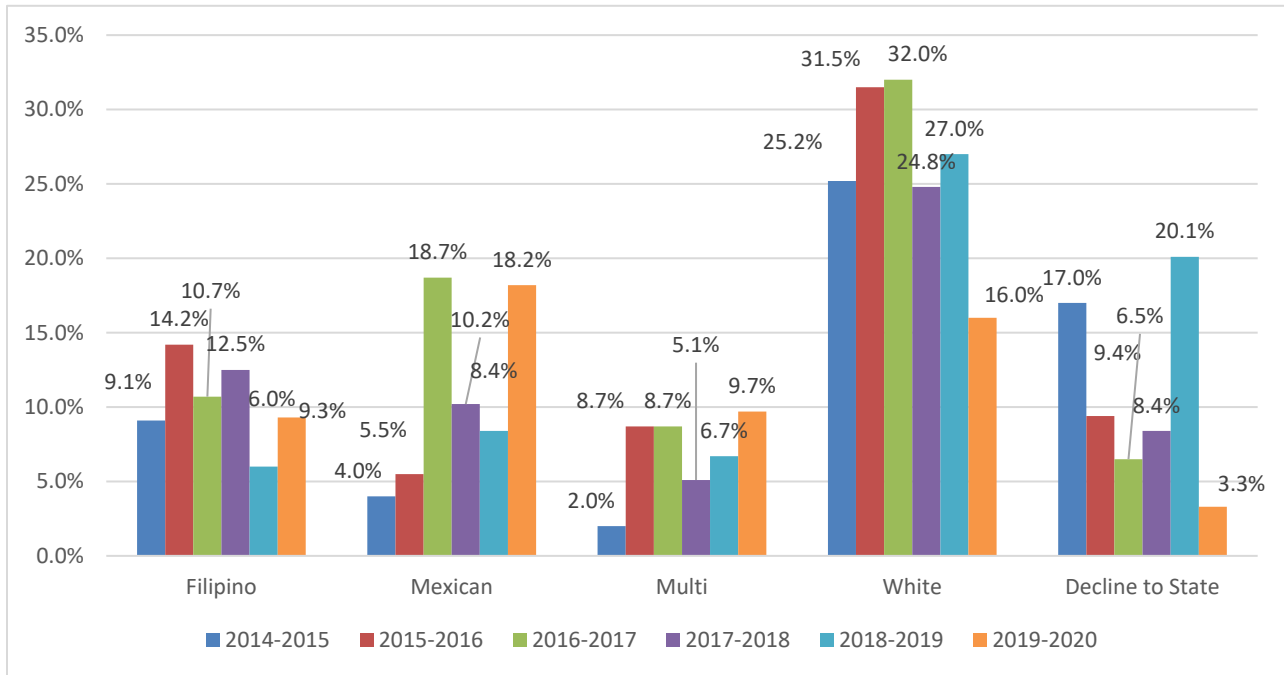
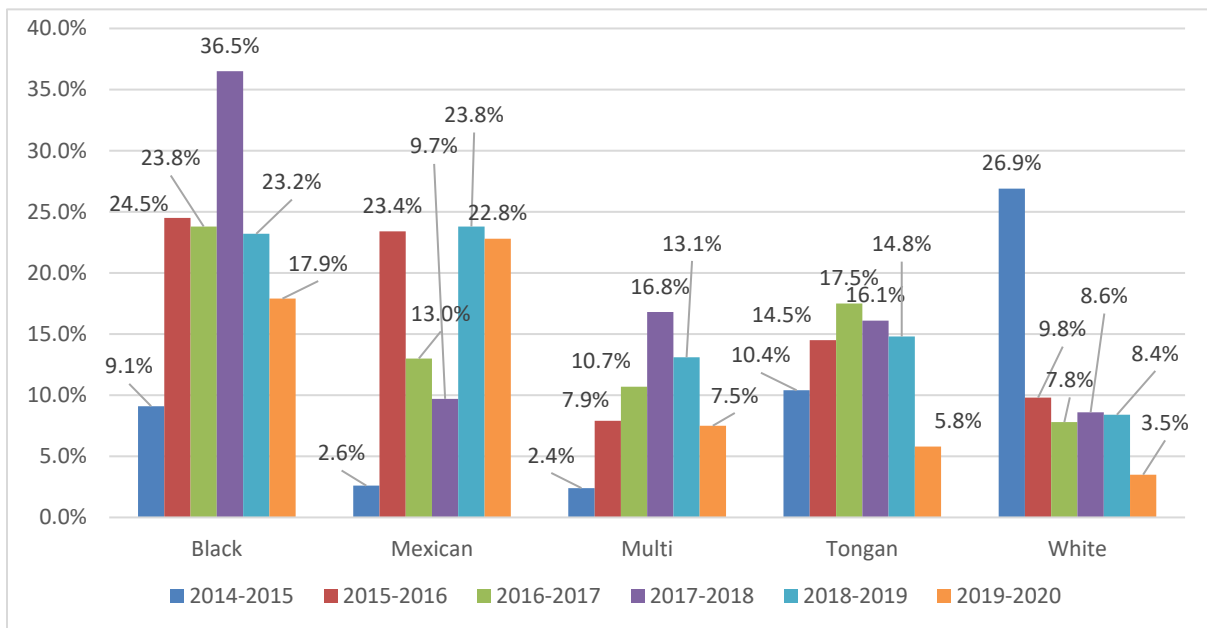


Figure 2b. Percentage of Race/Ethnicity Groups served by EPAMHO, FY 2014-2015 to FY 2019-2020



The NCOC has seen a fluctuation in outreach numbers overall and there are a few key differences in the racial/ethnic demographics of the outreach attendees. Outreach to Filipino, Mexican, and multi-racial attendees increased from FY 2018-2019 to FY 2019-2020. However, outreach to White attendees and those who declined to state their race/ethnicity decreased from FY 2018-2019 to FY 2019-2020.

The EPAPMHO has also seen a decrease in outreach numbers overall and there are a few key differences in the racial/ethnic demographics of the outreach attendees. In particular, from FY 2018-2019 to FY 2019-2020, the Black, multi-racial, Tongan, and White populations reported an increase by five percentage points, six percentage points, nine percentage points, and five percentage points, respectively. The Mexican population had a one-point percentage decrease. As a special note, the percentage of Hawaiian attendees, not shown in the Figure 2b, increased significantly in FY 2019-2020 to 31.5% compared to FY 2018-2019 (2.3%), FY 2017-2018 (0.9%), FY 2016-2017 (0.3%), FY 2015-2016 (0.8%), and FY 2014-2015 (1.0%).

Figures 3a and 3b present the percentages of the mental health and substance abuse referrals made as a result of attending the outreach events by collaborative for FY 2014-2015, FY 2015-2016, FY 2016-2017, FY 2017-2018, FY 2018-2019, and 2019-2020.

Figure 3a. Percentage of Mental Health/Substance Abuse referrals by NCOC, FY 2014-2015 to FY 2019-2020

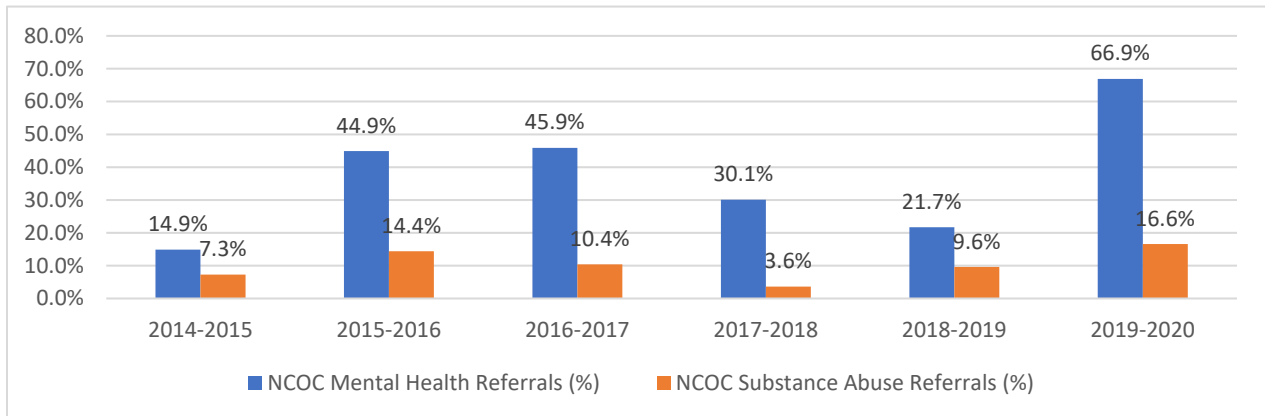
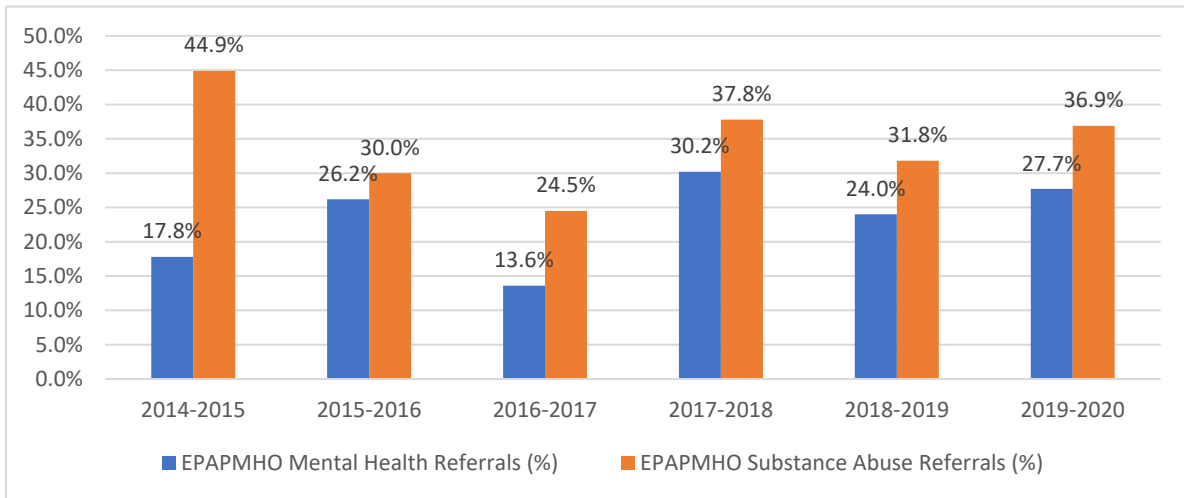


Figure 3b. Percentage of Mental Health/Substance Abuse referrals by EPAPMHO, FY 2014-2015 to FY 2019-2020



Mental health referrals in the NCOC collaborative has fluctuated over the years. In FY 2019-2020, mental health referrals increased significantly by 45 percentage points. Substance abuse referrals also increased in FY 2019-2020 by ten percentage points.

A similar pattern in mental health and substance referrals between FY 2018-2019 to FY 2019-2020 is observed in the EPAPMHO collaborative. Mental health referrals increased by three percentage points in FY 2019-2020. Substance abuse referrals increased by five percentage points in FY 2019-2020.

Figures 4a and Figure 4b present referrals to social services in FY 2014-2015, FY 2015-2016, FY 2016-2017, FY 2017-2018, FY 2018-2019, and 2019-2020 by each collaborative. The percentages represent percent of total attendee referrals to social services.

Figure 4a. Referrals to Social Services made by NCOC, FY 2014-2015 to FY 2019-2020

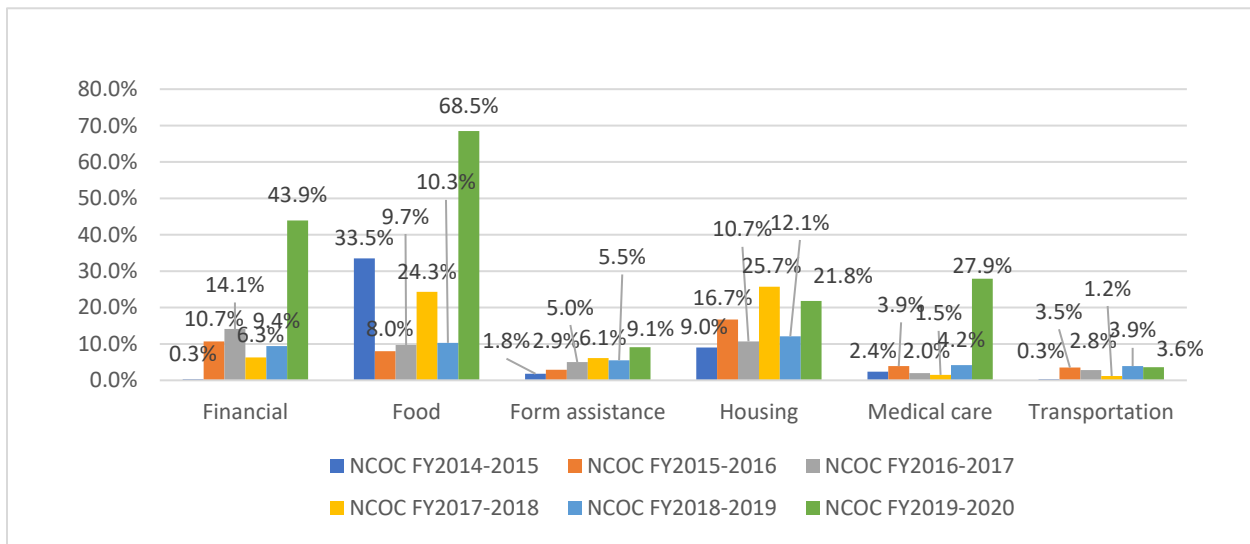
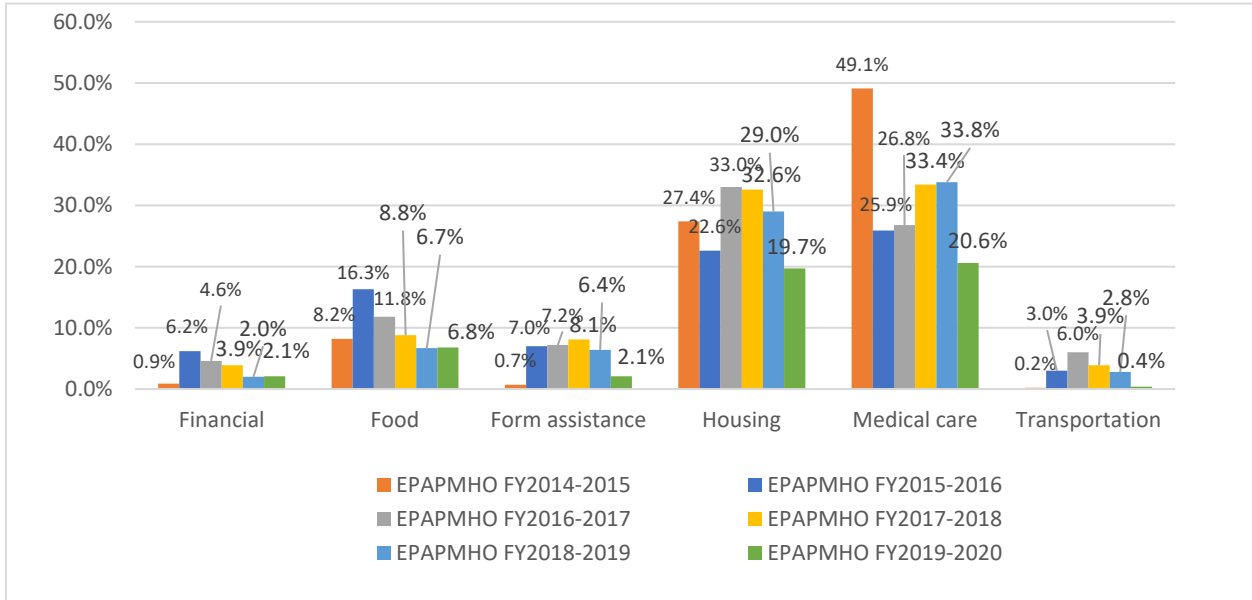


Figure 4b. Referrals to Social Services made by EPAPMHO, FY 2014-2015 to FY 2019-2020



- NCOC had 1,101 referrals in FY 2019-2020 to social services, as compared to 330 referrals in FY 2018-2019 and 592 referrals in FY 2017-2018 and 496 referrals in FY 2016-2017 and 485 referrals in FY 2015-2016 and 379 referrals in FY 2014-2015. In FY 2019-2020 EPAPMHO had 563 referrals to social services as compared to 921 in FY 2018-2019 and 727 in FY 2017-2018 referrals and 652 referrals in FY 2016-2017 and 1433 referrals in FY 2015-2016 and 438 referrals in FY 2014-2015.
- In FY 2019-2020, NCOC had a decrease in transportation compared to the prior year, going from 3.9% to 3.6%. There was an increase in percentage of referrals to financial (35 percentage points), food (58 percentage points), form assistance (4 percentage points), housing (10 percentage points), and medical care (24 percentage points) over the last two years.
- In FY 2019-2020, EPAPMHO had decreases in the percentage of referrals to form assistance (4 percentage points), housing (9 percentage points), medical care (13 percentage points), and transportation (2 percentage points) referrals. Percent of attendee referrals for financial and food increased by less than one percentage point.

The next two sections discuss the recipient and event characteristics in FY 2019-2020 for the NCOC and EPAPMHO collaboratives, respectively.

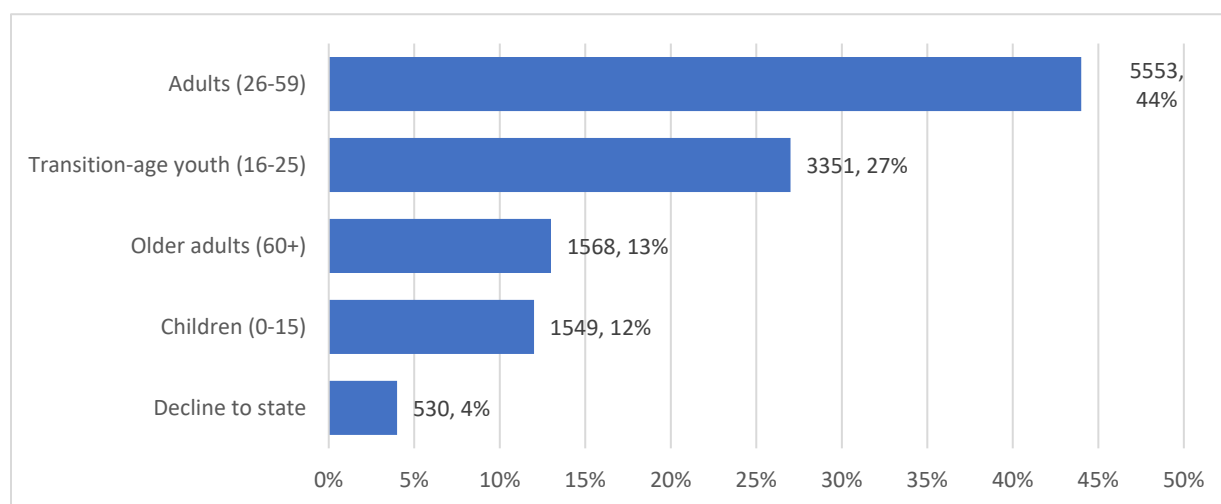
NCOC

In FY 2019-2020, there were 12,506 attendees at individual and group outreach events across the five provider organizations in the NCOC.

Demographics

Age: Attendees across NCOC outreach events were adults (26-59 years, 44%), transition-age youth (16-25 years, 27%), older adults (60 years or older, 13%), and children (0-15 years, 12%) in FY 2019-2020. Four percent of attendees declined to state their age. See **Figure 5** for the number and percentage of total outreach attendees representing each reported age group.

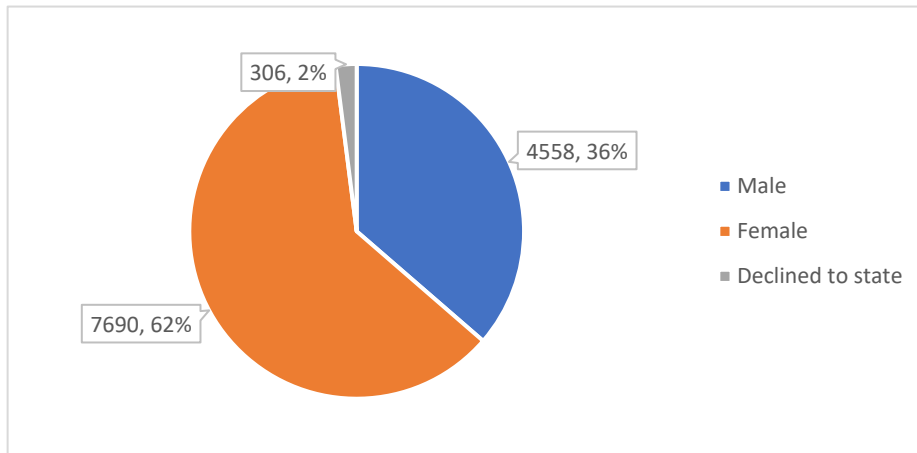
Figure 5. Age of Total Outreach Attendees Served by NCOC, FY 2019-2020



Note: Percentages may not sum to 100% because of rounding. The denominator for age percent is the sum of all age data reported. Total count for age reported may exceed the total number of attendees, because some providers may have reported individuals in two or more age groups, leading to extra counts in some cases for the group outreach attendees. The denominator for age percent is the sum of all age data reported.

Sex at birth: In FY 2019-2020, attendees across NCOC events were females (62%), males (36%). Two percent of attendees declined to state their sex at outreach events. See **Figure 6** for the number and percentage of outreach attendees reporting each sex type.

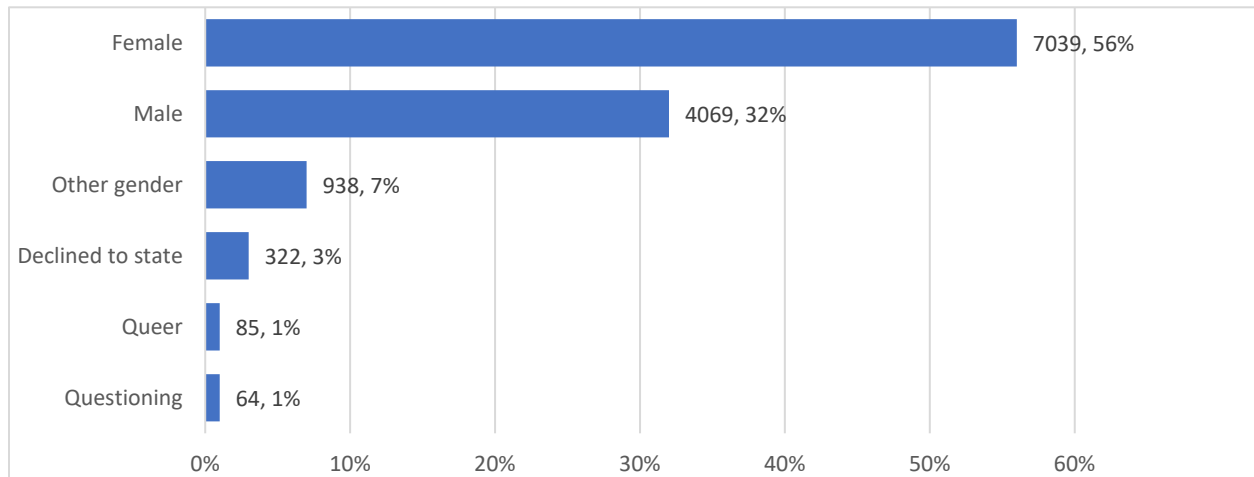
Figure 6. Sex at Birth of Outreach Attendees Served By NCOC, FY 2019-2020



Note: Percentages may not sum to 100% because of rounding. ** Total count for sex reported may exceed the total number of attendees, because some providers may have reported individuals in two or more sex groups, leading to extra counts in some cases for the group outreach attendees. The denominator for sex percent is the sum of all sex data reported.

Gender: Attendees in FY 2019-2020 identified themselves as female (56%), male (32%), other gender (7%), queer (1%), and questioning (1%). Less than 1 percent identified themselves as female-to-male transgender, male-to-female transgender, and indigenous. Three percent declined to state their gender. See **Figure 7** for the number and percentage of attendees reporting each gender type.

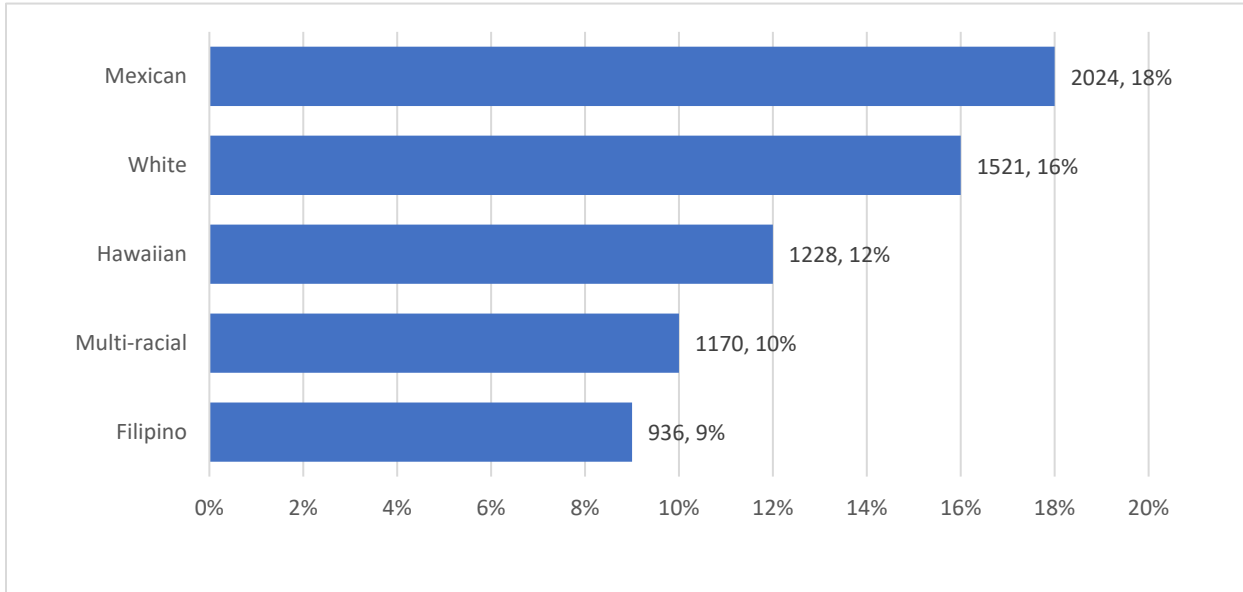
Figure 7. Gender of Outreach Attendees Served By NCOC, FY 2019-2020



Note: Percentages may not sum to 100% because of rounding. ** Total count for gender may exceed the total number of attendees, because some providers may have reported individuals in two or more gender groups, leading to extra counts in some cases. The denominator for gender percent is the sum of all gender data reported.

Race and ethnicity: In FY 2019-2020, the five largest racial/ethnic groups represented by all NCOC attendees were Mexican (18%), White (16%), Hawaiian (12%), and Filipino (9%). Ten percent of the attendees were multi-racial. See **Figure 8** for the number and percentage of attendees representing each reported racial/ethnic group.

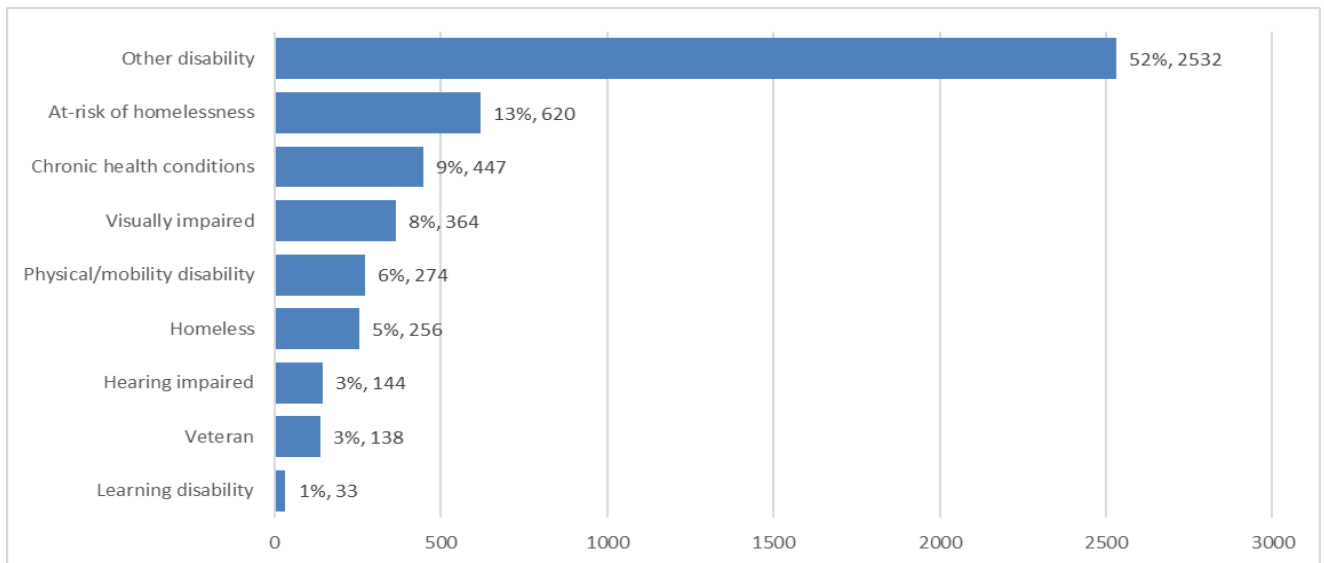
Figure 8. Race and Ethnicity of Outreach Attendees Served By NCOC, FY 2019-2020



Note: The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported. ** Total count for race/ethnicity may exceed the total number of attendees, because some providers may have reported individuals in two or more race/ethnicity groups, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special populations: Of the attendees indicating they were part of special populations, 52% had other disabilities, 13% were at risk for homelessness, 9% had chronic health conditions, 8% were visually impaired, 6% had a physical/mobility disability, 5% were homeless, 3% were hearing impaired, 3% were veterans, and 1% had a learning disability. Less than 1% had dementia and developmental disability. Refer to **Figure 9** for the number and percentage of attendees representing each special population in FY 2019-2020.

Figure 9. Special Populations Served By NCOC, FY 2019-2020



Note: Attendees could be included in more than one special population. Percentages may not sum to 100% because of rounding. The denominator for special population group is the sum of all special population data reported.

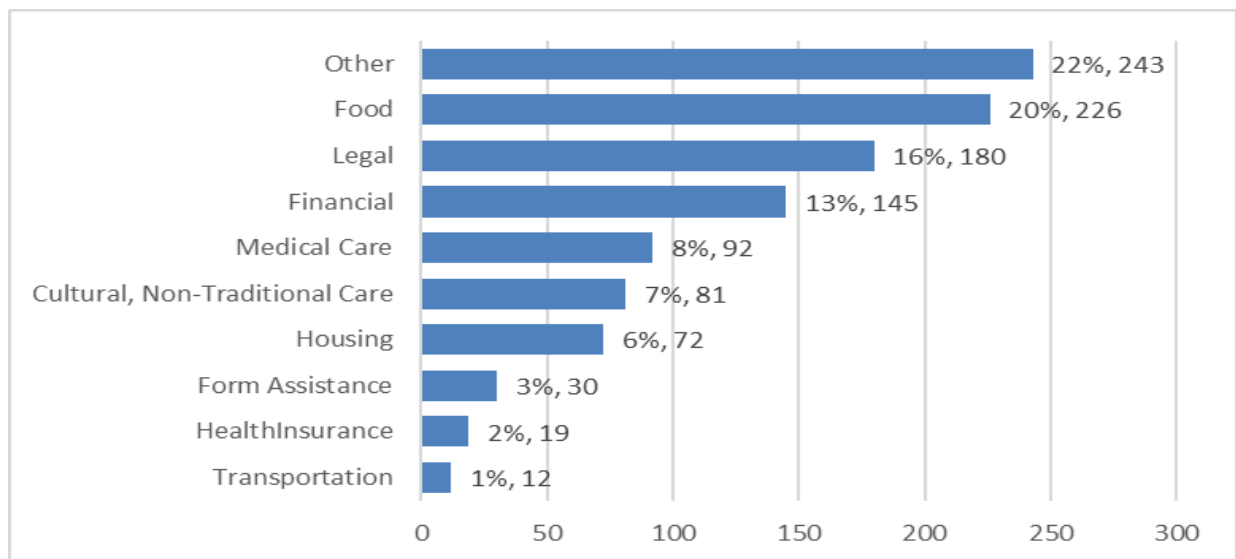
Additional outreach characteristics (individual outreach events only)

Previous Contact: Twenty-two percent of individual outreach events were conducted with attendees who had a previous outreach contact with NCOC.

Mental Health/Substance Abuse Referrals: NCOC individual outreach events resulted in mental health referrals (67%) and substance abuse referrals (17%) in FY 2019-2020.

Referrals to Social Services: Providers made 1102 referrals to 327 NCOC individual outreach attendees. Of the different referral types, the top four types of referrals made for attendees were in other category (22%), food (20%), legal (16%) and financial services (13%). Less than one percent were referred to emergency protective services. Other referrals that were reported included obtaining referrals for advocacy resources, clothing assistance, and utility assistance. In **Figure 10**, we summarize the number and percentage of attendees receiving a given type of referral in FY 2019-2020.

Figure 10. Referrals to Social Services, FY 2019-2020



Note: Percentages may not sum to 100% because of rounding. Attendees can choose more than one category. The denominator for referral group is the sum of all referral data reported.

Event characteristics

Location: NCOC individual outreach events primarily occurred over the phone (37%) or in health primary clinics (22%), unspecified field locations (17%), **other locations** (13%), and offices (11%) in FY 2019-2020. Less than one percent of attendees reported attending outreach events at non-traditional locations. Group outreach events primarily occurred in other community locations (56%), homes (24%), schools (10%), and **other locations** (9%), Less than

1% of attendees reported attending outreach events at hospitals or skilled nursing facilities. Other community locations included places such as Boys and Girls club, community centers, Daly City Youth Health Center, health fairs, fair grounds, malls, and public parks. The **other location** category includes all the locations that are reported that make up less than 10 percent of the total locations reported. **Figures 11 and 12** present individual and group outreach event locations in FY 2019-2020.

Figure 11. Locations of NCOC Individual Outreach Events, FY 2019-2020

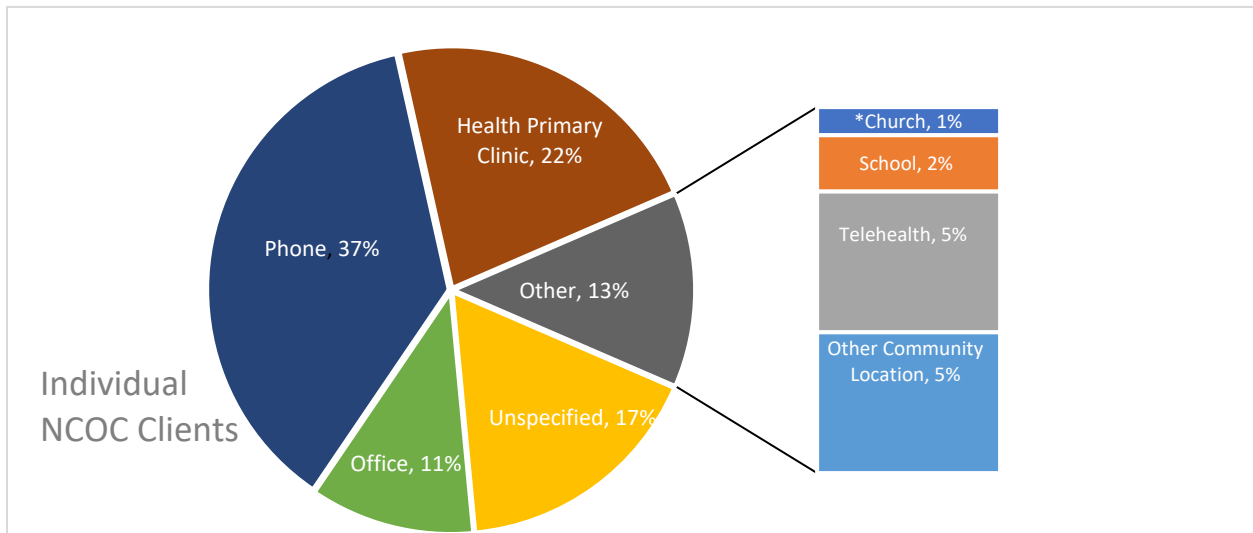
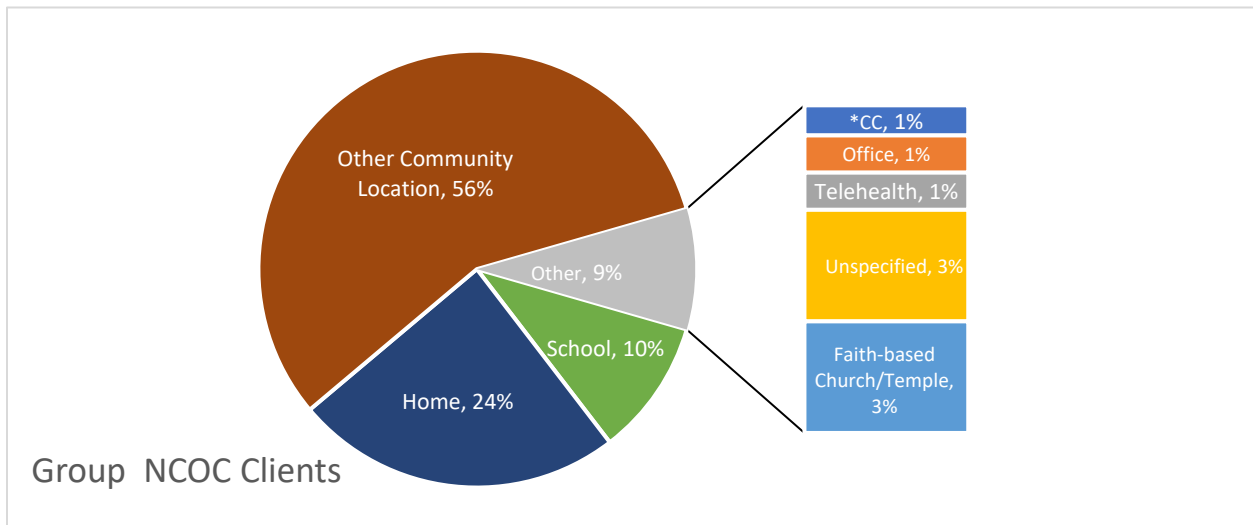


Figure 12. Locations of NCOC Group Outreach Events, FY 2019-2020



Note: CC = Age-Specific Community Center, Church = Faith based Church/Temple, Unspecified = Field (unspecified). Percentages may not sum to 100% because of rounding. Attendees can choose more than one category. The denominator for location percent is the sum of all location data reported.

Length of contact: For FY 2019-2020, the individual outreach events lasted from 5 to 120 minutes and lasted on average 32 minutes. The average length of NCOC group outreach events ranged from 1 to 240 minutes and lasted 110 minutes on average.

Language used: NCOC individual outreach events were conducted in English (72%), Mandarin (15%), Cantonese (11%), Spanish (1%), Tagalog (<1%), Tongan (<1%), and other languages (<1%) in FY 2019-2020. NCOC group outreach events were conducted in English (99%), Spanish (1%), and Tagalog (<1%) in FY 2019-2020.

Preferred language: NCOC individual outreach attendees preferred English (60%), Mandarin (15%), Cantonese (11%), Samoan (5%), Tongan (4%), Spanish (3%), and Tagalog (2%). One individual stated that they preferred to use another language. NCOC group outreach attendees preferred English (77%), Samoan (14%), Tagalog (3%), Cantonese (3%), Spanish (2%), Mandarin (1%), and Tongan (<1%). **Figures 13 and 14** present breakdowns of preferred languages at individual and group outreach events in FY 2018-2019.

Figure 13. Preferred Languages for NCOC Individual Outreach Attendees, FY 2019-2020

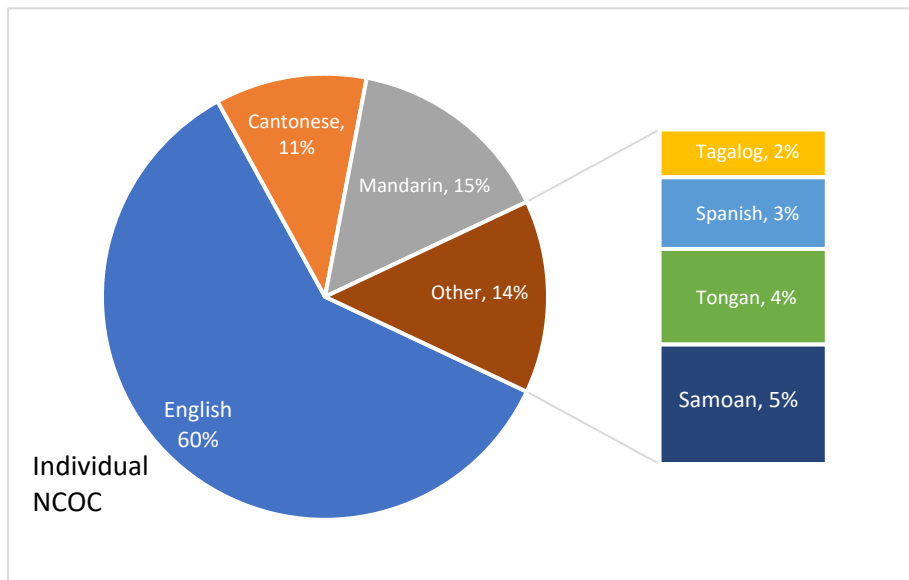
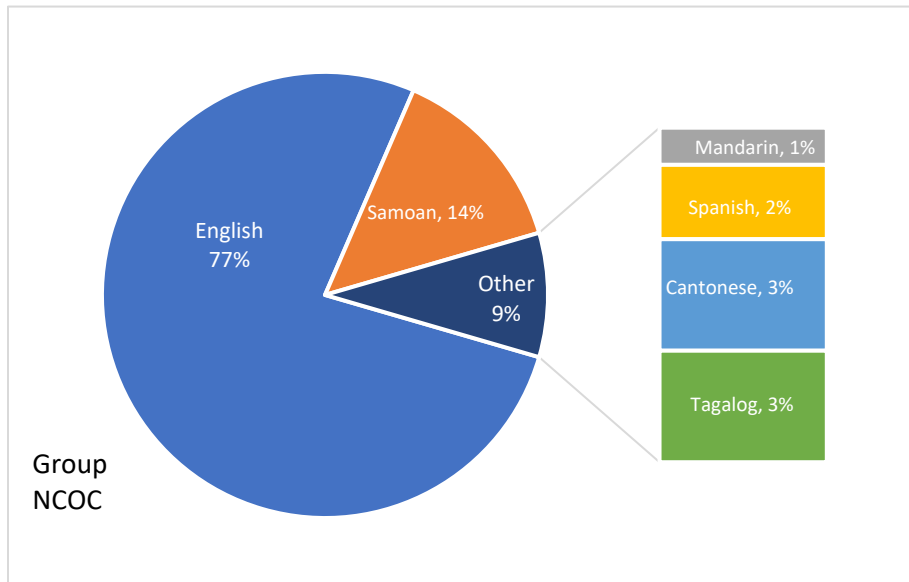


Figure 14. Preferred Languages for NCOC Group Outreach Attendees, FY 2019-2020



Note: Percentages may not sum to 100% because of rounding. The denominator for preferred language percent is the sum of all preferred language data reported.

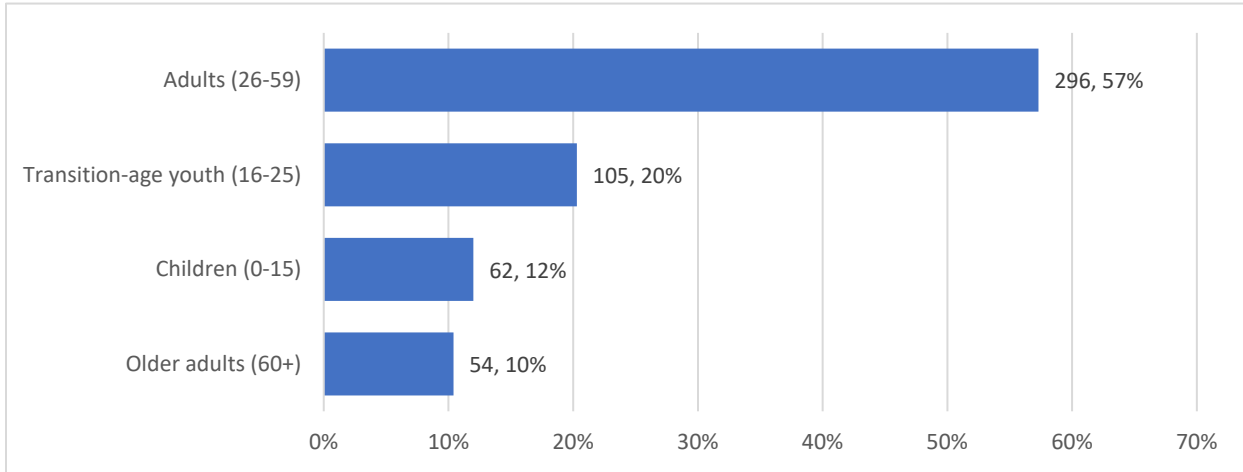
EPAPMHO

In FY 2019-2020, there were 417 attendees at individual and group outreach events across the three provider organizations in the EPAPMHO.

Demographics

Age: EPAPMHO individual and group outreach attendees were adults (26-59 years, 57%), transition-age youth (16-25 years, 20%), children (0-15 years, 12%), and older adults (60+ years or older, 10%) in FY 2019-2020. See **Figure 15** for the number and percentage of outreach attendees representing each reported age group.

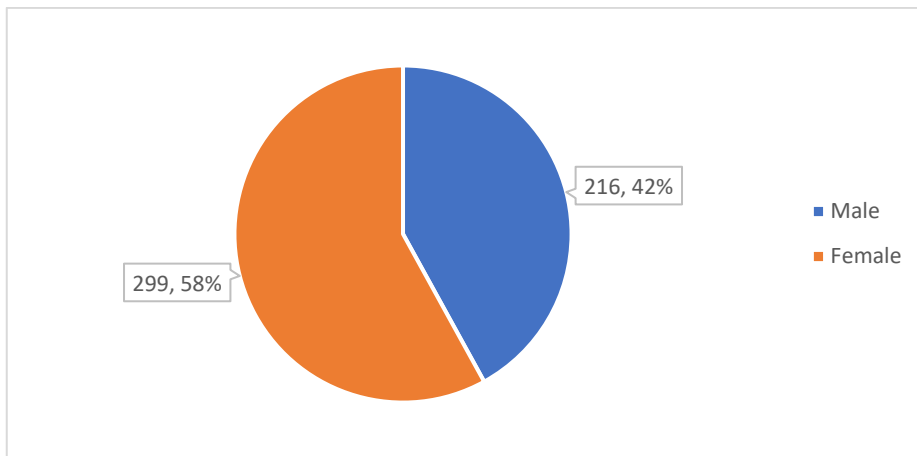
Figure 15. Age of Outreach Attendees Served By EPAPMHO, FY 2019-2020



Note: Percentages may not sum to 100% because of rounding. The denominator for age percent is the sum of all age data reported.

Sex at birth: Attendees across EPAPMHO outreach events were male (42%), female (58%), and less than one percent declined to state their sex at birth in FY 2019-2020. See **Figure 16** for the number and percentage of outreach attendees representing each reported sex.

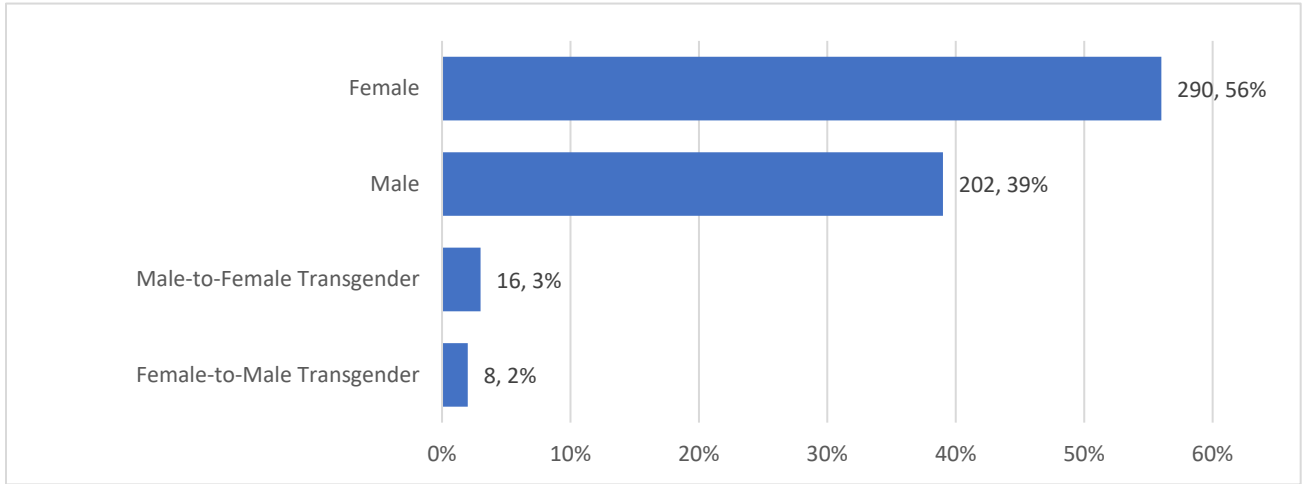
Figure 16. Sex at Birth of Outreach Attendees Served By EPAPMHO, FY 2019-2020



Note: Percentages may not sum to 100% because of rounding. The denominator for sex percent is the sum of all sex data reported.

Gender: Attendees across EPAPMHO individual and group outreach events identified themselves primarily as female (56%), male (39%), male-to-female transgender (3%), and female-to-male transgender (2%) in FY 2019-2020. See **Figure 17** for the number and percentage of individual and group outreach attendees representing each reported gender.

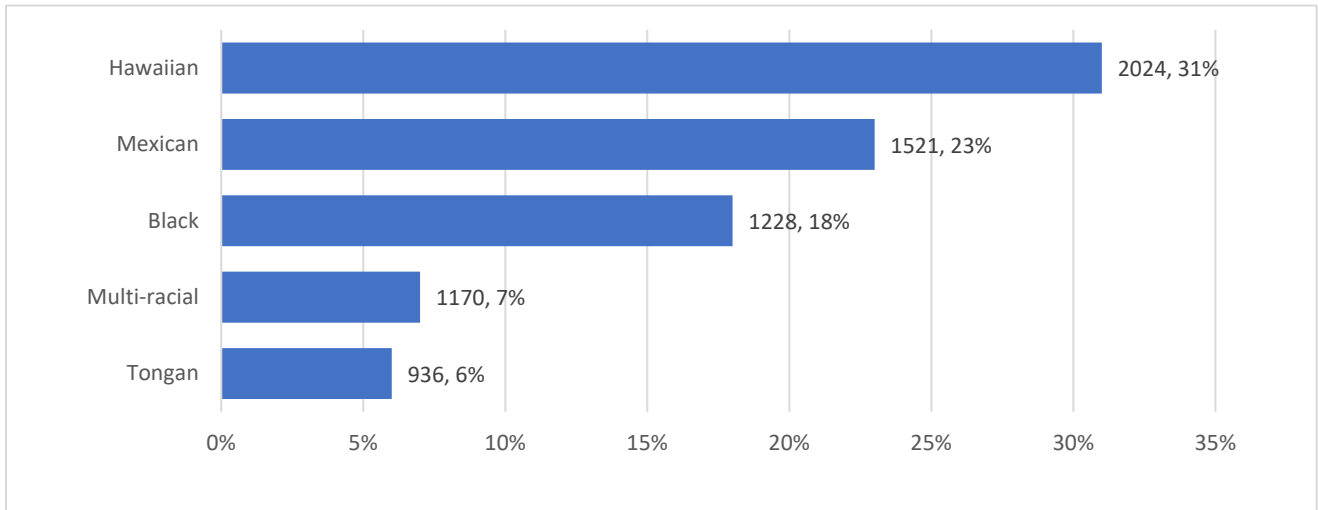
Figure 17. Gender of Outreach Attendees Served By EPAPMHO, FY 2019-2020



Note: Percentages may not sum to 100% because of rounding. ** Total count for gender may exceed the total number of attendees, because some providers may have reported individuals in two or more gender groups, leading to extra counts in some cases. The denominator for gender percent is the sum of all gender data reported.

Race and ethnicity: In FY 2019-2020, the four largest racial/ethnic groups represented by all EPAPMHO attendees were Hawaiian (31%), Mexican (23%), Black (18%), and Tongan (6%). Seven percent of the attendees were multi-racial. See **Figure 18** for the number and percentage of attendees representing each reported racial/ethnic group.

Figure 18. Race and Ethnicity of Outreach Attendees Served By EPAPMHO, FY 2019-2020

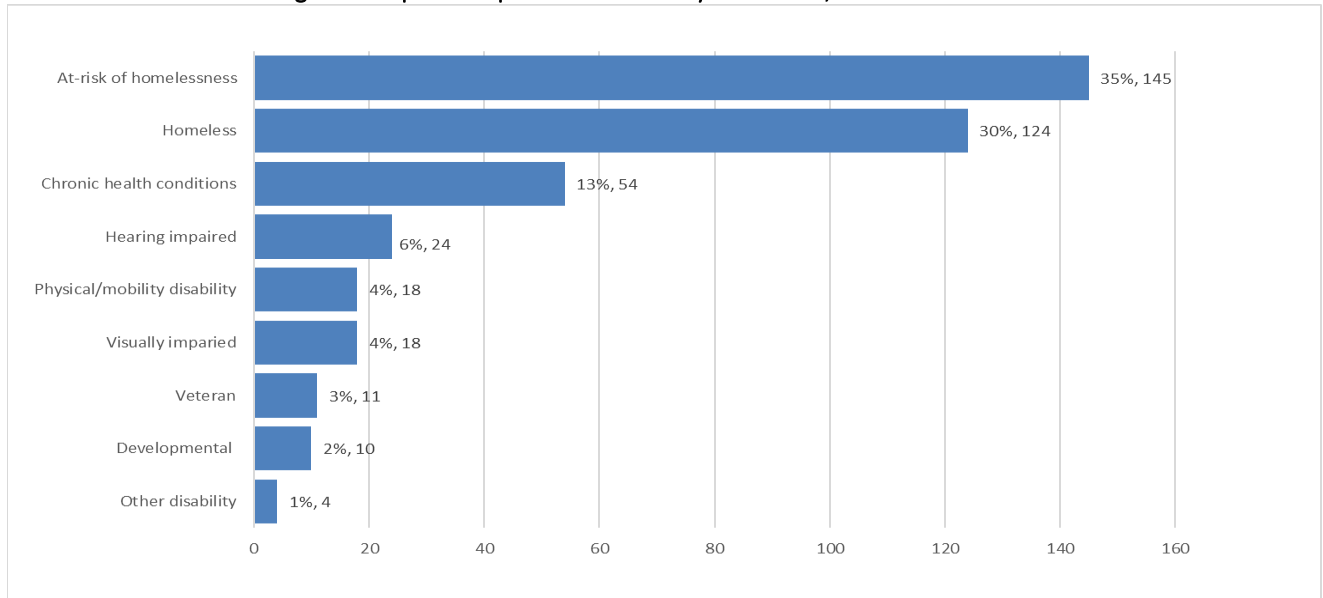


Note: Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special populations: Of the special populations, 35% were at-risk of homelessness, 30% were homeless, 13% had chronic health conditions, 6% were hearing impaired, 4% had a physical/mobility disability, 4% were visually impaired, 3% were veteran, 2% had a

developmental disability, 1% had other disabilities, less than 1% had a learning disability and dementia. Refer to **Figure 19** for the number and percentage of attendees representing each special population in FY 2019-2020.

Figure 19. Special Populations Served by EPAPMHO, FY 2019-2020



Note: Attendees could be included in more than one special population. The denominator for special population group is the sum of all special population data reported.

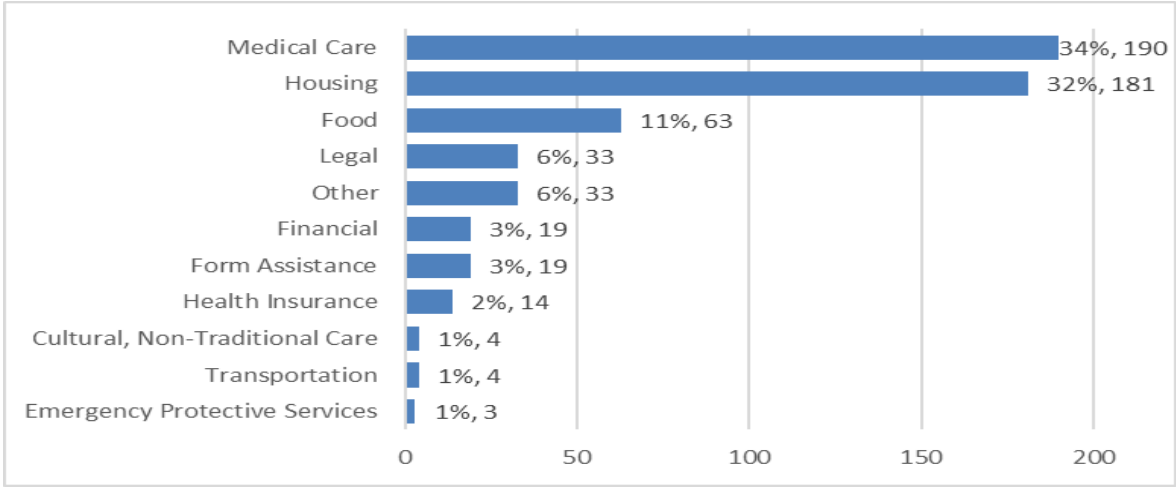
Additional outreach characteristics (individual outreach events only)

Previous Contact: Thirty-five percent of individual outreach events were conducted with attendees who had a previous outreach contact with EPAPMHO.

Mental Health/Substance Abuse Referrals: EPAPMHO individual outreach events resulted in mental health referrals (28%) and substance abuse referrals (37%) in FY 2019-2020.

Referrals to Social Services: Providers made 563 referrals to 311 EPAPMHO individual outreach attendees. Of the different referral types, the top five types of referrals made for attendees were for medical care (34%), housing (32%), food (11%), legal (6%), and other referrals (6%). Other referrals that were reported included obtaining referrals for COVID testing sites, job assistance, parenting classes, clothing assistance, and counseling resources. **Figure 20** summarizes the number and percentage of attendees receiving a given type of referral.

Figure 20. Referrals to Social Services, FY 2019-2020



Note: Percentages may not sum to 100% because of rounding. Attendees can choose more than one category. The denominator for referral group is the sum of all referral data reported.

Event characteristics

Location: EPAPMHO individual outreach events occurred in unspecified field locations (44%), offices (31%), other locations (12%). Eleven percent occurred over the phone in FY 2019-2020. Less than one percent occurred on the job or via mobile sites. EPAPMHO group outreach events occurred in offices (33%), over the phone (24%), in homes (19%), unspecified field locations (14%), and other community locations (10%). Other community locations included places such as YMCA and on zoom sessions. The **other locations** category includes all the locations that are reported that make up less than 10 percent of the total locations reported. **Figures 21 and 22** present individual outreach and group outreach event locations in FY 2019-2020.

Figure 21. Location of EPAPMHO Individual Outreach Events, FY 2019-2020

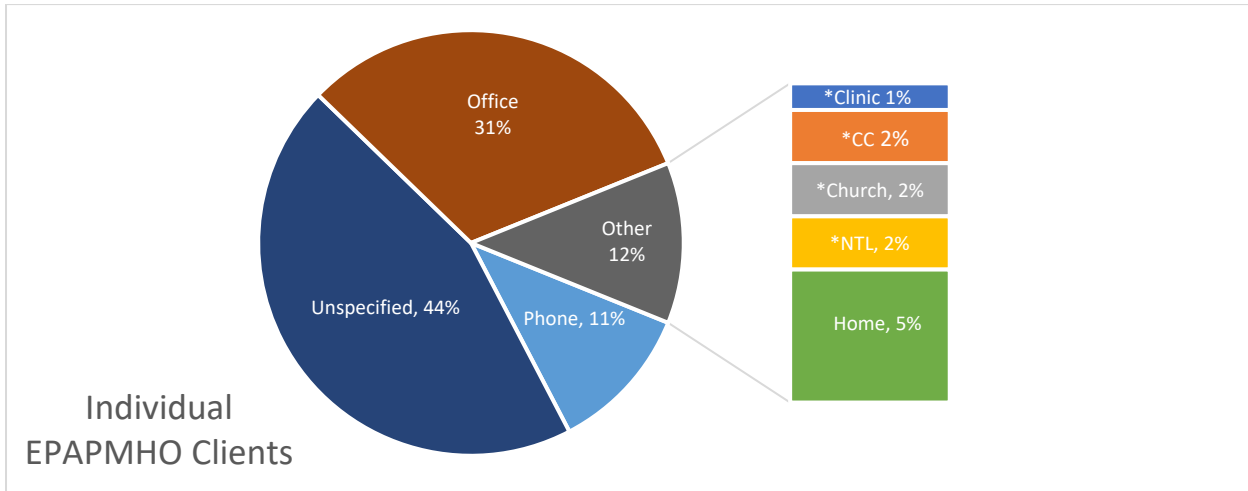
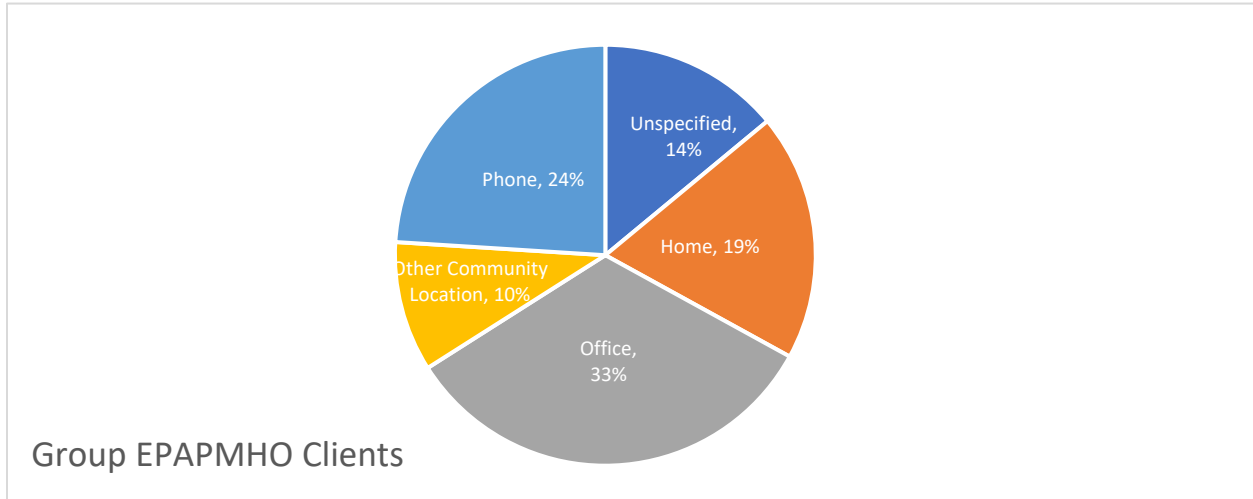


Figure 22. Location of EPAPMHO Group Outreach Events, FY 2019-2020



Note: *CC = Age-Specific Community Center, Clinic = Health/Primary Care Clinic, Church = Faith-based Church/Temple, NTL = Non-Traditional Location
Percentages may not sum to 100% because of rounding. Attendees can choose more than one category. The denominator for location percent is the sum of all location data reported.

Length of contact: In FY 2019-2020, the individual outreach events lasted from 10 to 60 minutes and were on average 31 minutes. The group outreach event lasted from 15 to 90 minutes and were on average 55 minutes.

Language used: EPAPMHO individual outreach events were conducted in English (51%), Spanish (39%), Samoan (6%), and Tongan (4%) in FY 2019-2020. Group outreach events were conducted in English (62%), Tongan (33%), and Samoan (5%) in FY 2019-2020.

Preferred language: EPAPMHO individual outreach attendees preferred English (49%), Spanish (39%), Samoan (6%), Tongan (5%), and Tagalog (1%) in FY 2019-2020. Attendees at the EPAPMHO group outreach preferred English (70%), Tongan (29%), and Samoan (1%). **Figures 23 and 24** presents breakdown of preferred languages at individual outreach events in FY 2019-2020.

Figure 23. Preferred Languages for EPAPMHO Individual Outreach Attendees, FY 2019-2020

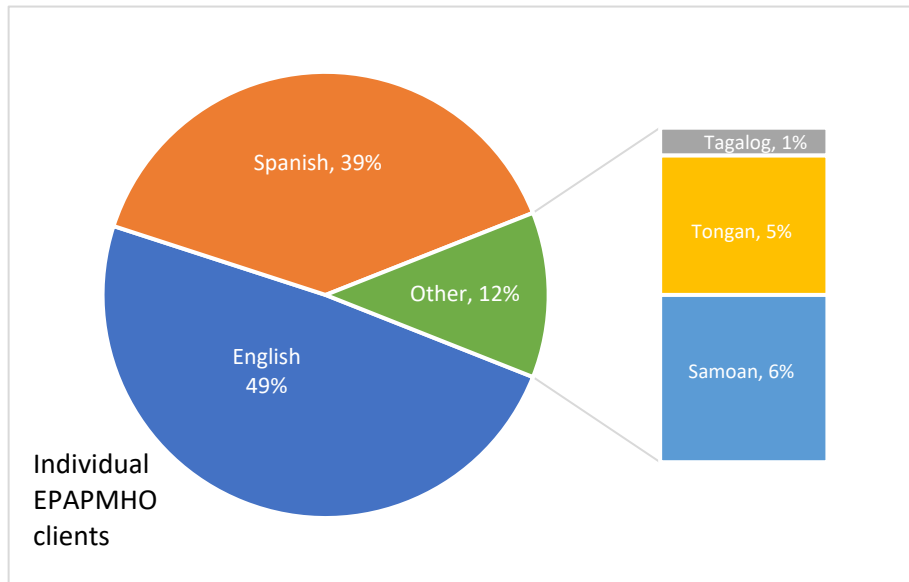
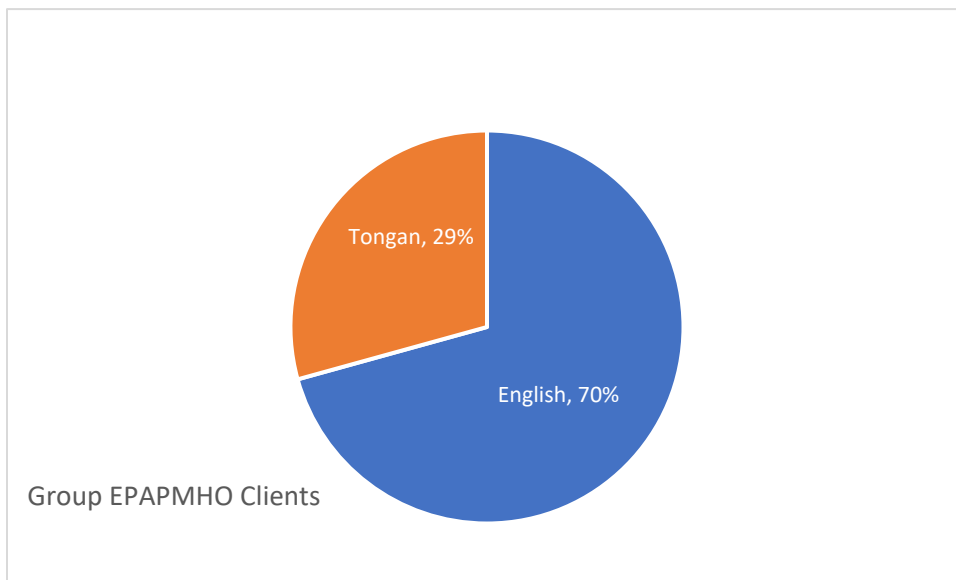


Figure 24. Preferred Languages for EPAPMHO Group Outreach Attendees, FY 2019-2020



Recommendations

We have several recommendations based on FY 2019-2020 data. These recommendations fall under two umbrellas: those aimed at enhancing outreach and those to improve data collection.

Enhance outreach

Continue to conduct outreach in languages other than English. This past reporting year showed an increase in outreach to diverse populations. The Hawaiian attendees at these outreach events increased over the last two years in the NCOC from 2% to 31%. Outreach to residents speaking another language increased from 21% (942 activities) to 30% (1,066 outreach activities). Outreach conducted were in multiple languages (<1% in Tagalog, 2% in Samoan, 2% in Tongan, 5% in Cantonese, 6% in Mandarin, and 13% in Spanish). However, certain languages that are preferred such as Samoan (preferred: 14%) have limited outreach (used: 2%). By increasing the number of languages offered, this will help ensure individuals who do not speak English are able to access services.

Improve data collection

Make other/unspecified categories clearer. Outreach staff have made an effort to provide better data collection and minimize missing data. For example, the reported percentage of outreach in “Other Community Location” decreased for individual outreach in the EPAPMHO over the last two years from 3% to 0%. A next step will be to further work at revising certain variables such as the number of participants who access social services. In this year’s finding, the percentage of individuals who reported being referred to “other social services” made up 22% of referrals for the NCOC collaborative for FY 2019-2020. This percentage remained the same compared to last year. This speaks to the need to expand upon the categories for this question.

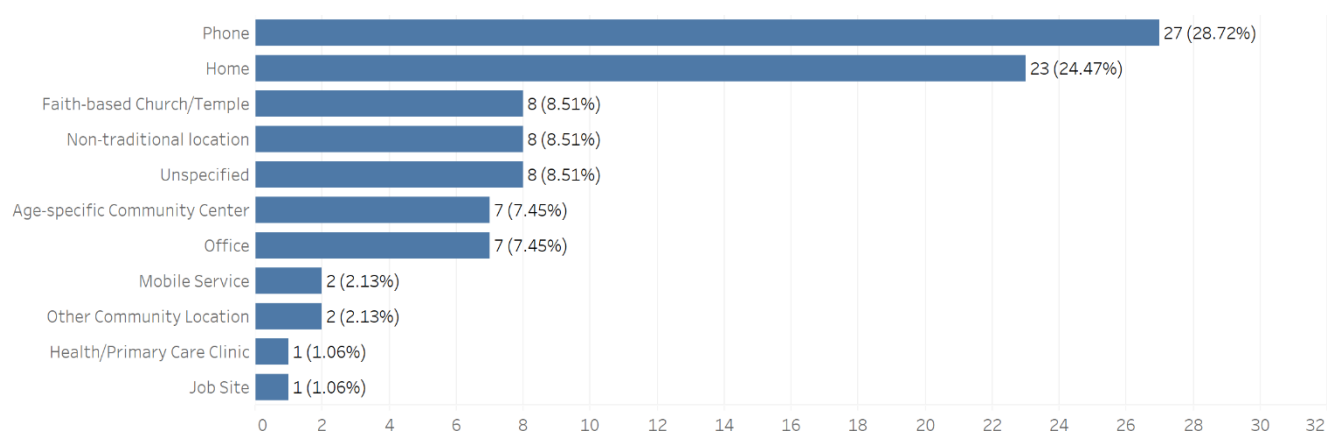
Appendix A. FY 2019-2020 Outreach, Anamatangi Polynesian Voices

For FY 2019-2020, Anamatangi Polynesian Voices reported a total of 94 outreach events, 73 individual events, and 21 group events. There were 240 attendees. The individual outreach events lasted from 15 to 60 minutes and were 46 minutes on average. The group outreach events lasted from 15 to 90 minutes and were 55 minutes on average.

Outreach events:

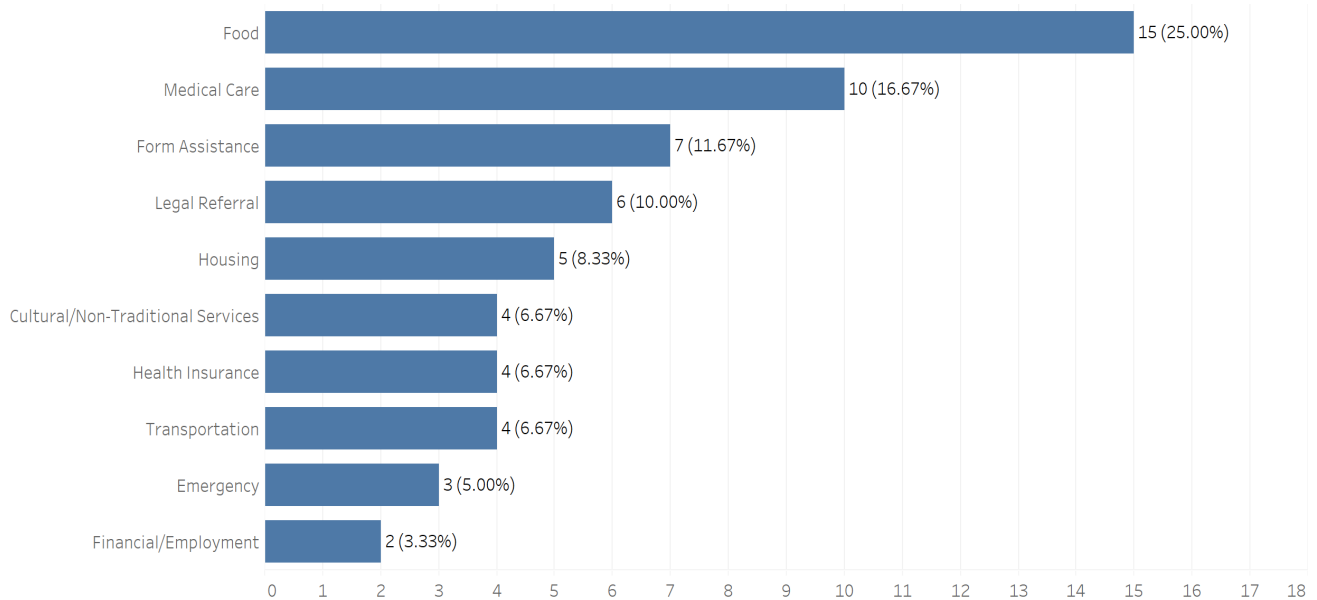
- Most frequently took place in over the phone (**28.7%**, n=27). Other locations of events and their respective percentages are shown in **Figure 1**.

Figure 1. Locations of Outreach events, FY 2019-2020



- Were conducted in English (**53.2%**; n=50), Samoan (**24.5%**; n=23), and Tongan (**22.3%**; n=21),
- Resulted in 39 mental health referrals and 2 substance abuse referrals.
- Resulted in 60 social service referrals (**See Figure 2**). An *individual* outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were made primarily to Food (**25%**; n=15), Medical Care (**16.7%**, n=10), Form Assistance (**11.7%**, n=7), Legal (**10%**, n=6), and Housing (**8.3%**, n=5).

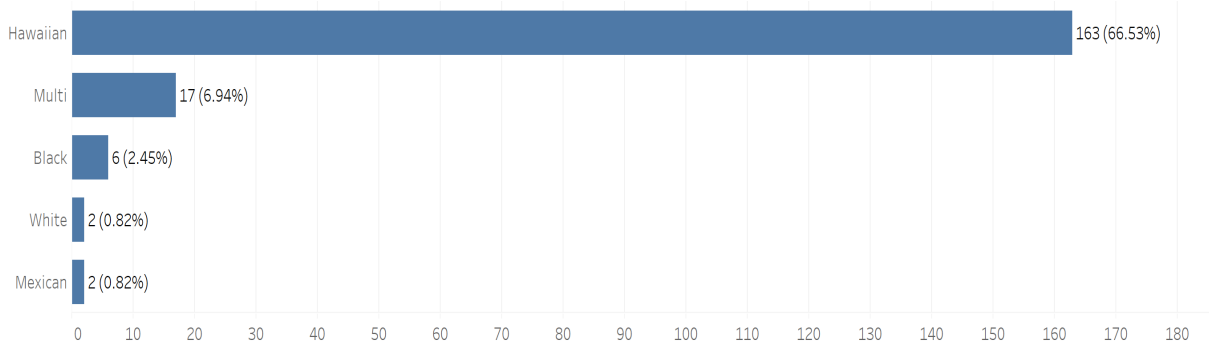
Figure 2. Social Service Referrals, FY 2019-2020



Outreach event attendees:

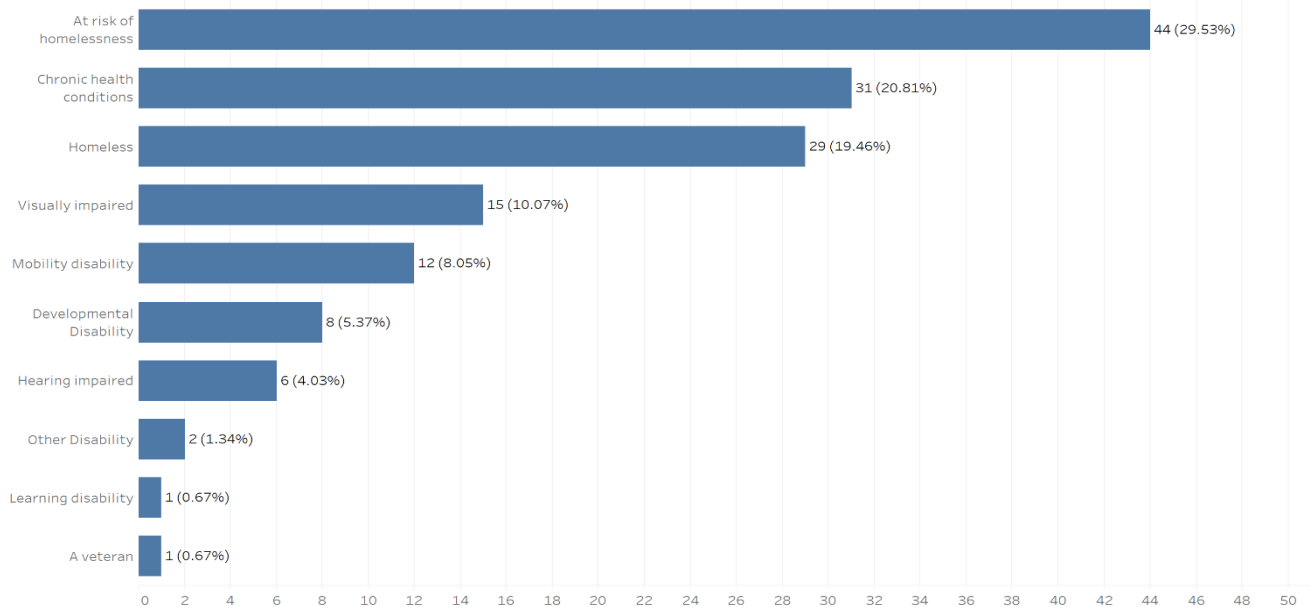
- Most often were female (**54.6%**, n=131). Forty-five percent were male (**44.6%**, n=107). Two individuals decline to state their sex at birth.
- Identified their gender as female (**53.8%**, n=129). Forty five percent identified as male (**44.6%**, n=107). One individual identified as male to female transgender, and one individual identified as female to male transgender. Two individuals declined to state their gender.
- Identified as Heterosexuals (**91.7%**, n=220), Gay/Lesbian (**3.8%**, n=9), Bisexual (**2.5%**, n=6), Questioning (**0.42%**, n=1), or Queer (**0.42%**, n=1). One percent of the attendees declined to state their sexual orientation (**1.3%**, n=3).
- Comprised of adults (26-59 years, **31.2%**; n=75), transition-age youth (16-25 years, **27.5%**; n=66), children (15 years and younger, **25.8%**; n=62), and older adults (60+ years, **15.4%**; n=37).
- Were primarily Hawaiian (**66.5%**, n=163), Tongan (**11.4%**, n=28), Samoan (**9.8%**, n=24), more than one race (**6.9%**, n=17), and Black (**2.5%**, n=6). (See Figure 3).

Figure 3. Attendees by Top Race/Ethnicity Category, FY 2019-2020



In FY 2019-2020, **22.9%** (n=55) Anamatangi Polynesian Voices attendees were in at least one special populations group. Special populations include those who are veterans, are homeless, are at risk of homelessness, are hearing impaired, are vision impaired, have dementia, have chronic health conditions, have a mobility disability, have a learning disability, or have a developmental disability. Amongst the special population group, **29.5%** were at risk of homelessness, **20.8%** had chronic health conditions, **19.5%** were homeless **10.1%** were visually impaired, **8.1%** had a mobility disability, **5.4%** had a developmental disability, **4.0%** were hearing impaired, **1.3%** had “other” disability, **0.7%** had a learning disability, and **0.7%** were veterans. (See Figure 4).

Figure 4. Special Populations, FY 2019-2020

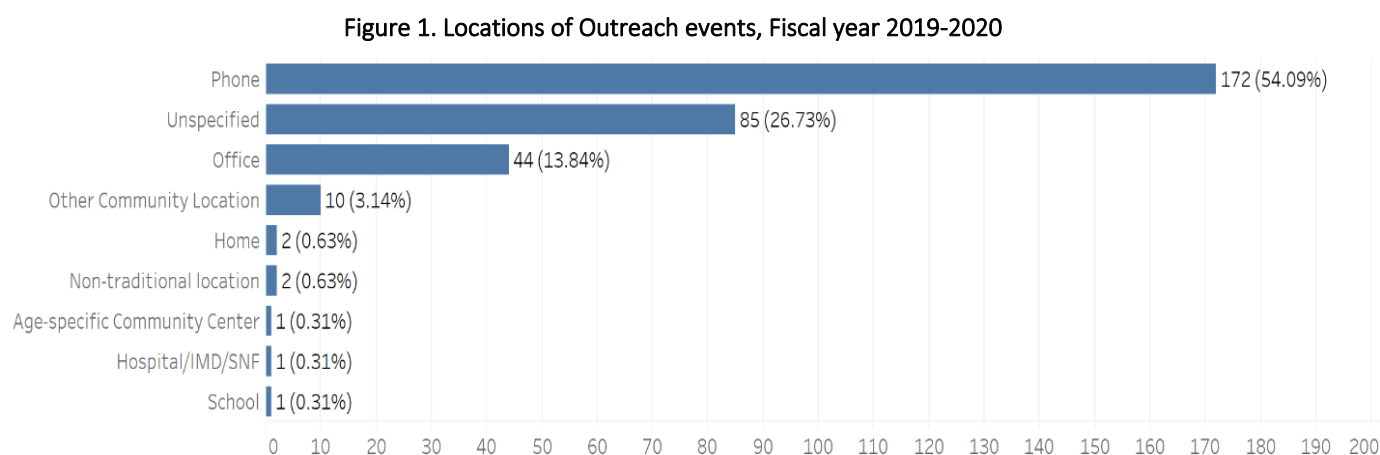


Appendix B. FY 2019-2020 Outreach, Asian American Recovery Services (AARS)

For FY 2019-2020, Asian American Recovery Services (AARS) reported a total of 318 outreach events, 304 individual events, and 14 group events. There were 898 attendees. Individual outreach events lasted from 10 to 120 minutes and lasted 29 minutes on average. The group outreach events lasted from 15 to 120 minutes and lasted on average 85 minutes.

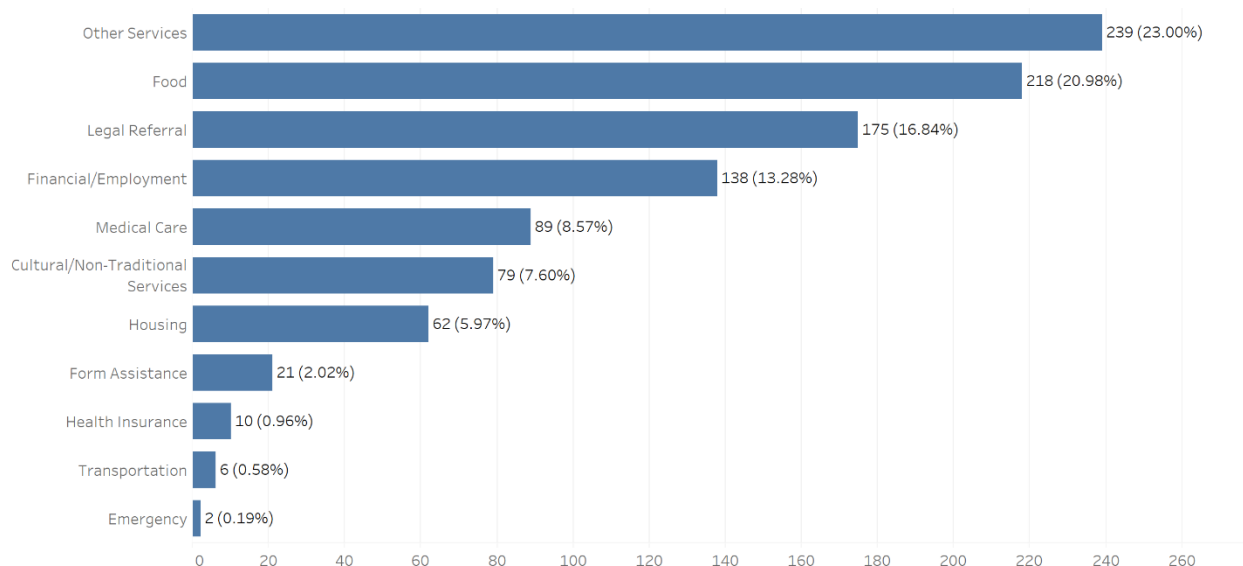
Outreach events:

- Most frequently took place over the phone (**54.1%**, n=172). Other locations of events and their respective percentages are shown in **Figure 1**.



- Were primarily conducted in English (**96.5%**, n=307) Spanish (**1.3%**, n=4), Mandarin (**0.9%**, n=3), Tongan (**0.6%**, n=2), Cantonese (**0.3%**, n=1), and other languages (**0.3%**, n=1).
- Resulted in 171 mental health referrals and 52 substance abuse referrals at the *individual* outreach events.
- Resulted in 1,039 social service referrals (**Figure 2**). An *individual* outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were primarily made to “other” services (**23.0%**, n=239), Food (**21.0%**, n=218), and Legal Referral (**16.8%**, n=175) services.

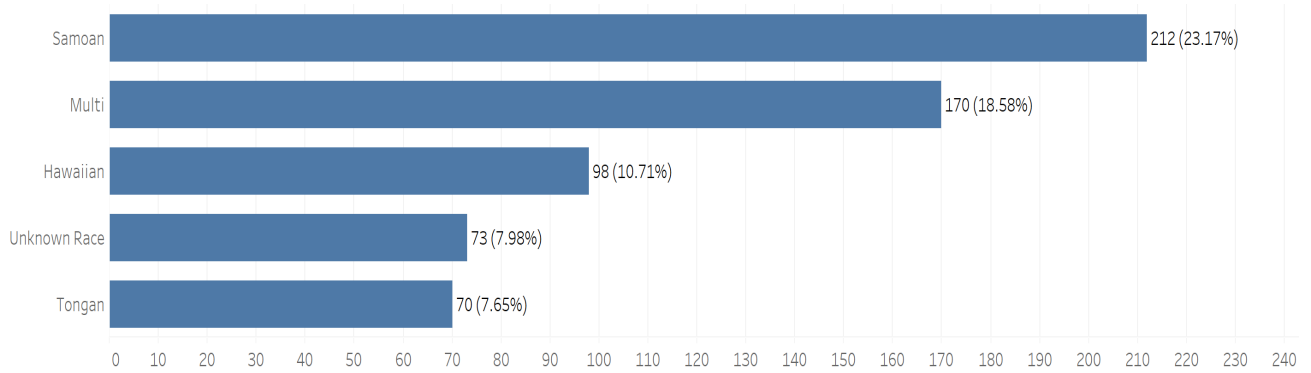
Figure 2. Social Service Referrals, FY 2019-2020



Outreach event attendees:

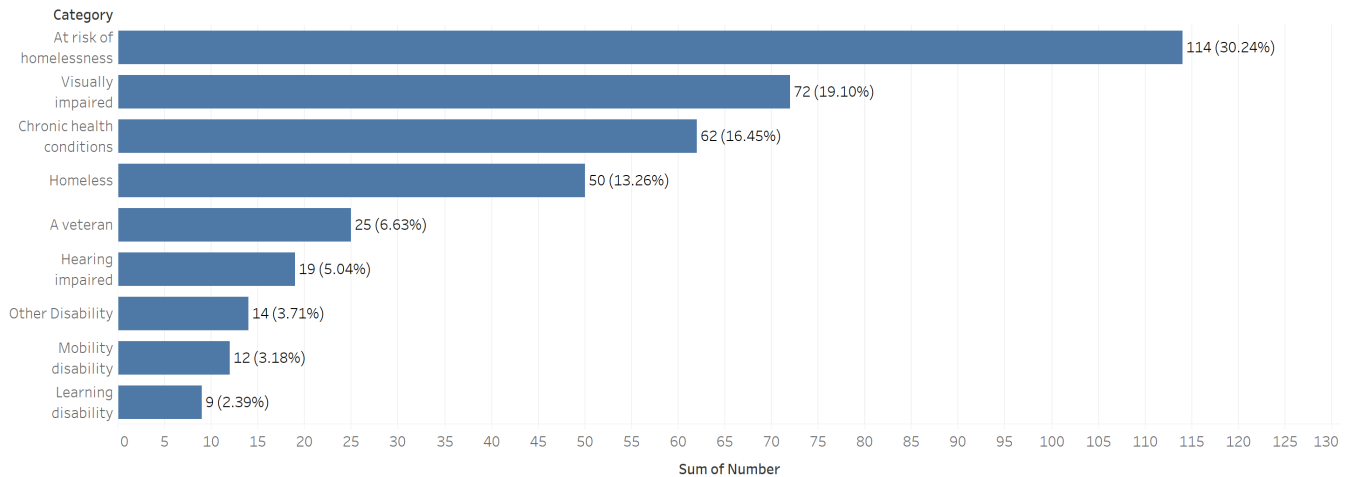
- Most often were female (**69.1%**; n=628). Thirty percent were male (**29.8%**; n=271). One percent declined to report their sex at birth.
- Identified their gender as female (**67.9%**, n=614), male (**29.6%**, n=268), female to male transgender (**0.8%**, n=7), genderqueer (**0.2%**, n=2), gender questioning (**0.2%**, n=2) and male to female transgender (**0.1%**, n=1). The remaining individuals identified as other gender (**0.1%**, n=1), or unknown gender (**1.1%**, n=10).
- Identified as Heterosexuals (**70.4%**; n=632), Gay/Lesbian (**5.8%**; n=52), Bisexual (**1.2%**; n=17), Queer (**1.6%**; n=14), Pansexual (**1.2%**; n=11), Asexual (**0.2%**; n=2), or Indigenous (**0.1%**; n=1). The remaining attendees declined to state (**18.4%**; n=165) or were questioning (**0.3%**; n=3) their sexual orientation.
- Comprised of adults (26-59 years, **57.8%**; n=520), transition-age youth (16-25 years, **16.7%**; n=150), children (15 years and younger, **13.7%**; n=123), and older adults (60+ years, **10.7%**; n=96).
- Were primarily Samoan (**23.2%**, n=212), more than one race (**18.6%**, n=170), Hawaiian (**10.7%**, n=98), unknown race (**8.0%**, n=73) or Tongan (**7.7%**, n=70). (**See Figure 3**).

Figure 3. Attendees by Top Race/Ethnicity Category, FY 2019-2020



In FY 2019-2020, **19.5%** (N=175) of AARS attendees were in at least one special population category. Special populations include those who: are veterans, are homeless, are at risk of homelessness, are hearing impaired, are vision impaired, have dementia, have chronic health conditions, have a mobility disability, have a learning disability, or have a developmental disability. Amongst the special population group, **30.2%** were at risk of homelessness, **19.1%** were visually impaired, **16.5%** had chronic health conditions, **13.3%** were homeless, **6.6%** were veterans, **5.0%** were hearing impaired, **3.7%** had “other” disability, **3.2%** had a mobility disability, and **2.4%** had a learning disability. (See Figure 4).

Figure 4. Special Population, FY 2019-2020



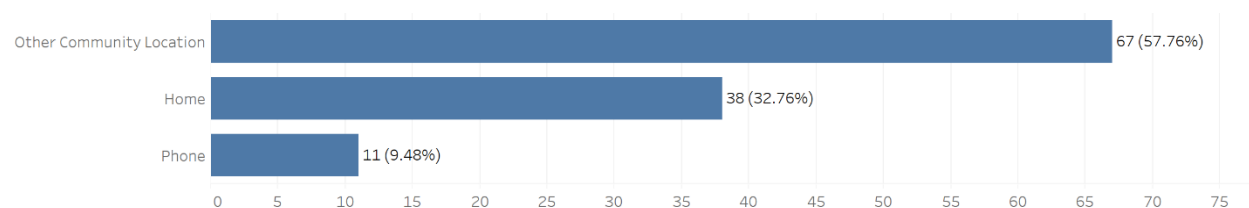
Appendix C. FY 2019-2020 Outreach, Daly City Peninsula Partnership Collaborative

For FY 2019-2020, Daly City Peninsula Partnership Collaborative reported a total of 116 outreach events, all group events. There were 5,999 attendees. The group outreach events lasted from 1 to 180 minutes and lasted on average 116.9 minutes.

Outreach events:

- Most frequently took place in other community locations (**57.8%**; n=67). Other locations of events and their respective percentages are shown in **Figure 1**.

Figure 1. Locations of Outreach events¹, Fiscal year 2019-2020



- Were conducted in English (**99.1%**; n=115) and Spanish (**0.9%**; n=1).
- Resulted in no mental health referrals and substance abuse referrals at the *individual* outreach events.
- Resulted in no social service referrals.

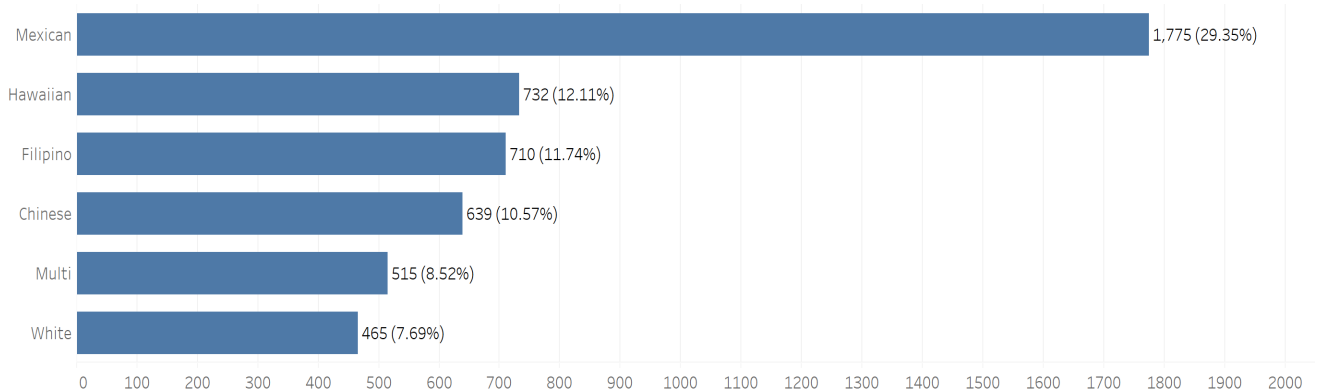
Outreach event attendees:

- Most often were female (**61.4%**; n=3,698). Thirty nine percent were male (**38.6%**; n=2,326).
- Most identified their gender as female (**61.1%**, n=3,680). Thirty nine percent identified as male (**38.9%**, n=2,342). Five individuals identified as other gender.
- Identified as Heterosexuals (**92.2%**; n=5,530), or Gay/Lesbian (**0.1%**; n=7). Eight percent of the attendees (**7.7%**; n=462) declined to state their sexual orientation.
- Comprised of adults (26-59 years, **47.6%**; n=2,858), transition-age youth (16-25 years, **23.3%**; n=1,398), children (15 years and younger, **14.0%**; n=840), and older adults (60+ years, **12.3%**; n=725). The remaining attendees (**3.0%**; n=180) declined to state their age.

¹ Home is referring to “Our Second Home” – an early childhood family resource center.

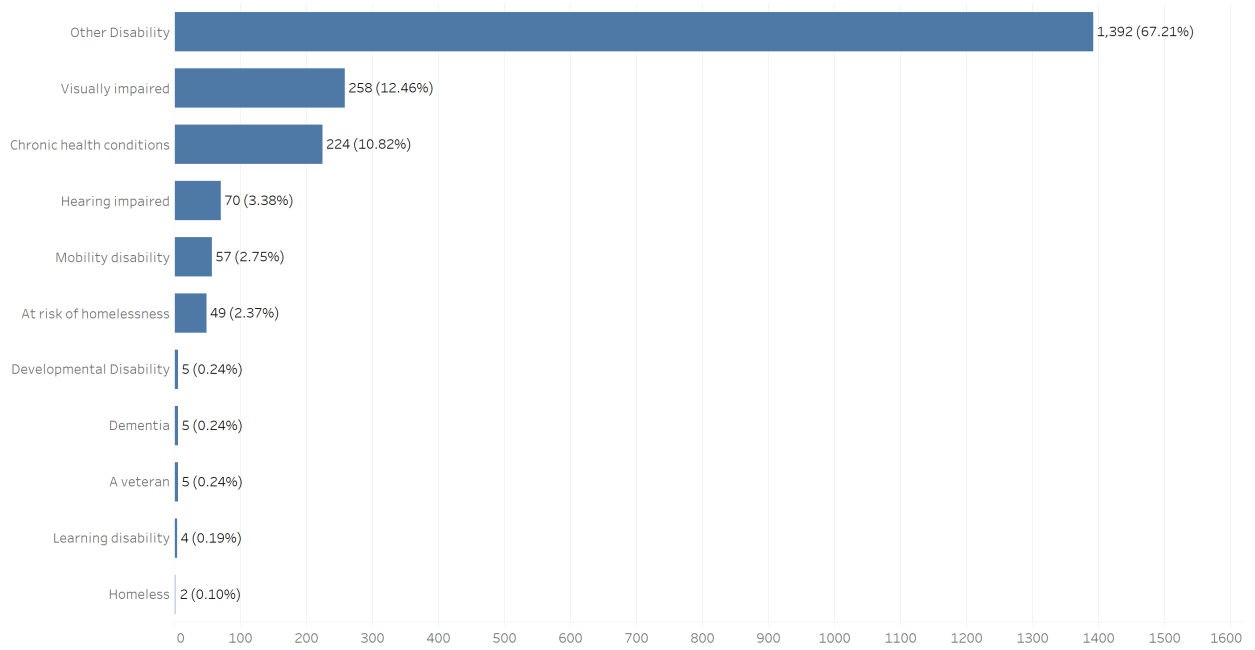
- Were primarily Mexican (**29.4%**; n=1,775), Hawaiian (**12.1%**; n=732), Filipino (**11.7%**; n=710), or Chinese (**10.6%**; n=639). (See Figure 2).

Figure 2. Attendees by Top Race/Ethnicity Category, FY 2019-2020



In FY 2019-20120, **34.5%** (n=2,071) of Daly City Peninsula Partnership attendees were in at least one special populations group. Special populations include those who: are veterans, are homeless, are at risk of homelessness, are hearing impaired, are vision impaired, have dementia, have chronic health conditions, have a mobility disability, have a learning disability, or have a developmental disability. Amongst the special population group, **67.21%** had “other” disability, **12.5%** were visually impaired, **10.8%** had chronic health conditions, **3.4%** were hearing impaired, **2.8%** had a mobility disability, **2.4%** were at risk of homelessness, **0.2%** were veterans, **0.2%** had dementia, **0.2%** had a learning disability, and **0.1%** were homeless. (See Figure 3).

Figure 3. Special Populations, FY 2019-2020



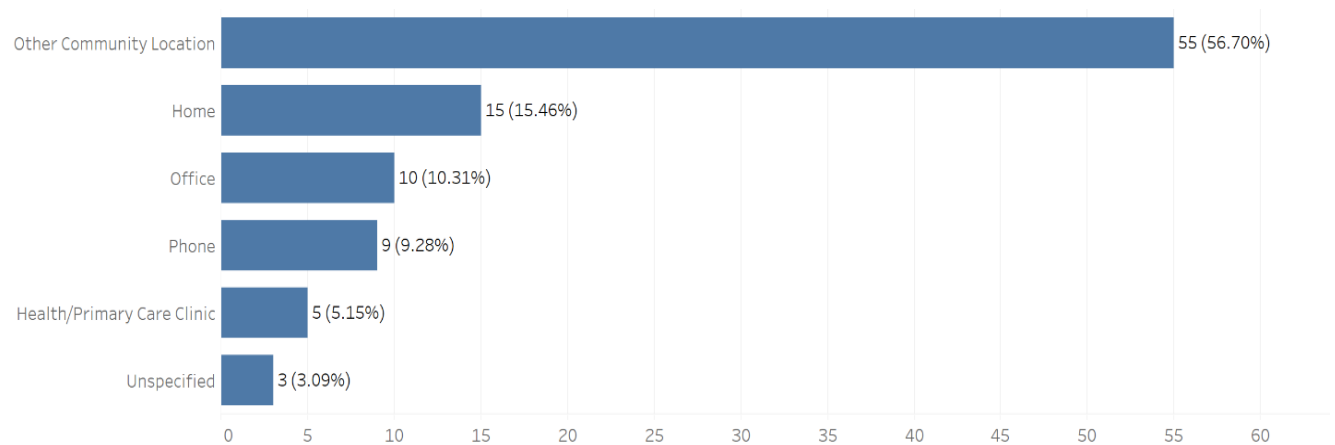
Appendix D. FY 2019-2020 Outreach, Daly City Youth Center

For FY 2019-2020, Daly City Youth Center reported a total of 97 outreach events, 23 individual events, and 74 group events. There were 2,712 attendees. Individual outreach events lasted from 5 to 67 minutes and lasted on average 177 minutes. Group outreach events lasted from 30 to 180 minutes and lasted on average 105 minutes.

Outreach events:

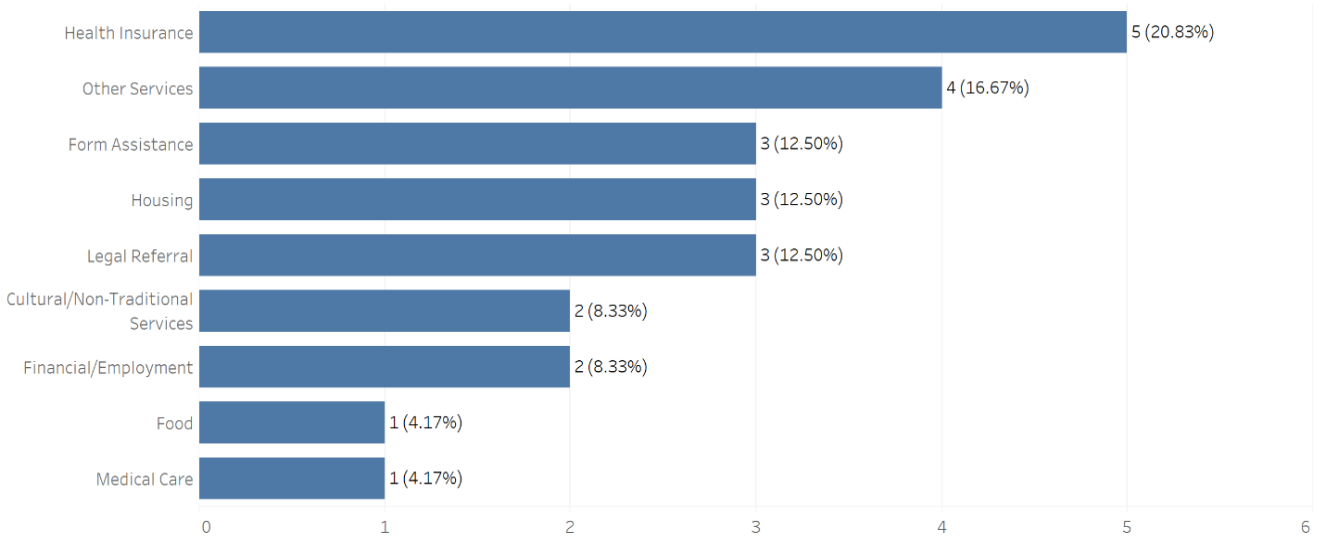
- Most frequently took place in other community locations (**56.7%**; n=55). Other locations of events and their respective percentages are shown in **Figure 1**.

Figure 1. Locations of Outreach events, Fiscal year 2019-2020



- Were conducted in English (**97.9%**, n=95), Spanish (**1.0%**, n=1), or Tongan (**1.0%**, n=1).
- Resulted in 14 mental health referrals at the *individual* outreach events.
- Resulted in 24 social service referrals (**See Figure 2**). An *individual* outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were primarily made to Health Insurance (**20.8%**; n=5), Other (**16.7%**; n=4), Form Assistance (**12.5%**; n=3), Housing (**12.5%**, n=3), and Legal Referral (**12.5%**, n=3).

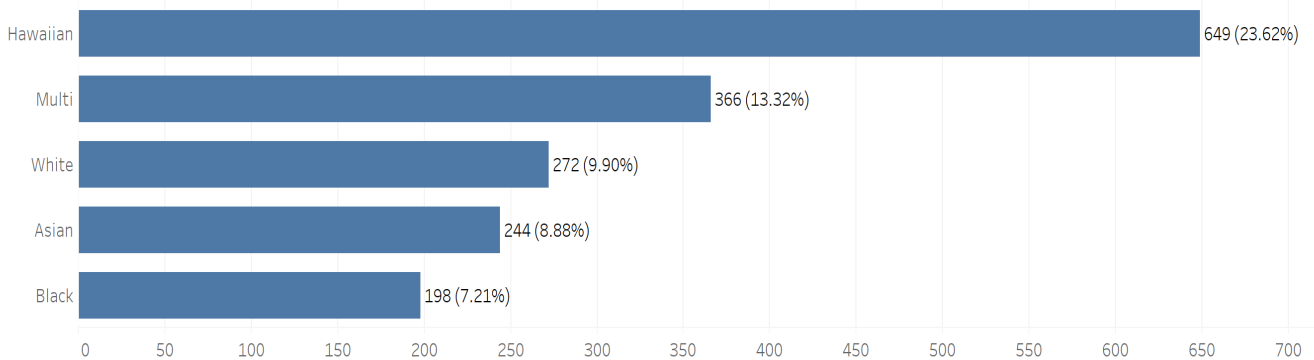
Figure 2. Social Service Referrals, Fiscal year 2019-2020



Outreach event attendees:

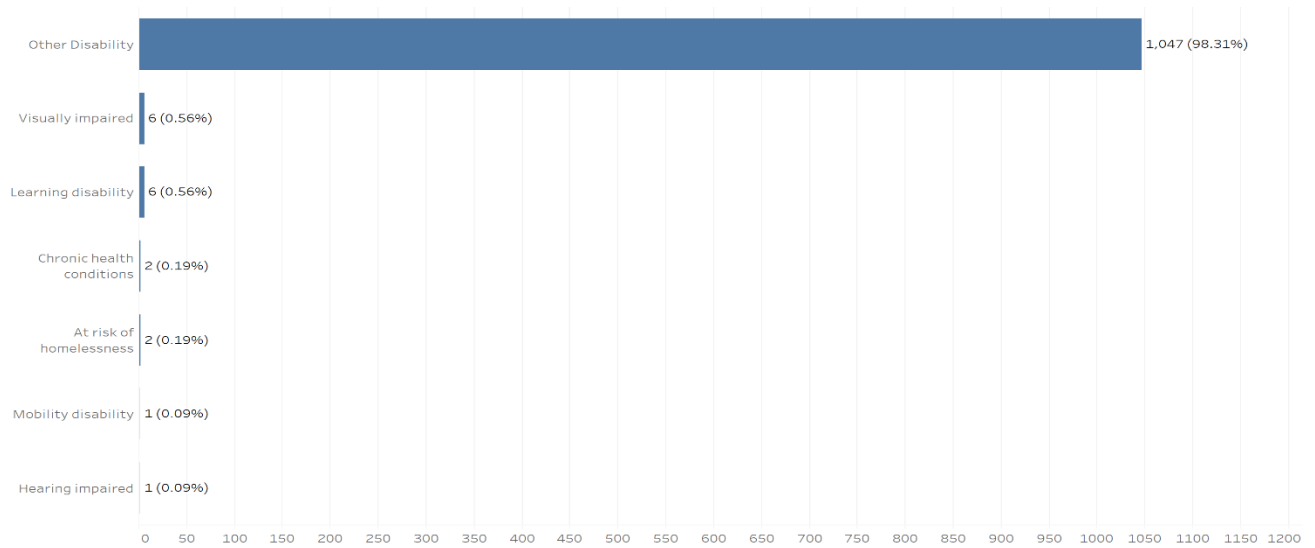
- Most often were female (**63.3%**; n=1,724). Thirty-three percent were male (**32.5%**; n=886). The remaining attendees (**4.2%**; n=114) declined to state their sex at birth.
- Identified their gender as female (**63.8%**, n=1,680), and male (**32.0%**, n=840). The remaining individuals declined to state their gender (**4.3%**, n=114).
- Identified as Heterosexual (**92.3%**; n=2,512), Gay/Lesbian (**0.2%**; n=5), Bisexual (**0.1%**; n=3), or Queer (**0.04%**; n=1). Seven percent of the attendees (**7.4%**; n=202) declined to state their sexual orientation.
- Comprised of transition-age youth (16-25 years, **48.0%**; n=1,313), adults (26-59 years, **34.9%**; n=955), children (15 years and younger, **10.0%**; n=274), and older adults (60+ years, **0.2%**; n=5). The remaining attendees (**6.8%**; n=186) declined to state their age.
- Were primarily Hawaiian (**23.6%**, n=649), more than one race (**13.3%**, n=366), White (**9.9%**, n=272), or Asian (**8.9%**, n=244). (**See Figure 3**).

Figure 3. Attendees by Top Race/Ethnicity Category, FY 2019-2020



In FY 2019-2020, **0.5%** (n=13) of Daly City Youth Center attendees were in at least one populations group. Special populations include those who are veterans, are homeless, are at risk of homelessness, are hearing impaired, are vision impaired, have dementia, have chronic health conditions, have a mobility disability, have a learning disability, or have a developmental disability. Amongst those in the special population group, **98.3%** had “other” disability, **0.6%** were visually impaired, **0.6%** had a learning disability, **0.2%** had chronic health conditions, **0.2%** were at risk of homelessness, **0.1%** had a mobility disability, and **0.1%** were hearing impaired (See Figure 4).

Figure 4. Special Populations, FY 2019-2020



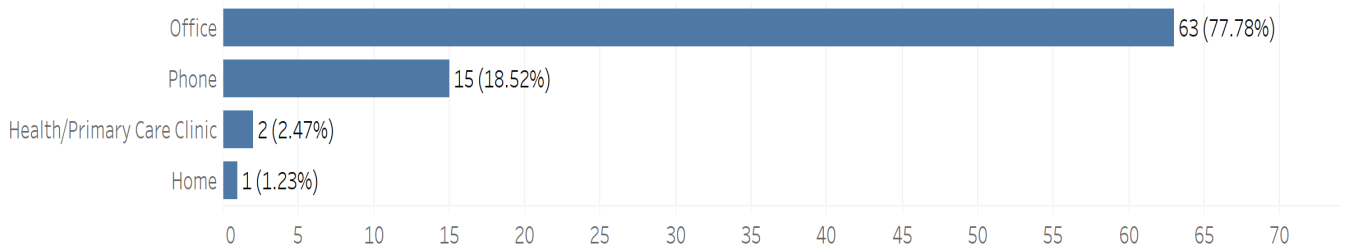
Appendix E. FY 2019-2020 Outreach, El Concilio

For FY 2019-2020, El Concilio reported a total of 81 individual outreach events. Individual outreach events lasted from 10 to 45 minutes and lasted on average 17 minutes.

Outreach events:

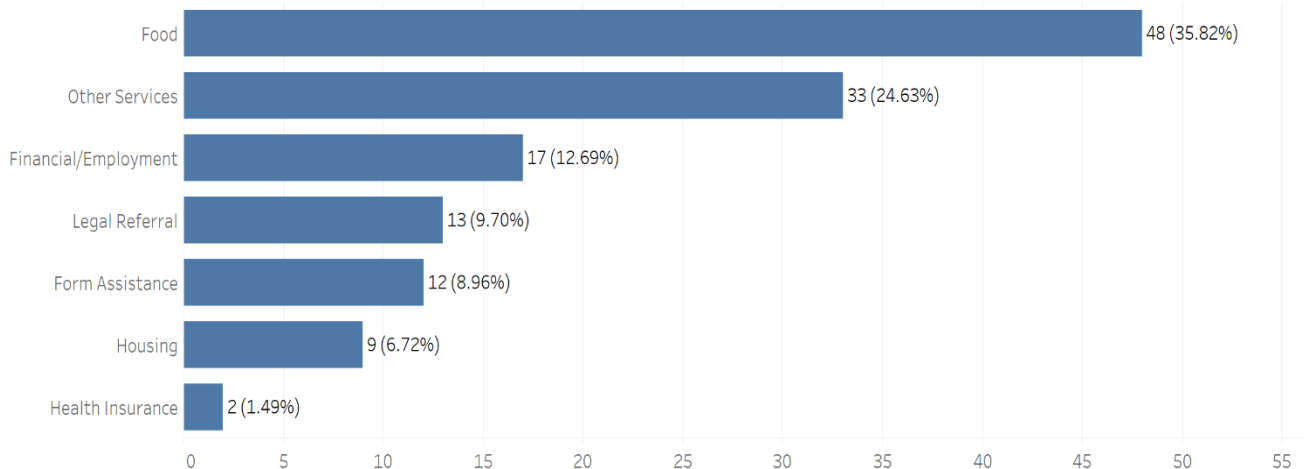
- Most frequently took place in offices (**77.8%**; n=63). Other locations of events and their respective percentages are shown in **Figure 1. (See Figure 1).**

Figure 1. Locations of Outreach events, Fiscal year 2019-2020



- Were conducted in Spanish (**88.9%**, n=72) and English (**11.1%**, n=9).
- Resulted in 16 mental health referrals and 1 substance use referral at the *individual* outreach events.
- Resulted in 134 social service referrals (**See Figure 2**). An *individual* outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were made for food, legal, housing, financial/employment, transportation, cultural, and health-related services. Referrals were made primarily to Food (**35.8%**, n=48), other services outside of the primary list (**24.6%**, n=33), and Financial/Employment (**12.7%**, n=17) services.

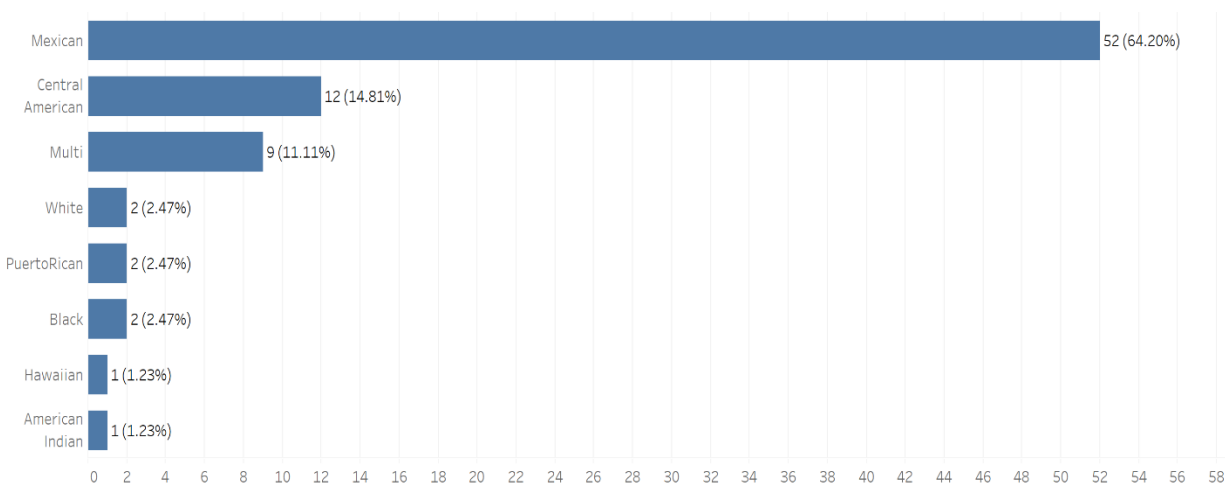
Figure 2. Social Service Referrals, FY 2019-2020



Outreach event attendees:

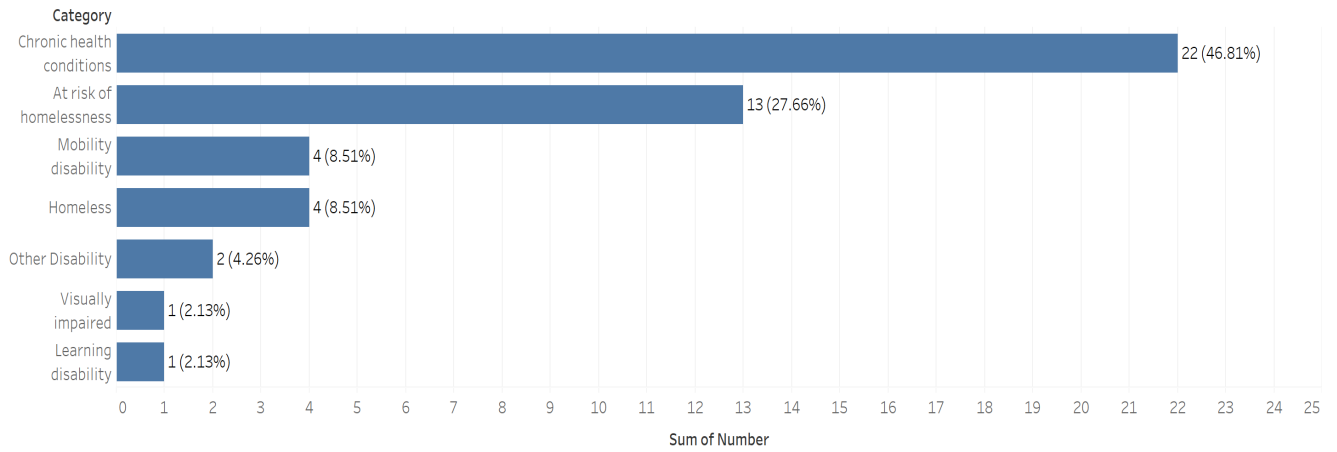
- Most often were female (**91.3%**; n=74). Nine percent were male (**8.7%**; n=7).
- Identified their gender as female (**87.7%**, n=71), male (**8.6%**, n=7), and male to female transgender (**3.7%**, n=1).
- Were Heterosexuals (**100.0%**, n=81).
- Comprised of adults (26-59 years, **84.0%**; n=68), older adults (60+ years, **11.1%**; n=9), and transition-age youth (16-25 years, **4.9%**; n=4).
- Were primarily Mexican (**64.2%**, n=52), Central American (**14.8%**, n=12), more than one race (**11.1%**, n=9), White (**2.5%**, n=2), Puerto Rican (**2.5%**, n=2), or Black (**2.5%**, n=2). (See Figure 3).

Figure 3. Attendees by Top Race/Ethnicity Category, FY 2019-2020



In FY 2019-2020, **48.1%** (n=39) of El Concilio attendees were in at least one special populations group. Special populations include those who are veterans, are homeless, are at risk of homelessness, are hearing impaired, are vision impaired, have dementia, have chronic health conditions, have a mobility disability, have a learning disability, or have a developmental disability. Amongst those in the special population group, **46.8%** had chronic health conditions, **27.7%** were at risk of homelessness, **8.5%** were homeless, **8.5%** had mobility disability, **4.3%** had “other” disability, **2.1%** were visually impaired, and **2.1%** had a learning disability. (See Figure 4).

Figure 4. Special Populations, FY 2019-2020



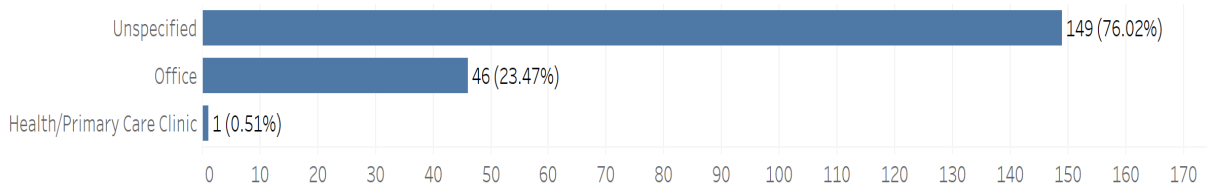
Appendix G. FY 2019-2020 Outreach, Free at Last

For FY 2019-2020, Free at Last reported a total of 196 individual outreach events. The events lasted from 15 to 45 minutes and were on average 32 minutes.

Outreach events:

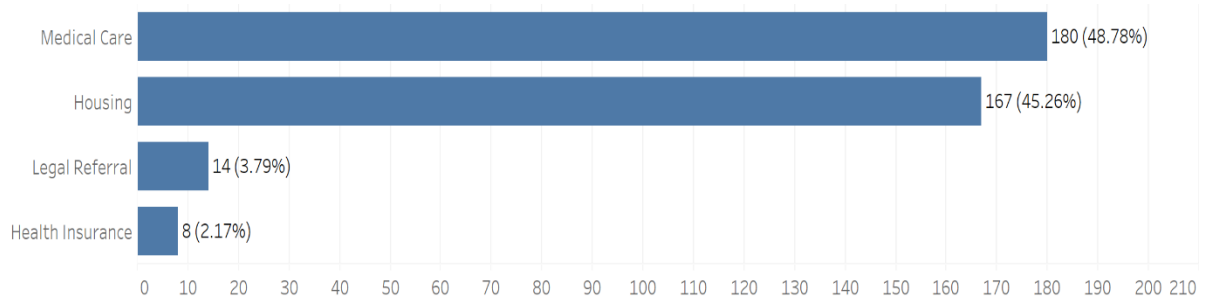
- Most frequently took place in unspecified locations (**76.0%**; n=149). Other locations of events and their respective percentages are shown in **Figure 1**. (See **Figure 1**).

Figure 1. Locations of Outreach events, Fiscal year 2019-2020



- Were conducted in English (**66.8%**, n=131) and Spanish (**33.2%**, n=65).
- Resulted in 42 mental health referrals and 126 substance abuse referrals at the *individual* outreach events.
- Resulted in 369 social service referrals (See **Figure 2**). An *individual* outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were made to Medical Care (**48.8%**, n=180), Housing (**45.3%**, n=167), Legal Referrals (**3.8%**, n=14) and Health Insurance (**2.2%**, n=8) services.

Figure 2. Social Service Referrals, Fiscal year 2019-2020

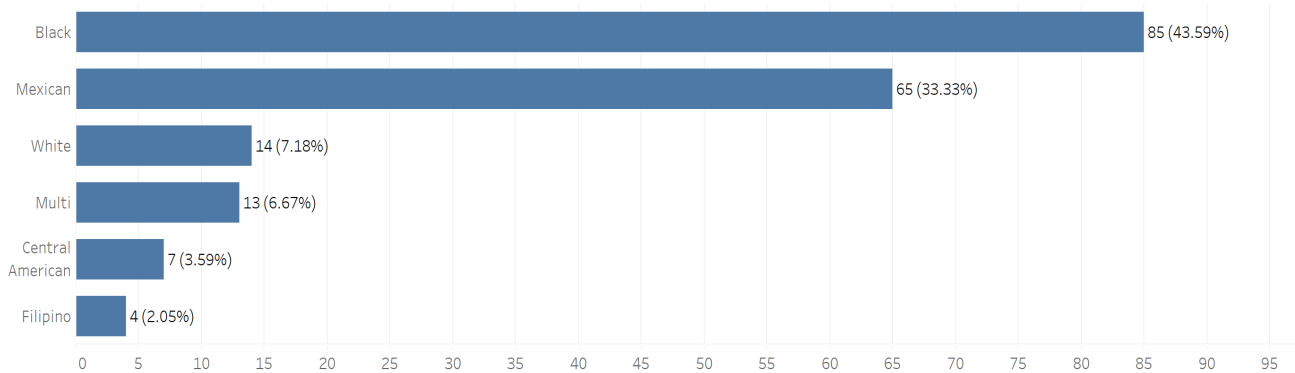


Outreach event attendees:

- Most often were male (**52.0%**, n=102). Forty eight percent were female (**48.0%**, n=94).
- Identified their gender as female (**45.7%**, n=90), male (**44.7%**, n=88), male to female transgender (**7.6%**, n=15), and female to male transgender (**2.0%**, n=4).

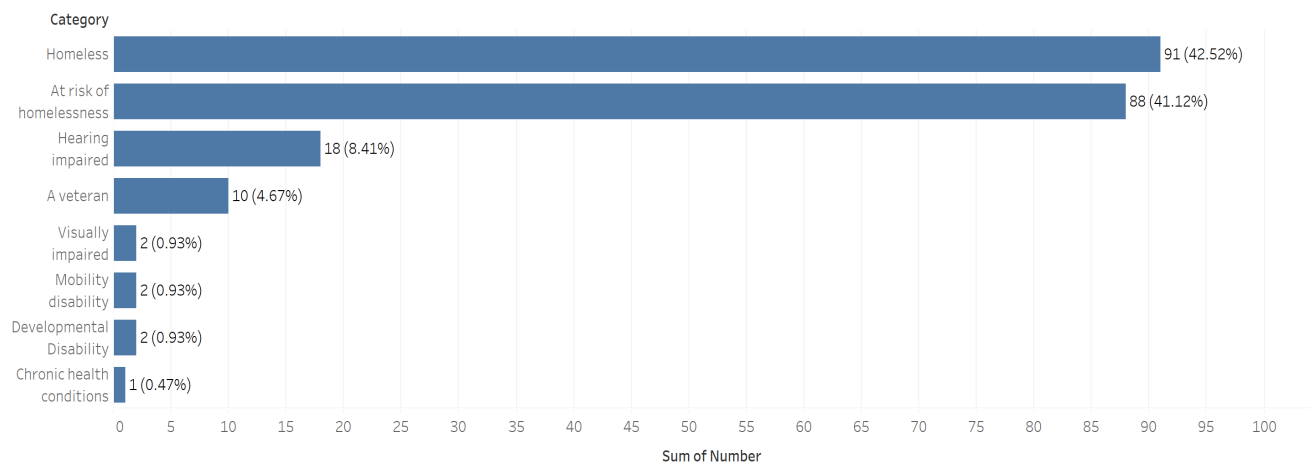
- Identified as Heterosexuals (**63.8%**, n=125), Gay/Lesbian (**12.8%**, n=25), or Bisexual (**11.2%**, n=22). Twelve percent chose more than one sexual orientation (**12.3%**; n=24).
- Comprised of adults (26-59 years, **78.0%**; n=158), transition-age youth (16-25 years, **17.9%**; n=35), and older adults (60+ years, **4.1%**; n=8).
- Were primarily Black (**43.6%**, n=85), Mexican (**33.3%**, n=65), White (**7.2%**, n=14), or more than one race (**6.7%**, n=13). (See Figure 3).

Figure 3. Attendees by Top Race/Ethnicity Category, FY 2019-2020



In FY 2019-2020, **91.3%** (n=179) Free at Last attendees were in at least one special populations group. Special populations include those who are veterans, are homeless, are at risk of homelessness, are hearing impaired, are vision impaired, have dementia, have chronic health conditions, have a mobility disability, have a learning disability, or have a developmental disability. Amongst those in the special population group, **42.5%** were homeless, **41.1%** were at risk of homelessness, **8.4%** were hearing impaired, **4.7%** were veterans, **0.9%** had a mobility disability, **0.9%** were visually impaired, **0.9%** had a developmental disability, and **0.5%** had chronic health conditions. (See Figure 4).

Figure 4. Special Populations, FY 2019-2020



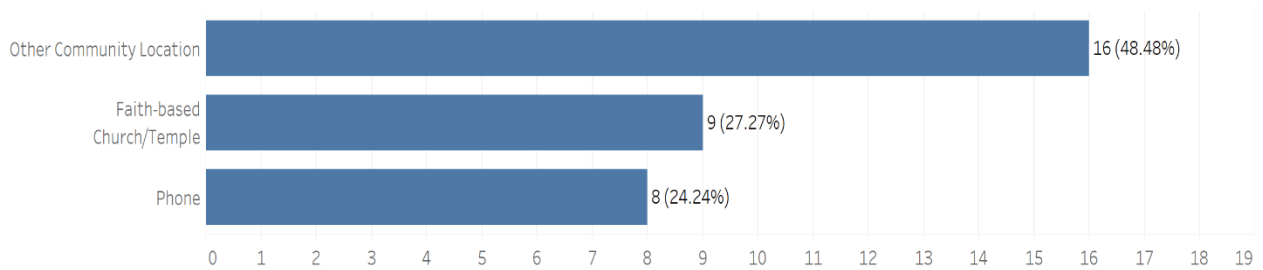
Appendix H. FY 2019-2020 Outreach, Pacifica Collaborative

For FY 2019-2020, Pacifica Collaborative reported a total of 33 outreach events, 18 individual outreach events, and 15 group outreach events. There were 2,471 attendees. Individual outreach events lasted from 15 to 60 minutes and lasted an average of 32 minutes. Group outreach events lasted from 90 to 120 minutes and lasted an average of 106 minutes.

Outreach events:

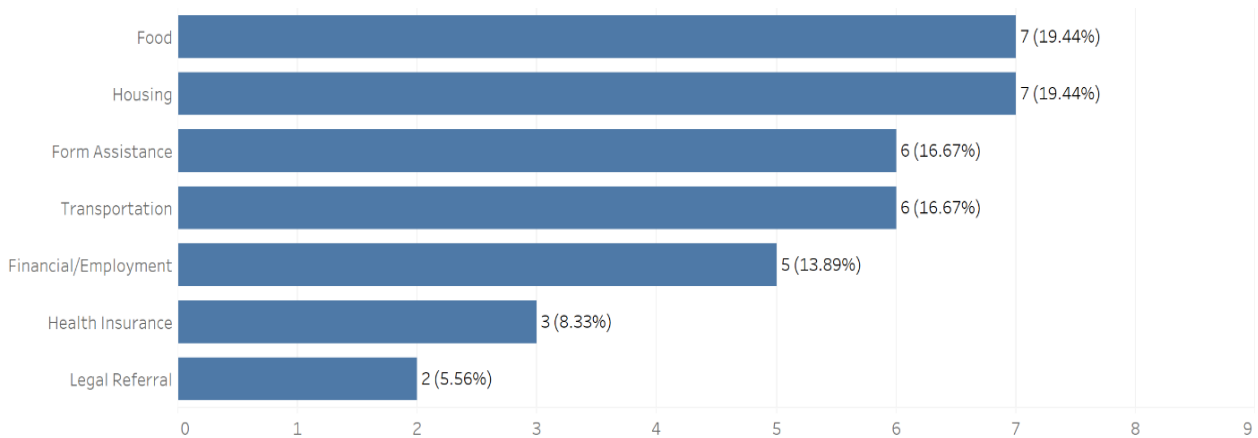
- Most frequently took place in other community locations (**48.5%**, n=16). Other locations of events and their respective percentages are shown in **Figure 1**.

Figure 1. Locations of Outreach events, Fiscal year 2019-2020



- Were conducted in English (**100.0%**, n=33).
- Resulted in 11 mental health referrals and 6 substance abuse referrals.
- Resulted in 36 social service referrals (**See Figure 2**). An *individual* outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were made primarily to Food (**19.4%**, n=7), Housing (**19.4%**, n=7), Form Assistance (**16.7%**, n=6), Transportation (**16.7%**, n=6) and Financial/Employment (**13.9%**, n=5) and services.

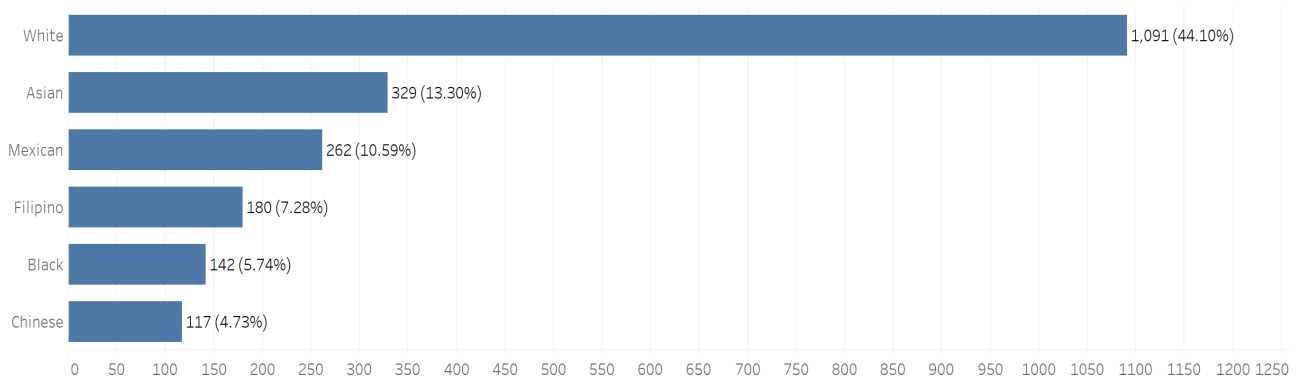
Figure 2. Social Service Referrals, Fiscal year 2019-2020



Outreach event attendees:

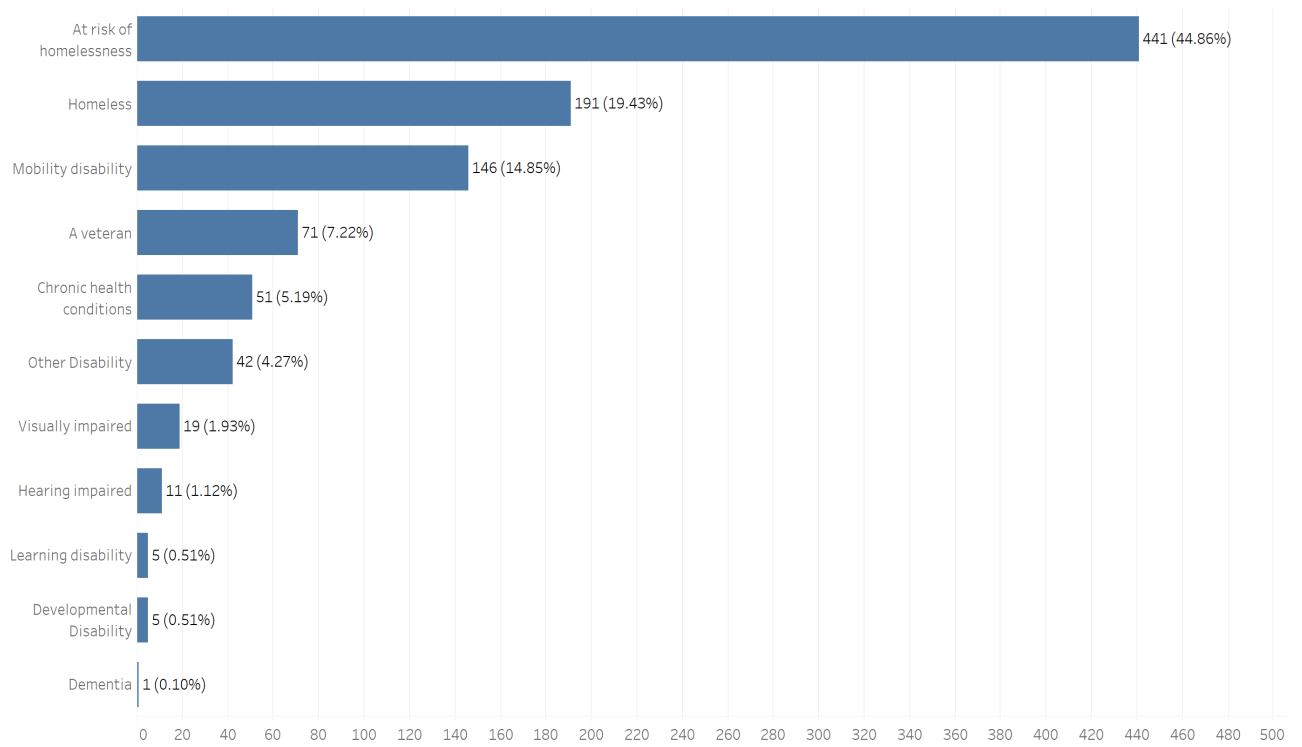
- Most often were female (**56.8%**, n=1,404). Thirty six percent were male (**35.8%**, n=885). There were 182 (**7.3%**) individuals who declined to state their sex at birth.
- Identified their gender as female (**55.5%**, n=926), male (**33.1%**, n=552), female to male transgender (**0.2%**, n=3), male to female transgender (**0.2%**, n=3), or gender questioning (**0.1%**, n=2), There were 182 (**10.9%**) individuals who indicated their gender as unknown.
- Identified as Heterosexual (**47.7%**, n=1,179), Gay/Lesbian (**7.2%**, n=177), Bisexual (**5.0%**; n=123), or Questioning (**0.3%**, n=8). Forty percent (n=986) declined to state their sexual orientation.
- Comprised of adults (26-59 years, **43.6%**; n=1,076), older adults (60+ years, **22.7%**; n=561), transition-age youth (16-25 years, **15.4%**; n=381), children (15 years and younger, **12.1%**; n=299), and those who declined to state their age (**6.2%**; n=154).
- Were primarily White (**44.1%**, n=1,091), Asian (**13.3%**, n=329), or Mexican (**10.6%**, n=262) (See Figure 3).

Figure 3. Attendees by Top Race/Ethnicity Category, FY 2019-2020



In FY 2019-2020, **0.9%** (n=22) Pacifica Collaborative attendees were in at least one special populations group. Special populations include those who are veterans, are homeless, are at risk of homelessness, are hearing impaired, are vision impaired, have dementia, have chronic health conditions, have a mobility disability, have a learning disability, or have a developmental disability. Amongst those in the special population group, **44.9%** were at risk of homelessness, **19.4%** were homeless, **14.9%** had a mobility disability, **7.2%** were veterans, **5.2%** had chronic health conditions, **4.3%** had “other” disability, **1.9%** were visually impaired, **1.1%** were hearing impaired, **0.5%** had a learning disability, **0.5%** had a developmental disability and **0.1%** had dementia (See Figure 4).

Figure 4. Special Populations, FY 2019-2020



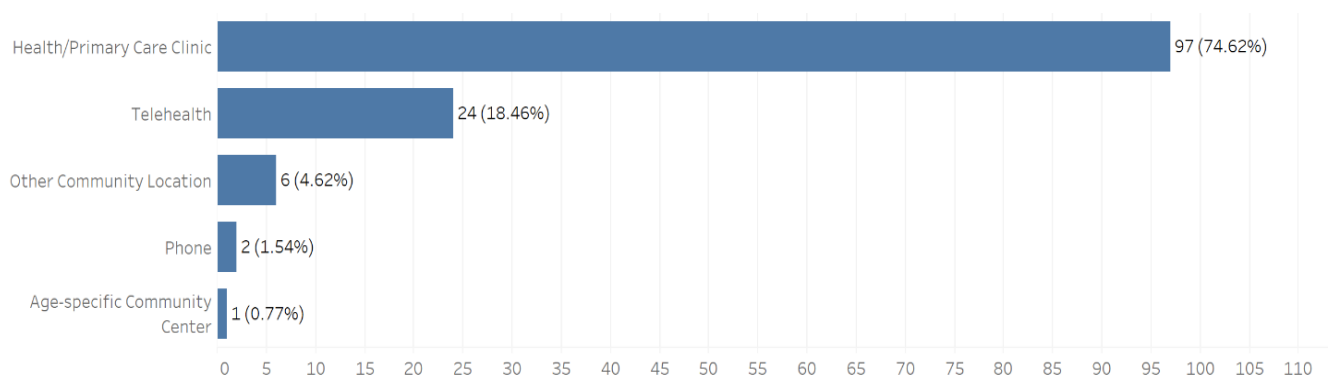
Appendix I. FY 2019-2020 Outreach, Star Vista

For FY 2019-2020, Star Vista reported a total of 13 outreach events, 1 individual outreach event and 12 group outreach events. There were 426 attendees. Individual outreach events lasted from 50 to 50 minutes on average 32 minutes. Group outreach events lasted from 90 to 240 minutes and lasted on average of 106 minutes.

Outreach events:

- Most frequently took place in a primary care clinic (**74.6%**, n=97). Other locations of events and their respective percentages are shown in **Figure 1**.

Figure 1. Locations of Outreach events, Fiscal year 2019-2020



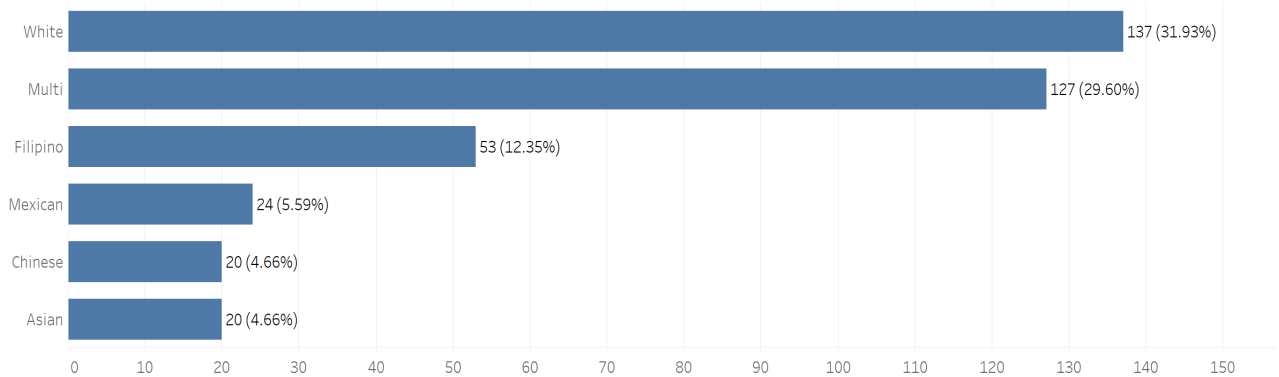
- Were conducted in Mandarin (**52.3%**, n=68), Cantonese (**38.5%**, n=50), English (**7.7%**, n=10), Spanish (**0.8%**, n=1) and Tongan (**0.8%**, n=1).
- Resulted in 114 mental health referrals and 19 substance abuse referrals.
- Resulted in 2 social service referrals. An *individual* outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were made to Medical (**100%**, n=2) services.

Outreach event attendees:

- Most often were female (**55.4%**; n=236). Forty-five percent were male (**44.6%**; n=190).
- Identified their gender as female (**30.2%**, n=129), Queer (**29.4%**, n=83), male (**15.7%**, n=67), questioning (**14.1%**, n=60), female to male transgender (**3.5%**, n=15), male to female transgender (**2.8%**, n=12), and Indigenous gender (**0.5%**, n=2). Fourteen percent (n=59) identified their gender as “other”.

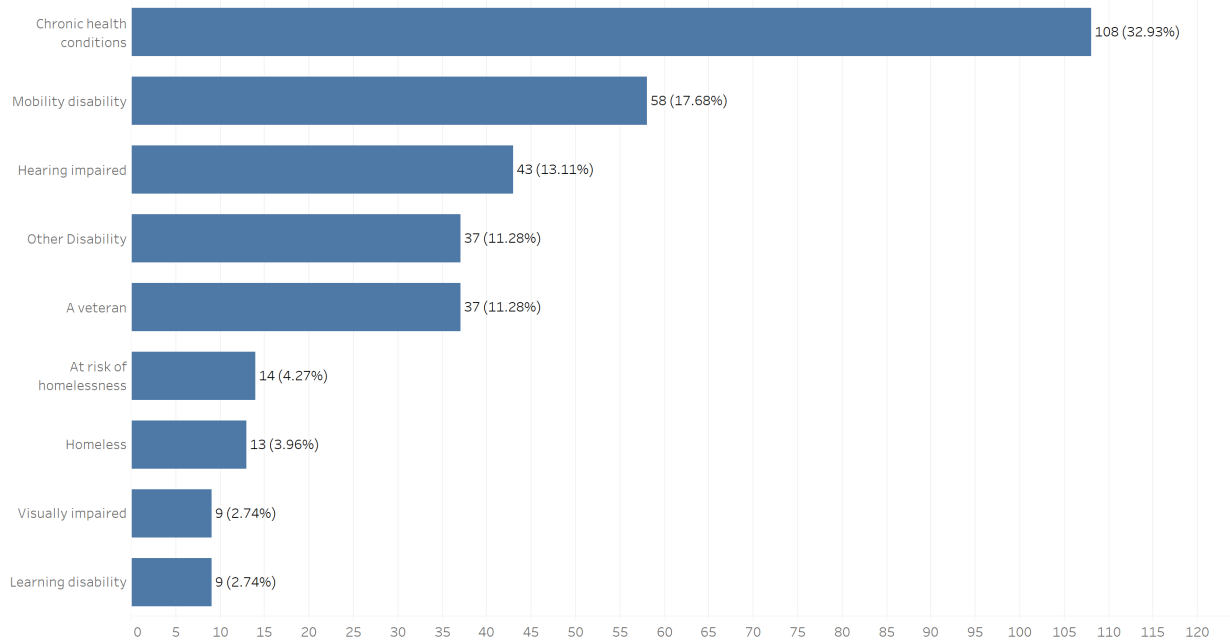
- Identified as Heterosexual (**38.3%**, n=168), Gay/Lesbian (**31.9%**, n=136), Questioning (**11.0%**, n=47), Queer (**9.4%**, n=40), Bisexual (**6.6%**, n=28), “Other” sexual orientation (**1.2%**; n=5), or Pansexual (**0.9%**, n=4). Less than a percent of individuals declined to state their sexual orientation (**0.7%**, n=3).
- Were older adults (60+ years, **40.5%**; n=181), adults (26-59 years, **32.2%**; n=144), transition-age youth (16-25 years, **24.4%**; n=109), and children (15 years and younger, **2.9%**, n=13).
- Were primarily White (**31.2%**, n=137), more than one race (**29.6%**, n=127), Filipino (**12.4%**, n=53), or Mexican (**5.6%**, n=24). (See Figure 2).

Figure 2. Attendees by Top Race/Ethnicity Category, FY 2019-2020



In FY 2019-2020, **30.5%** (n=130) of Star Vista attendees were in at least one special populations group. Special populations include those who are veterans, are homeless, are at risk of homelessness, are hearing impaired, are vision impaired, have dementia, have chronic health conditions, have a mobility disability, have a learning disability, or have a developmental disability. Amongst those in the special population group, **32.9%** had chronic health conditions, **17.7%** had a mobility disability, **13.1%** were hearing impaired, **11.3%** had “other” disability, **11.3%** were veterans, **4.3%** were at risk of homelessness, **4.0%** were homeless, **2.7%** had a learning disability and **2.7%** were visually impaired. (See Figure 3).

Figure 3. Special Populations, FY 2019-20



Appendix J. Attendees by Race/Ethnicity by Collaborative, FY 2014-2020

Race/Ethnicity	NCOC						EPAPMHO					
	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020
Black	152 (4.1%)	153 (3.2%)	200 (2.7%)	49 (3.1%)	167 (3.0%)	685 (5.4%)	50 (9.1%)	205 (24.5%)	64 (23.8%)	200 (36.5%)	152 (23.2%)	93 (17.9%)
White	930 (25.2%)	902 (31.5%)	944 (32.0%)	111 (24.8%)	84 (27.0%)	2024 (16.0%)	44 (26.9%)	82 (9.8%)	54 (7.8%)	47 (8.6%)	55 (8.4%)	18 (3.5%)
American Indian	7 (0.2%)	48 (1.0%)	94 (1.3%)	67 (0.8%)	56 (1.0%)	90 (0.7%)	0 (0.0%)	8 (1.0%)	5 (0.7%)	1 (0.2%)	2 (0.3%)	1 (0.2%)
Middle Eastern	7 (0.2%)	60 (1.3%)	66 (0.9%)	14 (1.4%)	28 (0.5%)	44 (0.3%)	0 (0.0%)	0 (0.0%)	1 (0.1%)	0 (0.0%)	0 (0.0%)	2 (0.4%)
Eastern European	0 (0.0%)	0 (0.0%)	10 (0.1%)	12 (0.2%)	2 (0.0%)	5 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
European	0 (0.0%)	0 (0.0%)	6 (0.1%)	8 (0.1%)	21 (0.4%)	5 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Mexican	147 (4.0%)	260 (5.5%)	103 (18.7%)	6 (10.2%)	462 (8.4%)	2302 (18.2%)	43 (2.6%)	196 (23.4%)	90 (13.0%)	53 (9.7%)	156 (23.8%)	119 (22.8%)
Puerto Rican	1 (0.0%)	6 (0.1%)	28 (0.4%)	4 (0.1%)	10 (0.2%)	44 (0.3%)	1 (0.1%)	4 (0.5%)	0 (0.0%)	1 (0.2%)	2 (0.3%)	2 (0.4%)
Cuban	0 (0.0%)	0 (0.0%)	9 (0.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.1%)	0 (0.0%)	0 (0.0%)	1 (0.2%)	0 (0.0%)
Central American	0 (0.0%)	0 (0.0%)	79 (1.1%)	71 (5.9%)	32 (6.0%)	127 (1.0%)	0 (0.0%)	0 (0.0%)	9 (1.3%)	7 (1.3%)	12 (1.8%)	19 (3.6%)
South American	0 (0.0%)	0 (0.0%)	24 (0.3%)	51 (0.6%)	15 (0.3%)	27 (0.2%)	0 (0.0%)	0 (0.0%)	1 (0.1%)	1 (0.2%)	1 (0.2%)	0 (0.0%)
Caribbean	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (0.0%)	0 (0.0%)	5 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Other Latino	192 (5.2%)	87 (1.8%)	N/A	N/A	N/A	N/A	8 (13.8%)	0 (0.0%)	N/A	N/A	N/A	N/A
Asian	N/A	N/A	20 (0.3%)	5 (12.8%)	50 (10.0%)	873 (6.9%)	N/A	N/A	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.2%)
Filipino	336 (9.1%)	78 (14.2%)	304 (10.7%)	0 (12.5%)	331 (6.0%)	1170 (9.3%)	8 (15.0%)	18 (2.2%)	17 (2.5%)	8 (0.1%)	9 (1.4%)	4 (0.8%)
Chinese	96 (2.6%)	246 (5.2%)	308 (4.1%)	97 (3.7%)	212 (3.9%)	936 (7.4%)	96 (5.8%)	2 (0.2%)	2 (0.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Japanese	11 (0.3%)	30 (0.6%)	59 (0.8%)	55 (0.7%)	26 (0.5%)	37 (0.3%)	3 (0.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Korean	17 (0.5%)	29 (0.6%)	45 (0.6%)	34 (0.4%)	12 (0.2%)	39 (0.3%)	4 (0.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
South Asian	15 (0.4%)	16 (0.3%)	44 (0.6%)	70 (0.9%)	17 (0.3%)	222 (1.8%)	11 (0.7%)	2 (0.2%)	2 (0.3%)	1 (0.2%)	2 (0.3%)	1 (0.2%)
Vietnamese	1 (0.0%)	23 (0.5%)	13 (0.2%)	13 (0.2%)	11 (0.2%)	84 (0.7%)	35 (2.1%)	2 (0.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Cambodian	18 (0.5%)	1 (<0.1%)	0 (0.0%)	8 (0.1%)	2 (0.0%)	8 (0.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Laotian	0 (0.0%)	2 (<0.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.1%)	4 (0.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Mien	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Other Asian	37 (1.0%)	0 (0.0%)	N/A	N/A	N/A	N/A	4 (0.2%)	0 (0.0%)	N/A	N/A	N/A	N/A
Tongan	287 (7.8%)	237 (5.0%)	176 (2.4%)	61 (0.8%)	47 (0.9%)	89 (0.7%)	2 (10.4%)	121 (14.5%)	21 (17.5%)	88 (16.1%)	97 (14.8%)	30 (5.8%)
Samoan	280 (7.6%)	343 (7.2%)	347 (4.6%)	63 (2.0%)	201 (3.7%)	503 (4.0%)	23 (7.5%)	90 (10.8%)	49 (7.1%)	35 (6.4%)	57 (8.7%)	26 (5.0%)
Fijian	9 (0.2%)	24 (0.5%)	0 (0.0%)	8 (0.1%)	3 (0.1%)	21 (0.2%)	1 (0.1%)	14 (1.7%)	3 (0.4%)	3 (0.5%)	5 (0.8%)	1 (0.2%)
Hawaiian	31 (0.8%)	29 (0.6%)	40 (0.5%)	50 (1.9%)	188 (3.4%)	1521 (12.1%)	16 (1.0%)	7 (0.8%)	2 (0.3%)	5 (0.9%)	15 (2.3%)	164 (31.5%)
Guamanian	10 (0.3%)	26 (0.5%)	24 (0.3%)	5 (0.1%)	0 (0.0%)	0 (0.0%)	1 (0.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Multi	72 (2.0%)	414 (8.7%)	651 (8.7%)	07 (5.1%)	369 (6.7%)	1228 (9.7%)	39 (2.4%)	66 (7.9%)	74 (10.7%)	92 (16.8%)	86 (13.1%)	39 (7.5%)
Other Race	402 (10.9%)	101 (2.1%)	151 (2.0%)	54 (3.2%)	140 (2.5%)	113 (0.9%)	14 (0.8%)	2 (0.2%)	3 (0.4%)	4 (0.7%)	3 (0.5%)	0 (0.0%)
Unknown Race	626 (17.0%)	446 (9.4%)	488 (6.5%)	71 (8.4%)	06 (20.1%)	412 (3.3%)	16 (1.0%)	12 (1.4%)	93 (13.5%)	2 (0.4%)	1 (0.2%)	1 (0.2%)
Total**	3684	4761	7483	7996	5492	12614	1650	836	690	548	656	521

Note: Percentages may not sum to 100% because of rounding. **Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported. N/A indicates the category was not available or discontinued during the specific fiscal year.

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APPENDIX 12. INNOVATION PROJECTS EVALUATION REPORTS



San Mateo County Pride Center Fiscal Year 2019-20 Evaluation Report

A Mental Health Services Act Innovation Project



Prepared by:

Resource Development Associates

April 2021





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Introduction

Project Overview and Learning Goals

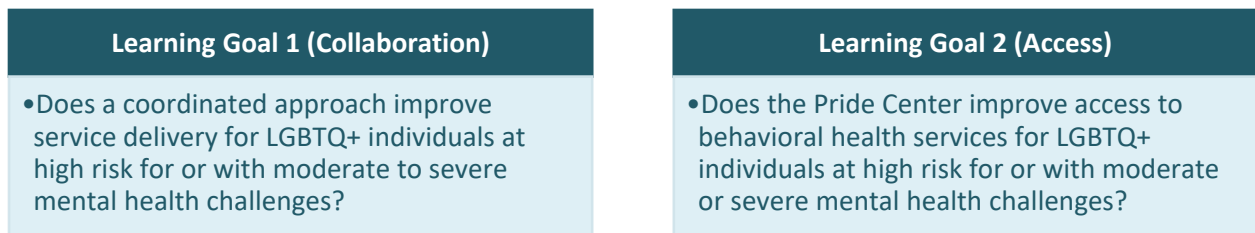
The San Mateo County Pride Center is an Innovation (INN) program under the Mental Health Services Act (MHSA) that is funded by the San Mateo County Behavioral Health Recovery Services (BHRS) department. The San Mateo County Pride Center (Pride Center or the Center) is a formal collaboration of three partner organizations: StarVista, Peninsula Family Service (PFS), and Adolescent Counseling Services (ACS).

- **MHSA INN Project Category:** Introduces a new mental health practice or approach.
- **MHSA Primary Purpose:** 1) Promote interagency *collaboration* related to mental health services, supports, or outcomes and 2) Increase *access* to mental health services to underserved groups.
- **Project Innovation:** While it is not new to have an LGBTQ center providing social services, there is no model of a coordinated approach across mental health, social and psycho-educational services for this marginalized community.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the project on July 28, 2016, and BHRS began implementation in September 2016. The Pride Center opened to the public on June 1, 2017. The following report provides findings from the fourth year of implementing the San Mateo County Pride Center, from July 1, 2019 to June 30, 2020.¹

In accordance with the requirements for MHSA INN programs, BHRS selected two Learning Goals—Collaboration and Access—as priorities to guide the development of the Pride Center. As Figure 1 demonstrates, BHRS sought to explore how this innovative model of coordinated service delivery and community engagement could enhance access to mental health services within underserved LGBTQ+ populations, particularly for individuals at high risk for, or with, acute mental health challenges. In turn, the program domains of Collaboration and Access are areas in which the Pride Center might serve as a model to expand of mental health services for LGBTQ+ individuals in other regions.

Figure 1: San Mateo County Pride Center Learning Goals



¹ Because the first year of implementation was devoted to planning, development, and startup of the Pride Center, this report sometimes refers to this fourth year of the program as the “third year of operations.” That is, the Pride Center itself has been open to the public for three years, while the Innovation program has been active for four years.





Project Need

Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and other (LGBTQ+) individuals commonly experience depression, anxiety, suicidal thoughts, substance abuse, homelessness, social isolation, bullying, harassment, and discrimination. LGBTQ+ individuals are at higher risk of mental health issues compared to non-LGBTQ+ individuals given that they face multiple levels of stress, including subtle or overt homophobia, biphobia, and transphobia.² Across the United States, a majority (70%) of LGBTQ+ students report having experienced harassment at school because of their sexual orientation and/or gender identity, and suicide is the second leading cause of death for LGBTQ+ youth ages 10-24.³

These nationwide trends are no less evident in San Mateo County. According to the San Mateo County LGBTQ Commission's 2018 countywide survey of 546 LGBTQ+ residents and employees, nearly half of adult respondents (44%) identified a time in the past 12 months when they felt like they needed to see a professional for concerns about their mental health, emotions, or substance use. At the same time, 62% of adult respondents felt that there are not enough local health professionals adequately trained to care for people who are LGBT, and fewer than half (43%) felt their mental health care provider had the expertise to care for their needs. Among LGBTQ+ youth who responded to the survey, three-quarters (74%) reported that they had considered harming themselves in the past 12 months, and two-thirds (65%) did not know where to access LGBTQ+ friendly health care.⁴

In this context, BHRS developed the San Mateo County Pride Center as a coordinated behavioral health services center to address the need for culturally specific programs and mental health services for the LGBTQ+ community. The establishment of the Pride Center also fulfills the MHSA principle to promote interagency collaboration and increase access to mental health services for underserved groups.

Project Description and Timeline

As a coordinated service hub that meets the multiple needs of high-risk LGBTQ+ individuals, the Pride Center offers services in three components:

1. *Social and Community Activities:* The Pride Center aims to outreach, engage, reduce isolation, educate, and provide support to high-risk LGBTQ+ individuals through peer-based models of wellness and recovery that include educational and stigma reduction activities.
2. *Clinical Services:* The Pride Center provides mental health services focusing on individuals at high risk of or already with moderate to severe mental health challenges.
3. *Resource Services:* The Pride Center serves as a hub for local, county, and national LGBTQ+ resources, including the creation of an online and social media presence. Pride Center staff host

² King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people. *BMC Psychiatry*, 8:70

³ GLSEN, *2017 National School Climate Survey*; The Trevor Project, "Facts About Suicide."

<<<https://www.thetrevorproject.org/resources/preventing-suicide/facts-about-suicide/>>>

⁴ San Mateo County LGBTQ Commission, "Survey Results of San Mateo County LGBTQ+ Residents and Employees," 2018 ed.



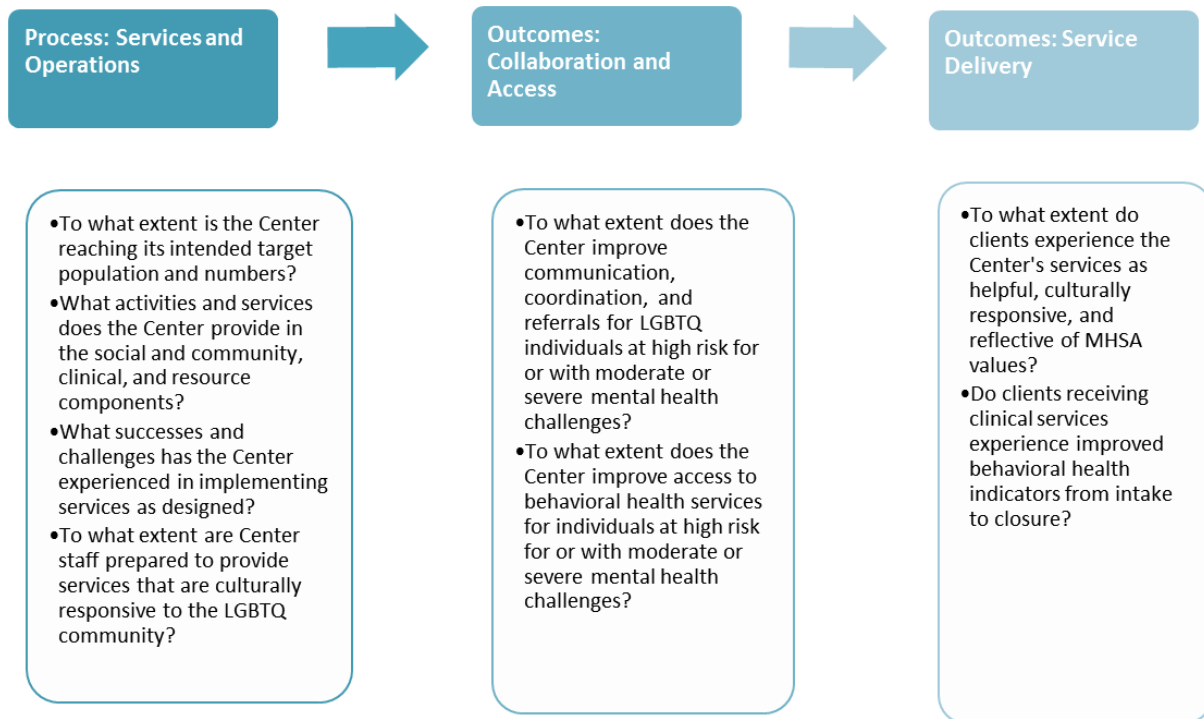
year-round trainings and educational events for youth, local public and private sector employees, community service providers, and other community members. Common topics include understanding sexual orientation and gender identity, surveying common LGBTQ+ issues and mental health challenges, and learning how to provide culturally affirmative services to LGBTQ+ clients.

Evaluation Overview

In 2017, BHRS contracted Resource Development Associates (RDA) to conduct the evaluation of the Pride Center implementation and outcomes. RDA collaborated with BHRS staff, Center leadership staff, and Center partners to develop data collection tools measure program and service outcomes. In order to maximize RDA's role as research partners and fulfill MHPA Innovation evaluation principles, this evaluation uses a collaborative approach throughout, including Pride Center staff and partners in operationalizing the evaluation goals into measurable outcomes and interpreting and responding to evaluation findings.

BHRS seeks to learn how the Pride Center enhances access to culturally responsive services, increases collaboration among providers, and, as a result, improves service delivery for LGBTQ+ individuals at high risk for or with moderate to severe mental health challenges. To guide the evaluation, RDA and BHRS have developed evaluation questions in three categories (see Figure 2). By reaching the Pride Center's goals in terms of service and operations, and by improving collaboration, the Pride Center hopes to improve access and overall service outcomes for clients.

Figure 2. Evaluation Domains and Questions





Evaluation Methods

RDA developed a mixed methods evaluation that incorporates both process and outcome evaluation components.

- A **mixed methods** approach allows the evaluation to track quantitative measures of service delivery and outcomes, while also gathering qualitative input on how and why activities and outcomes occurred. Using multiple sources to explore the evaluation questions also enables comparison and corroboration of findings across data sources.
- The **process evaluation** component explores the extent to which the Pride Center has been implemented as planned, as well as the strengths and challenges the county has experienced in implementation. The process evaluation considers the perspective of various stakeholders, including Pride Center staff and participants alike. Evaluating the implementation of Pride Center activities and services enables BHRS, Pride Center leadership staff, and Center partners to make real-time adjustments that may improve the operations and outcomes of the Center.
- The **outcome evaluation** component assesses the extent to which the Pride Center—through its collaborative approach to service delivery—improves access to services and client-level behavioral health outcomes.

Data Collection

In line with RDA's mixed methods approach, this evaluation includes both quantitative and qualitative tools to measure indicators in three domains: Center services and operations, the Center's Learning Goals (Collaboration and Access to Services), and service delivery outcomes. Below we describe the measures that the evaluation will use along with the data collection methods that we will use to measure each of the indicators.

Attendance and Demographic Reporting

To document the Pride Center's service population, Center staff and RDA collaborated to create a protocol for monitoring the number and characteristics of individuals who participate in onsite programs and services. Because the Pride Center provides an array of services with varying degrees of participation—including drop-in services, one-time community events, ongoing peer support groups, and clinical services—it was important to define what constitutes *meaningful* participation at the Pride Center for the purposes of collecting and reporting demographic data to the MHSOAC.

The Pride Center serves marginalized individuals who may be hesitant to provide personal information on paper, even anonymously. Asking new attendees to fill out an extensive demographic form could feel unwelcoming to individuals who have experienced fear, stigma, and trauma related to their LGBTQ+ identity or other life circumstances. In order to maintain a welcoming environment, Center staff determined that individuals who attend the Center *more than once*, as well as any clients receiving clinical services, would be considered meaningful participants and would be asked to complete a demographic



form. To capture the total number of individuals served, the Pride Center decided to also track attendance through a sign-in sheet that captures basic personal information, but does not include the full range of demographic variables listed in the updated INN regulations.

The demographic form was designed to capture all elements required by the MHSOAC. The Pride Center and its partners decided to add additional categories to the questions regarding sexual orientation and gender identity in order to include a wider spectrum of LGBTQ+ identities. These revisions were aligned with BHRS's initiative to revise Sexual Orientation, Gender Identity, & Gender Expression (SOGIE) questions on health intake forms. The Pride Center and its partners also decided to add three additional items to the demographic form: housing status, income, and employment status. In the summer of 2019, the Pride Center staff and RDA made a few additional changes to some of the demographic categories: rewording some of the options for sexual orientation and gender identity, streamlining the options for ethnicity, adding a separate question about intersex identity, and revising the options for housing status to align better with commonplace categories in homelessness services systems.

RDA developed an online format of the demographic survey using a HIPAA-compliant version of Survey Gizmo/Alchemer, which Pride Center staff used to input data for paper surveys through the end of 2018. Starting in January 2019, the Pride Center began collecting participant demographic data via an online format in Efforts to Outcomes (ETO), StarVista's client management database.

Participant Experience Survey

RDA developed a survey to gauge Pride Center participants' experiences and approval of the Center's onsite programs, staff members, mental health services, and community space. The survey is designed to be administered annually at a point in time to as many participants as possible. The survey includes statements that invite respondents to indicate their level of agreement with each statement on a four-level Likert scale (Disagree, Somewhat Disagree, Somewhat Agree, Agree). In addition, the survey asks the number of times participants have visited the Pride Center and contains an optional demographic section.

This year, because of the COVID-19 pandemic, all surveys were administered online using a HIPAA-compliant version of Survey Gizmo/Alchemer. This year's survey added several questions related to individuals' participation in remote services during the shelter-in-place. In addition, this year's survey added questions to explore the likelihood that participants would continue to participate in the Pride Center, and the reasons why they would or would not likely continue. The revised Participant Experience Survey is included in Appendix A.

In FY2019-20, 43 individuals responded to the survey. This is a lower number than participated in previous years (last year 93 responses were received). It is likely that COVID-19 contributed to the decrease in responses, as in previous years the survey was distributed both online and in person at the Pride Center.

Clinical Assessment and Survey Data

There are four data sources for participants who accessed clinical services at the Pride Center, which encompass psychotherapy and case management services.





1. **Type of service and average durations of treatment.** This data indicates the type of service (individual, couple, family, or group) and the average number of months clients were enrolled in clinical services.
2. **Demographic data for clinical participants.** Analyzing the demographic background of clinical participants allows for a comparison with the demographics of all Pride Center participants.
3. **Baseline results from the Child and Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA).** The CANS and ANSA are open domain tools for use in multiple individual-serving systems that address the needs and strengths of individuals, adolescents, and their families. San Mateo County BHRS has designated the CANS as the required tool for its contracted providers. The Pride Center standardized the use of the CANS and ANSA for all clinical clients during 2018-2019 and trained staff to conduct the assessment and enter the data into ETO. Staff administer the assessment at intake, at regular follow-up intervals, and at discharge to gauge clients' progress during their time in clinical services. See Appendix B for the CANS and ANSA instruments.
4. **Baseline results from a brief mental health self-assessment.** This short, three-question survey that the Pride Center developed in consultation with RDA asks participants about their mental health, anxiety levels, and emotional wellbeing over the past 30 days:
 - How would you rate your mental health in the last 30 days? (Poor/Fair/Good/Excellent)
 - How would you rate your ability to cope with stress in the last 30 days? (Poor/Fair/Good/Excellent)
 - I have benefited from the services that I am receiving or participating in at the Pride Center. (Strongly Disagree, Disagree, Neutral, Agree, Strongly Agree)

By administering the survey alongside the more comprehensive CANS and ANSA assessments, Pride Center staff have a quick method to document changes in patients' wellness over time.

Collaboration Instrument

As collaboration is the core innovative element of this MHSA INN project, it was crucial for the evaluation team to operationalize the concept of collaboration so that it could be measured over time. RDA researched validated survey tools intended to measure collaboration among a team of service providers, including both management-level staff (who may not work directly with clients) and direct service staff. RDA and BHRS selected the Assessment of Interprofessional Team Collaboration Scale II (AITCS-II), developed by Dr. Carole Orchard.⁵ RDA implemented the AITCS-II survey for the first three years of the evaluation. After reviewing results and speaking with Pride Center staff, the evaluation team determined that the data provided by the survey was not as relevant to the evaluation as initially intended. The survey focuses on internal team collaborative dynamics, which the first three years of evaluation have shown to be strong. The survey was not effective in measuring interagency collaboration in the Pride Center collaborative model. Therefore, beginning in FY2019-20, the evaluation team discontinued the use of the

⁵ Orchard, C. A., King, G. A., Khalili, H. and Bezzina, M. B. (2012), Assessment of Interprofessional Team Collaboration Scale (AITCS): Development and testing of the instrument. *J. Contin. Educ. Health Prof.*, 32: 58–67. doi:10.1002/chp.21123



collaboration survey, and instead explored the collaborative model through interviews with partner agency leadership and a focus group with partner agency staff.

Focus Groups with Pride Center Participants

With feedback from BHRS and the Pride Center Director, the evaluation team developed a semi-structured focus group guide to learn from participants about their experiences with programs onsite, to what extent the Pride Center facilitates access to services for LGBTQ+ individuals, and any suggestions for improvement.

In FY2019-20, the evaluation team, in partnership with Pride Center staff, determined that the focus of the qualitative data collection should be to learn about why participants choose to engage—or not to engage—with the Pride Center. The intention behind this focus was to understand more about disparities in access and cultural responsiveness of the Pride Center. RDA and the Pride Center defined key populations of interest to delve into these topics: 1) older adults, 2) black, indigenous, and people of color (BIPOC), 3) Asian and Pacific Islander (API) individuals, 4) Spanish-speaking individuals, 5) youth, and 6) participants living outside of the central San Mateo area. Due to the COVID-19 shelter-in-place, RDA and the Pride Center developed a plan for RDA to conduct virtual focus groups during the week following San Mateo County’s annual LGBTQ+ Pride week. The Pride Center and partner agencies supported with outreach for the focus groups. Ultimately, RDA conducted four focus groups and one interview with Pride Center participants, reaching a total of 16 individuals. The youth focus group was not held due to low registration, but some youth participated in the other focus groups.

Focus Groups with Staff and Community Advisory Board

RDA held one focus group with Pride Center staff (minus the Program Director), one with the Community Advisory Board, and one with staff from the Pride Center partner agencies. These focus groups offered insight into the Pride Center’s operations, including the extent to which staff members have been able to collaborate with each other, the CAB, and the partner organizations.

Key Informant Interviews with Partner Organizational Staff

The evaluation team conducted phone interviews with leadership from StarVista, Peninsula Family Service, and Adolescent Counseling Services to gain insight into the roles and responsibilities of partner organizations vis-à-vis the Pride Center, the kinds of regular support that the partner organizations provide, and staff’s perspectives on the Pride Center’s major successes and challenges.

Measures and Data Sources

Table 1 indicates the key measures and data sources the evaluation uses to assess outreach and implementation, collaboration and access to services, and service delivery outcomes.



Table 1. Evaluation Measures and Data Sources

Outreach and Implementation of Services	Data Sources
Number of individuals reached	<ul style="list-style-type: none"> • Participant Demographic Form • Participant Sign-In • Outreach and Meeting Tracking Sheets
Types of activities and services provided in the social and community, clinical, and resource components	<ul style="list-style-type: none"> • Participant Services Data • Focus Groups with Participants • Focus Group with Staff • Quarterly progress reports
Successes and challenges of implementing services as designed	<ul style="list-style-type: none"> • Focus Group with Staff • Interviews with Center Leadership and partners • Focus Group with Community Advisory Board (CAB) • Regular communications with Pride Center leadership and staff
Cultural responsiveness of services	<ul style="list-style-type: none"> • Focus Groups with Participants • Focus Group with Staff • Participant Experience Survey
Collaboration and Access to Services	Data Sources
Effectiveness of communication, coordination, and referrals for LGBTQ+ individuals with moderate to severe mental health challenges	<ul style="list-style-type: none"> • Focus Group with Staff • Focus Group with CAB • Focus Groups with Participants • Participant Experience Survey
Improved access to behavioral health services for individuals with moderate to severe health challenges	<ul style="list-style-type: none"> • Focus Groups with Participants • Participant Experience Survey
Service Delivery Outcomes	Data Sources
Client service experience (E.g., Experience with services, facility, and service providers)	<ul style="list-style-type: none"> • Participant Experience Survey • Focus Groups with Participants
Improved health outcomes among clients	<ul style="list-style-type: none"> • Clinical Service Data • Participant Experience Survey • Focus Groups with Participants

Data Analysis

To analyze the quantitative data, RDA examined frequencies, averages, and ranges. To analyze qualitative data, RDA transcribed focus group and interview participants' responses to appropriately capture the responses and reactions of participants. RDA thematically analyzed responses from participants to identify commonalities and differences in participant experiences.



Implementation Update

Changes to Innovation Project during Reporting Period

In December 2019, the Director of the Daly City Partnership, the fourth partner in the Pride Center collaborative model, transitioned out of their position. Without the presence of the Director, Daly City Partnership made the decision to withdraw from the collaborative model. Given that the Pride Center no longer had a partner agency located in North County, Pride Center staff examined the needs in North County and began to strategize to fill this gap.

Key Accomplishments

Below are highlights from the Pride Center's activities during the FY2019-20 program year.

- *Providing psychotherapy services for individuals, groups, couples, and families.* Pride Center clinicians employ a range of different modalities, including cognitive and dialectical behavioral therapy (CBT and DBT), mindfulness-based therapy, emotionally focused couples' therapy, narrative therapy, play therapy, and expressive arts therapy.
- *Providing case management services.* A dedicated case manager supports participants in accessing supportive resources and coordinating services. These services include both weekly drop-in hours, long-term case management, and a monthly legal name and gender marker change workshop to assist transgender and gender nonconforming clients with updating their legal documents to better match their identity.
- *Operating the Center as a "one-stop shop" and resource hub for LGBTQ+ community members.* The Pride Center continues to host an LGBTQ+ resource library, and provides community members with free amenities like clothing, toiletries, makeup products, shoes, bags, safer sex products, and chest binders (gender-affirming items used by the transgender, genderqueer, and nonbinary community). In addition, Pride Center staff help to field participants' ad hoc needs and requests for support.
- *Hosting multiple peer support groups (PSGs).* PSGs active during the program year included:
 - Gay Men's Group (Ages 18+)
 - Gaymers (Ages 18+)
 - Grown Folks (Ages 18-30)
 - LGBTQ+ Youth Group (ages 10-17)
 - Polyamory Peer Power (Ages 18+)
 - Queer Womxn's Group (Ages 18+)
 - Sisters Are Doing It (Ages 55+)
 - Trans Group (Ages 18+)



San Mateo County Behavioral Health and Recovery Services

Pride Center: 2019-20 Annual Report

- *Operating Older Adult Programs, for people ages 50 and older who live or work in San Mateo County.* Programs and activities for older adults include a weekly Mindfulness Meditation, a monthly lunch, a monthly book club, and a quarterly Senior Affordable Housing Workshop.
- *Running many different educational events, social activities, and community-based programs at the Center throughout the year.* In-person events included regular film screenings, speakers' events and discussions, meals and coffee breaks, informational sessions, and events cosponsored with other organizations and companies.
- *Continuing to offer the Pride Center name change workshop.* As the only local center providing this type of workshop on a monthly basis, the name change workshop has grown to be a sought-after service that has gained widespread recognition and referrals. In FY 2019-20, the clinic served 34 unique individuals from San Mateo County and 49 individuals in total. Beyond San Mateo County, the clinic also served individuals from counties including Alameda, Contra Costa, Marin, San Francisco, Santa Clara, San Joaquin, and San Diego. To date, the legal name and gender change workshop has served a total of 170 participants.
- *Training public agencies and private organizations on matters of sexual orientation and gender identity, both at the Pride Center and throughout the county.* Staff regularly conduct trainings for service providers, public employees, youth, and many other community members throughout the county. The most common training module involves core information about SOGIE and LGBTQ+ inclusion. Staff also conducted trainings on transgender rights, trans-inclusive policies, gender pronouns, and cultural humility. In FY 2019-20, the Pride Center delivered 20 trainings reaching 299 participants.
- *Hiring new Program Director, Francisco (Frankie) Sapp:* Having worked both nationally in the US and provincially in Ontario, Canada, Frankie has been entrenched in social justice advocacy and programming for 20 years. He began working with youth and creating workshops around leadership, advocacy, and anti-oppression and quickly moved into the field of HIV, where he ran a peer education program around HIV prevention, substance use, and harm reduction. Frankie's portfolio also includes experience speaking about sexuality, gender identity, active listening, sex education, and equity. He is well-versed in volunteer management, event planning and coordination, public speaking, and community networking. Frankie views his work through a lens of intersectionality and implements his vision utilizing strategic thinking. He is deeply connected to his Filipino roots and has a complicated history with the messiness between gender and sexuality.
- *Transitioning to fully virtual operation during COVID-19.* The Pride Center transitioned all programming, including mental health services, peer support groups, trainings, and social events to telehealth and Zoom events.
 - **Virtual Clinical Services:** Clinical services (therapy and case management) were successfully transitioned to remote, telehealth platforms to continue providing much-needed support and care to clients. Policy and procedure adaptations and were



implemented to ensure the efficacy of the program. For many of the clinical staff, this was the first time providing telehealth services and the team quickly overcame any initial obstacles with great success. The new foundation that has been built around the use of telehealth platforms will benefit the Pride Center in the years to come and will also help increase access to services for clients.

- **1st Virtual San Mateo County PRIDE Week Celebration:** Along with members of the PRIDE Initiative and fellow committee members, the San Mateo County Pride Center played an integral role in hosting a week's worth of virtual programming for the first virtual PRIDE celebration in San Mateo County. Altogether, virtual PRIDE week programming reached over 9,000 viewers. Additionally, for the first time in the county's history, every single city raised the LGBTQ+ Pride flag and passed proclamations in recognition of June as Pride Month – a momentous step for LGBTQ+ visibility and inclusion.
- **Virtual SOGIE Trainings:** Calling on the support of its newest Program Director, who has extensive experience with providing online webinars and trainings, the Pride Center proudly launched its first ever virtual Sexual Orientation, Gender Identity, and Gender Expression (SOGIE) training.
- **1st LGBTQ+ Adult Prom:** For the past several years, the Pride Center has hosted an LGBTQ+ youth prom, but in September 2019 it was proud to host its first ever LGBTQ+ prom for adults! The theme was "Somewhere Over the Rainbow: A Peninsula MasQueerade." In total, 125 adult participants were in attendance for a fabulous night of fun music, delicious food, drag entertainment performances, and the company of fellow LGBTQ+ friends and loved ones. The event was also a fundraiser to help support the Pride Center and all of its programs.



Consumer Population

Numbers Served

All Participants

During FY 2019-20, there were **3,395 contacts** with Pride Center programs, trainings, and services (which includes duplicated participants). This included 1,575 unique individuals who completed a sign-in sheet for in-person programs and services (from July 2019 to March 2020), and 1,526 people who participated in a training held by Pride Center staff. The total number of people is larger than the sum of these two, as Pride Center staff were unable to tally the number of unique individuals (ages 18 and older) who attended a peer group, or who were members of other programs (such as PFLAG or Alcoholics Anonymous) who convened at the Pride Center. In addition, the Pride Center engaged thousands of individuals through outreach efforts throughout the year. As of the end of the fiscal year, the Pride Center had 1,096 Instagram followers, 1,000 Facebook followers, and 251 Twitter followers.

Clinical Services

Since the start of clinical services in FY2017-18, the Pride Center has served a total of **283 individuals**. During FY2019-20, **133 clients** were active in clinical services (68 in therapy, 51 in case management, and 14 in both). Of these, **81 clients** were new clients who began services in FY2019-20. Of the clients who received therapy during FY19-20, the average treatment duration was 10.9 months.

Participant Background

All Participants

During FY2019-20, a total of **434 new participants** completed the demographic survey. The results are summarized below and presented in full in Appendix C.⁶ Table 2 below also includes a comparison of new participants in FY2019-20 to all participants over time.

⁶ *Note on reporting:* To comply with HIPAA requirements and protect the confidentiality of participating individuals, this report only presents data for response categories with at least five responses. Where fewer than five responses were received, some categories have been combined.



Age: The majority of participants (84%) reported being between the ages of 16 and 59. Ten percent (10%) were 60 or older, and 7% were 15 or younger.

Language: Nearly all participants (96%) reported speaking English in their households. Other responses included Spanish, Cantonese, American Sign Language, and Portuguese.

Race: More than half of participants (60%) identified as white (51% identified as white only). This was followed by participants who identified as Hispanic or Latino/a/x (21%) and Asian or Asian American (17%). In total, 49% of participants identified as either multiracial or people of color.

When comparing the race of Pride Center participants to the population of San Mateo County in 2019, the Pride Center saw a higher percentage of white participants (39% of the county, vs. 51% of participants who identified as only white) and a lower percentage of Asian participants (31% of the county, vs. 17% of Pride Center participants). One-quarter (24%) of county residents are Hispanic or Latino/a/x, which is nearly consistent with Latinx representation at the Pride Center (21%). While only 6% of Pride Center participants identified as Black, this represents twice the percentage of Black residents in the county (3%). Native Hawaiian, Pacific Islander, Native American, and Alaska Native participants were represented at rates comparable to the population of San Mateo County (2% and 1% of county residents, respectively).⁷

Ethnicity: For participants in FY2019-20, the most commonly identified ethnicity was European (45%). Latinx participants most commonly identified as Mexican or Chicano/a/x (15%). Among Asian American participants, the most common ethnicities were Chinese (8%) and Filipino/a/x (7%). Smaller proportions of the participants identified as Eastern European (7%) and African (4%).

Figure 3: Center Participants by Age in FY2019-20 (n=426)

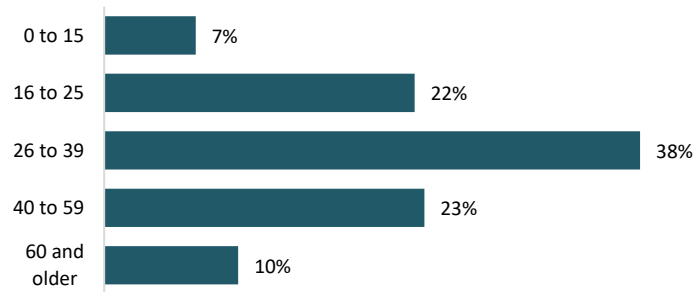
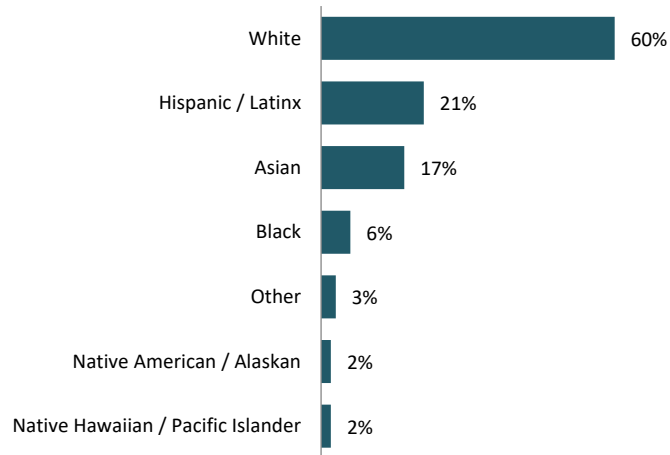


Figure 4: Pride Center Participants by Race in FY2019-20 (n=412)

note: participants could select multiple answers



⁷ "U.S. Census Bureau Quick Facts: San Mateo County, California," *U.S. Census Bureau website*. <<<https://www.census.gov/quickfacts/sanmateocountycalifornia>>>



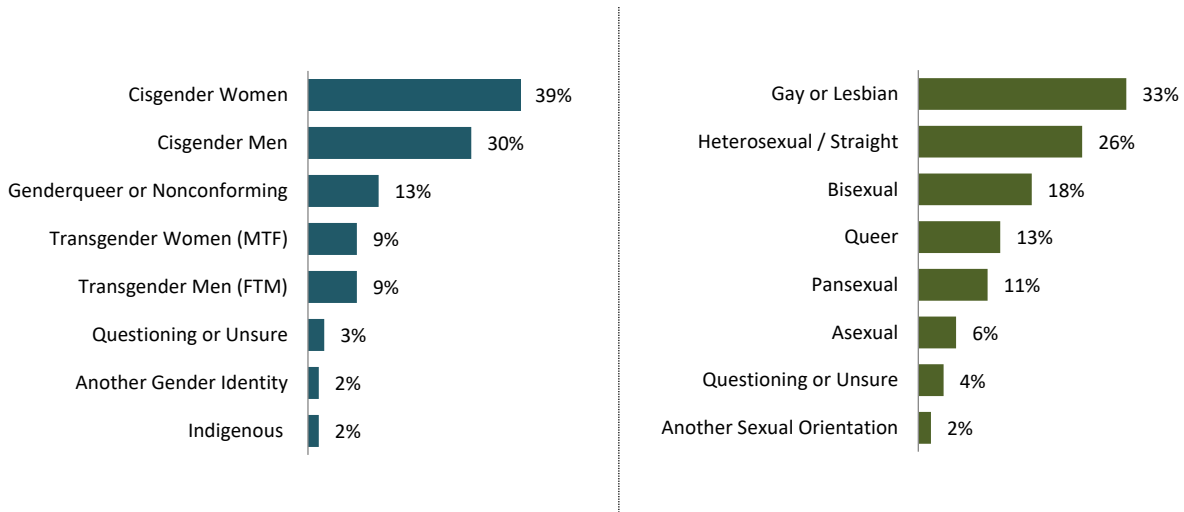


Sex: Fifty-five percent (55%) of participants responded that they were assigned female at birth, and 45% responded that they were assigned male at birth.

Gender Identity: In all, 69% of participants identified as cisgender: 39% percent identified as cisgender women and 30% identified as cisgender men. Eighteen percent (18%) of participants identified as either transgender men or women, and 13% identified as genderqueer or gender non-conforming. The remainder of respondents identified as an indigenous gender identity, another gender identity, or as questioning or unsure of their gender identity.

Sexual Orientation: Gay and lesbian individuals accounted for 33% of survey responses, and 26% of the participants identified as heterosexual or straight. Eighteen percent (18%) identified as bisexual, 13% identified as queer, and 11% identified as pansexual. The remaining participants reported that they were asexual, questioning, or identified with another sexual orientation.

Figure 5: Participants by Gender Identity (N=400) and Sexual Orientation (N=405) in FY2019-20



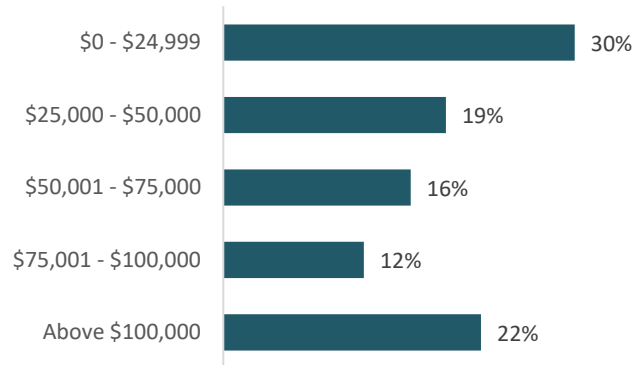
Disability Status: Slightly more than half of participants (58%) reported having no disabilities or health conditions. Of those that reported some type of disability, the most commonly reported were mental health conditions (30%) and chronic health conditions (10%).

Employment: More than half of participants (58%) reported having full-time employment, with 19% reporting part-time employment and 22% identifying as students. Five percent (5%) of participants were retired, and the remaining participants were unemployed and looking at the time of the survey (4%), unemployed and not looking for a job (4%), or unable to work due to a disability or illness (4%).



Income: As Figure 6 shows, the Pride Center draws adult participants across the socioeconomic spectrum with 30% of participants earning \$0-\$24,999 and 22% of participants earning more than \$100,000 annually. Among survey respondents ages 18 or older, over half are considered Extremely Low Income (less than \$36,540) or Very Low Income (less than \$60,900) for San Mateo County, based on 2019 US Department of Housing and Urban Development (HUD) individual income levels.⁸

Figure 6: Adult Participants by Personal Income (n=329) in FY2019-20



Housing: Most participants ages 18 and older (85%) reported having stable housing, and an additional 5% reported that they were staying with family or friends. The remaining respondents reported that they were homeless or unsheltered, living in a shelter or transitional housing, or had another form of housing.

Veteran Status: Ninety-seven percent (97%) of adult participants reported that they were not armed forces veterans.

⁸ 2020 San Mateo County Income Limits as determined by HUD. Retrieved from <https://housing.smcgov.org/sites/housing.smcgov.org/files/2020%20Income%20Limits%20revised%2004282020.pdf>



Demographic Comparison

In order to understand participant demographic trends, the table below highlights key differences and similarities between FY2019-20 participants and A) participants receiving clinical services in FY2019-20, and B) all participants from the Pride Center opening through FY2019-20. The comparison shows that among *clinical service participants*, higher proportions were children or transition age youth, transgender, questioning or unsure of their sexual orientation, and Latinx. Among *new participants*, higher proportions were 26-39 years old, female at birth, and cisgender women.

Table 2. Demographic Comparison to FY2019-20 Participants

Category	A. Clinical Participants FY2019-20	B. Pride Center Opening through FY2019-20
Age	Compared to all FY2019-20 participants, a higher percentage of clinical participants were age 25 or under (47%).	Compared to participants across all years, a slightly higher percentage of new participants in FY2019-20 were adults ages 26-39.
Race	Compared to all FY2019-20 participants, a higher percentage of clinical participants identified as Latinx/o/a (27%), and a lower percentage identified as White (52%) or Asian (12%).	Overall, the racial breakdown was generally the same for new FY2019-20 participants and participants across all years. There was a slight decrease in the proportion of participants of color from FY2018-19 to FY2019-20 (from 52% to 49%).
Sex at Birth	Compared to all FY2019-20 participants, a slightly higher percentage of clinical participants reported that they were assigned male at birth (50%).	Compared to participants across all years, a slightly higher percentage of new participants in FY2019-20 reported that they were assigned female at birth.
Sexual Orientation	Compared to all FY2019-20 participants, a higher percentage of clinical participants reported they are questioning or unsure of sexual orientation (13%).	Overall, the breakdown of sexual orientation was generally the same for new FY2019-20 participants and participants across all years.
Gender Identity	Compared to all FY2019-20 participants, a slightly higher percentage identified as transgender (41%).	Compared to participants across all years, a slightly higher percentage of new participants in FY2019-20 identified as cisgender women.



Clinical Services Data

This section presents data on participants in clinical services from FY2017-18 through FY2019-20.

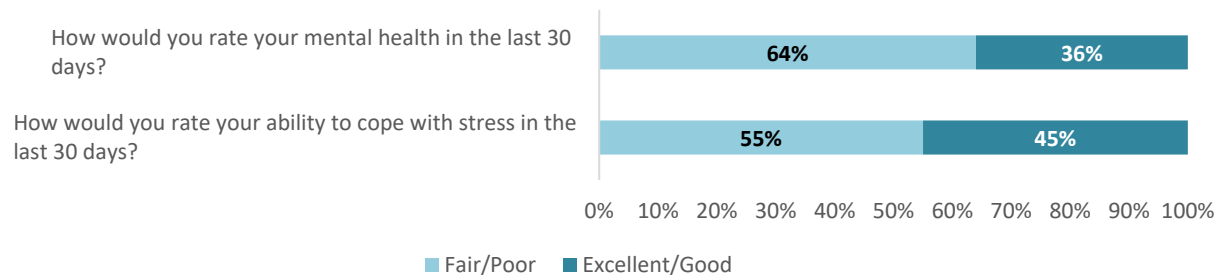
Client Self-Assessment

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

Baseline Data

Baseline data was available for **56 clients**. At initial assessment, nearly two-thirds of clients (64%) rated their mental health as poor or fair, and a little over half (55%) rated their ability to cope with stress as poor or fair (see Figure 7). For both self-assessment questions, “fair” was the most common response at baseline. Only 5% of clients rated their mental health as “excellent” and no client rated their ability to cope with stress as excellent.

Figure 7. Clients’ Initial Screening Experiences (n=56)



Follow-up Data

Follow-up assessments (either a 6-month or discharge assessment) were available for **16 clients** from FY2017-18 through FY2019-20. For individuals who had multiple follow-up assessments, the most recent assessment was used to determine change. The average time between assessments was 218 days (7.3 months), ranging from 48 to 461 days.

The data below includes the 16 clients who had both an initial and a follow-up assessment. Figure 8 and Figure 9 indicate that at follow-up, a higher percentage of clinical clients reported positive mental health and ability to cope with stress. For example, while less than half of clients rated their mental health in the previous 30 days as good or excellent at their initial assessment, more than half did at follow-up. Less than 40% of clients rated their ability to cope with stress in the previous 30 days as good or excellent at their initial assessment, and more than 60% did at follow-up. It should be noted that because the overall number of follow-up assessments was small, these improvements should not be generalized to all clients.



Figure 8. Clients’ Mental Health in Last 30 Days (n=16)

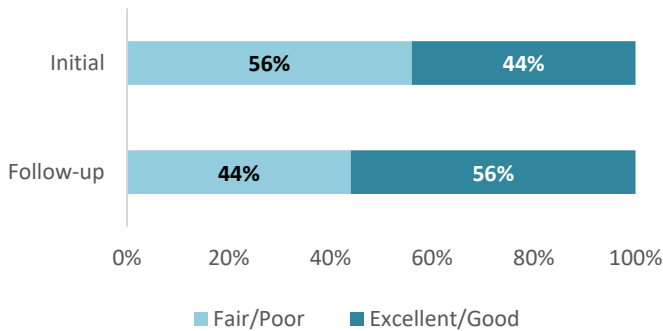
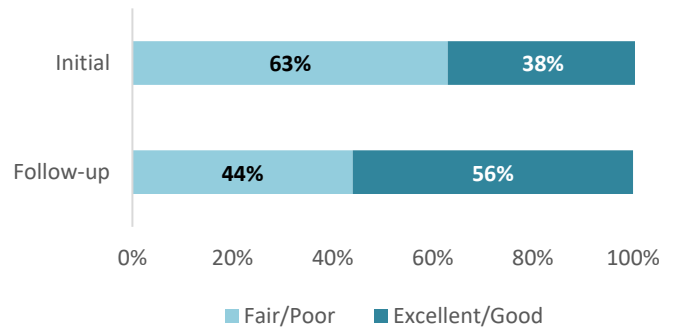


Figure 9. Clients’ Ability to Cope with Stress in Last 30 Days (n=16)



Client Strengths and Needs

This section summarizes the results of the assessments administered to clinical service participants—the Child and Adolescent Strengths and Needs (CANS) for youth and the Adult Needs and Strengths Assessment (ANSA) for adults.⁹

- **71** adults had an initial ANSA
 - **49** had an initial and follow-up
- **16** youth had an initial CANS
 - **8** had an initial and follow-up

The follow-up analysis includes only individuals who had both an initial and follow-up assessment (either a 6-month or discharge assessment) between FY2017-18 and FY2019-20. For individuals who had multiple follow-up assessments, the most recent assessment was used to determine change. For the ANSA, the average time between assessments was 284 days (8.1 months), ranging from 14 to 742 days. For the CANS, the average time between assessments was 169 days (5.6 months), ranging from 119 to 253 days.

The ANSA/CANS “actionable range” is defined as a score of 2 or 3. To interpret change over time, a positive change is indicated by a decrease in score.

The analysis included the primary domains of the assessments: Functioning Domain, Strengths Domain, Cultural Factors, Behavioral/Emotional Needs, Risk Behaviors, and Caregiver Resources and Needs (CANS). The ANSA and CANS scoring rubric is as follows: 0 = no evidence; 1 = history, suspicion; 2 = action needed; and 3 = disabling, dangerous, immediate action. To

explore clients’ needs from multiple angles, the analysis examined average ANSA and CANS scores for each domain and for the individual items within each domain. In addition, the analysis examined the percent of clients who received ANSA scores in the actionable range.¹⁰ Key takeaways from the analysis are presented below. For full assessment results, see Appendix C.

⁹The CANS/ANSA was not administered if: a) the client only attended a one-off Name and Gender Change Workshop or was a drop-in client seeking out resources; b) the client was only a participant in the Kennedy Middle school group; or c) the client was active for less than 1-2 months or had several no-shows that prevented staff from gathering enough data for a proper assessment.

¹⁰ Because of the small number of follow-up CANS assessments, this analysis was only conducted for the ANSA.





Overall Level of Need

At both the initial and follow-up assessment, each needs domain had an average score of less than 1, which falls between “no evidence” and “history or suspicion” and is below the actionable range (see Table 3 and Table 4). See below for a note on interpreting the Strengths Domain.¹¹

Table 3. Average ANSA Domain Scores and Change Over Time

Domain	N	Baseline Avg Score	Follow-up Avg Score	Avg Change
Functioning Domain	48	0.64	0.59	-0.05
Strengths Domain	49	1.78	1.80	0.02
Cultural Factors	48	0.55	0.51	-0.04
Behavioral/Emotional Needs	49	0.73	0.67	-0.06
Risk Behaviors	48	0.23	0.18	-0.05

Table 4. Average CANS Domain Scores and Change Over Time

Domain	N	Baseline Avg Score	Follow-up Avg Score	Avg Change
Functioning Domain	8	0.50	0.39	-0.11
Strengths Domain	8	1.75	1.30	-0.45
Cultural Factors	8	0.54	0.42	-0.12
Caregiver Resources and Needs	8	0.35	0.34	-0.01
Child Behavioral/Emotional Needs	8	0.44	0.39	-0.05
Risk Behaviors	8	0.11	0.14	0.03

Areas of Highest Need

Although the average baseline score at the domain level was less than 1, several items within the domains had average scores between 1 and 2 (“action needed”), indicating that a higher proportion of clients had a score in the actionable range for these items. Table 5 and Table 6 below show the needs with an average baseline score of 1 or higher for adults and youth. Table 5 also demonstrates the percent of adults that received a score of 2 or 3 (the actionable range) for these items.

Table 5. Items with Highest Average Need at Baseline: ANSA

ANSA Item	N	Average Baseline Score	Percent of Clients in Actionable Range
Anxiety	49	1.57	65%
Depression	48	1.54	58%
Family Relationships	48	1.44	54%
Social Functioning	47	1.26	40%
Adjustment to Trauma	49	1.24	49%
Cultural Stress	48	1.04	27%

¹¹ The Strengths Domain uses the following rubric: 0 = centerpiece strength, 1 = useful strength, 2 = identified strength, and 3 = no evidence. Unlike the needs domains, a score of 2 may not indicate that action is needed.





Table 6. Items with Highest Average Need at Baseline: CANS

CANS Item	N	Average Baseline Score
Anxiety	8	1.50
Sexual Development	8	1.13
Cultural Stress	8	1.13
Depression	8	1.00
Caregiver Knowledge	8	1.00

The data above demonstrate that mental health issues, particularly anxiety, depression, and trauma, were prevalent among Pride Center’s clinical clients. Family and social relationships also rose to a high level of need. For adults, these needs included both family and peer relationships; for youth, the need focused on caregiver knowledge, likely related caregivers’ competency around LGBTQ+ issues. For youth who may be earlier in their development of their sexuality and/or their LGBTQ+ identity, sexual development also arose as an area of higher need. It is also notable that cultural stress was indicated as an area of need for both adults and youth.¹²

Changes in Needs Over Time

While it is not possible to attribute improvements solely to clinical services, results suggest that clinical clients showed improvement in key needs, including anxiety, depression, adjustment to trauma, and family relationships.

Average Domain and Item Scores

Between the initial and follow-up assessment, the average scores for each domain showed slight positive changes (Table 3 and Table 4 above). While changes in average domain scores were small, several items within the domains saw improvements. Items that saw an improvement of 0.20 points or more are shown in Table 7 and Table 8. Notably, four of the items with the highest need (anxiety, depression, adjustment to trauma, and family relationships) were among those with the most improvement.

Table 7. Items with Highest Changes in Average ANSA Scores

ANSA Item	N	Baseline Avg Score	Follow-up Avg Score	Avg Change
School*	23	0.61	0.30	-0.31
Anxiety	49	1.57	1.31	-0.26
Depression	48	1.54	1.29	-0.25
Cultural Identity	33	0.94	0.70	-0.24
Adjustment to Trauma	49	1.24	1.00	-0.24
Family Relationships	48	1.44	1.21	-0.23

*Note that this item was completed for only 23 of the clients, as it was not applicable to all adult clients.

¹² Cultural stress refers to “circumstances in which the individual’s cultural identity is met with hostility or other problems within his/her environment due to differences in attitudes, behavior, or beliefs of others (this includes cultural differences that are causing stress between the individual and his/her family). Racism, homophobia, gender bias and other forms of discrimination would be rated here.) See:

http://www.acbhcs.org/providers/CANS/docs/ANSA/ANSA_25_Manual.pdf





High-need items at baseline that *did not* show improvement at follow-up were social functioning and cultural stress.

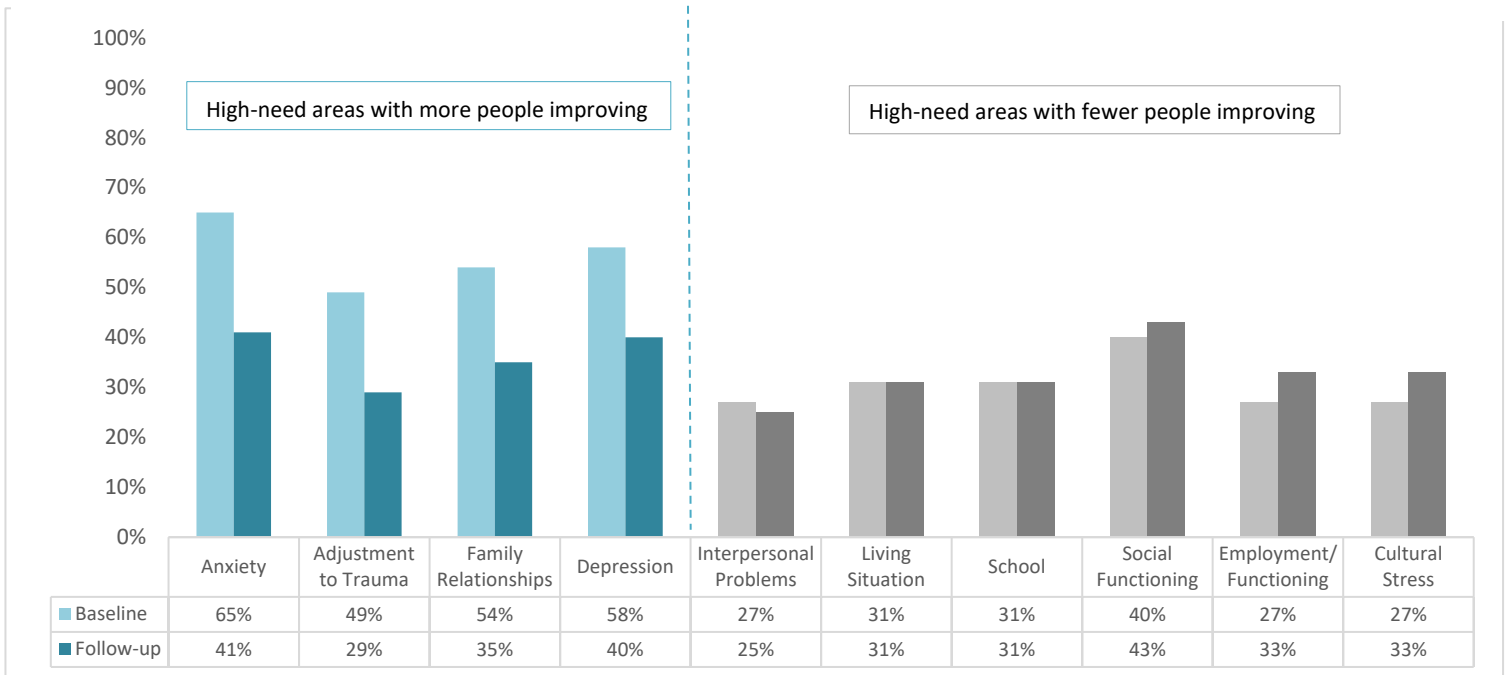
Table 8. Items with Highest Changes in Average CANS Scores

CANS Item	N	Baseline Avg Score	Follow-up Avg Score	Avg Change
Anxiety	8	1.50	0.88	-0.62
Recreational	7	0.57	0.14	-0.43
Social Resources (Caregiver)	8	0.75	0.38	-0.37
Decision-making	8	0.50	0.25	-0.25
Sexual Development	8	1.13	0.88	-0.25
Language	8	0.38	0.13	-0.25
Adjustment to Trauma	8	0.63	0.38	-0.25

Percent of Clients in Actionable Range

As mentioned above, an additional analysis was conducted with ANSA data (there were not enough CANS follow-up assessments). Figure 10 depicts the items for which at least one-quarter of adults received a score in the actionable range. For each item, the first column represents the percent of clients with an actionable score at baseline, and the second column represents the percent of clients with an actionable score at follow-up. As shown on the left-hand side of the chart, there were substantial decreases (i.e., improvements) in the percentage of clients with an actionable score for key items such as anxiety, adjustment to trauma, family relationships, and depression. This suggests that some clients with higher need achieved greater stability during the time they received clinical services.

Figure 10. Percent of Adult Clients with Score in Actionable Range





Additionally, some items that did not have many clients in the actionable range also saw marked improvements at follow-up, including the recreational and sexual development items. As shown in the right-hand side of the chart, some items with a high percentage of clients in the actionable range did not show much change, or showed negative change, from the initial to follow-up assessment, including interpersonal problems, living situation, social functioning, employment, and cultural stress.

The two analyses of change over time (looking at average scores and the actionable range) highlight some differences in the items showing change. For instance, the average scores for school improved and the average for social functioning remained relatively stable. However, the percent of participants in the actionable range did not improve in the area of school and showed negative change in the area of social functioning. These results may indicate that there were a few lower-need clients who improved a lot—enough to change the average—but that higher-need clients are not seeing improvement in that area. The results may also indicate that while some clients saw improvement, a need emerged for other clients between the initial and follow-up assessment. Items including employment/functioning and cultural stress saw negative change both in the average score and in the percent of participants in the actionable range.

Strengths

For adults and youth, the strengths with the most positive average scores at baseline were as follows:

Adults

- Resilience
- Resourcefulness
- Optimism
- Talents and interests
- Interpersonal/social connectedness

Youth

- Resilience
- Family strengths
- Relationship permanence
- Talents and interests
- Optimism

At follow-up, the largest improvements in adults' strengths were seen in the spiritual/religious item, talents and interests, and resilience. Notably, from initial to follow-up assessment, job history and vocational strengths saw the greatest *decline* of any item (needs or strengths), which may be an indication of the economic effects of COVID-19.

Across both adults and youth, the biggest change at the domain level was an improvement in the Strengths Domain for youth. Youth saw improvements in nearly all items within this domain, with the greatest gains in interpersonal/social connectedness, natural supports, and cultural identity.



Progress Toward Learning Goals

This section discusses the progress that the San Mateo County Pride Center has made toward achieving its two learning goals. A summary of key findings is presented below, followed by a detailed discussion of each learning goal.

Learning Goal 1: Impact of Coordinated Service Delivery Model

Internal Collaboration: Pride Center staff have continued to collaborate with each other to serve clients and facilitate linkages to services within and outside of the Pride Center.

Collaboration with Partner Agencies: The Pride Center's collaborative organizational model has expanded the Pride Center's reach both geographically and demographically.

External Collaboration: The Pride Center has become a key part of a larger network of providers advancing LGBTQ+ inclusion and visibility in San Mateo County.

Collaborative Organizational Model: As the Pride Center has continued to operate as a partnership of three agencies, several factors have emerged as core needs for an effective model, including: clarity of roles and responsibilities, venues for communication, organizational culture, leadership support, support with administrative requirements, staffing and turnover, and funding and sustainability.

Learning Goal 2: Improved Access to Mental Health Services

Improved Access and Outcomes: The Pride Center has substantially increased access to mental health services for LGBTQ+ individuals, and this access also appears to be leading to improvements in mental health outcomes for clinical clients. In addition, the evaluation has consistently found that having a safe space to build community is an important protective factor for both clinical and non-clinical participants.

Clinical Service Capacity and Reach: The Pride Center has continued to prioritize mental health services for members of underserved and marginalized communities but has struggled to engage Black/African American clients. The Pride Center has continued to strengthen its clinical program by navigating requirements to enable Medi-Cal reimbursement for clients with all levels of mental health need. The Pride Center has developed partnerships with external organizations to extend the county's capacity to provide LGBTQ+ responsive mental health care.

Facilitators of Access and Engagement: Sharing outreach and information about the Pride Center, offering services at different times of day, providing services or referrals outside of the central San Mateo region, and helping older adults address technology barriers have assisted with access to the Pride Center. Feeling a sense of community at the Pride Center, feeling welcome and safe at the Pride Center, and enjoying the services and programs have promoted ongoing engagement. During COVID-19, the Pride Center successfully shifted to fully virtual programming, maintaining a touchpoint for LGBTQ+ community members during this difficult time.

Barriers to Access and Engagement: Participants highlighted two common reasons that they were hesitant to engage in the Pride Center: 1) they did not feel represented among Pride Center staff and/or participants, or 2) they did not see programming that reflected their identity. While services were virtual for much of FY19-20, the geographic spread of the county and limited public transportation have remained a challenge to ensuring access to in-person services.



Learning Goal 1: Impact of Coordinated Service Delivery Model

Learning Goal: Does a coordinated approach improve service delivery for LGBTQ+ individuals at high risk for or with moderate to severe mental health challenges?

Levels of Collaboration

Consistent with previous years, Pride Center staff have continued to collaborate with each other to serve clients and facilitate linkages to services within and outside of the Pride Center. Staff have developed positive working relationships within the Pride Center, supported by regular team meetings and clear communication. The clinical team and Case Manager often work together to establish care plans for clients. Similar to previous years' findings, respondents to the Participant Experience Survey found it easier to connect to services *within* the Center than *outside* the Center.

The Pride Center's collaborative organizational model has improved service delivery capacity by expanding the Pride Center's reach both geographically and demographically. All Pride Center partner agencies—Star Vista, Peninsula Family Service, and Adolescent Counseling Services—agreed that being part of a collaborative model has not only contributed to the Pride Center's success; it has also enhanced their individual organizations' services. As the lead agency, StarVista reported that they are better able to reach youth, older adults, and the northern part of the county because of their partnerships with PFS and ACS. The Pride Center can reach more individuals because of the name recognition and visibility of their partners. In turn, PFS reported that being a partner agency has expanded the population they serve and has increased their agency's cultural sensitivity to the LGBTQ+ community.

The Pride Center has become a key part of a larger network of providers advancing LGBTQ+ inclusion and visibility in San Mateo County. The Pride Center's outreach efforts and organizational partnerships have helped the Pride Center build a large, countywide network. The Center's early successes have bolstered its reputation in the county as an authoritative source on LGBTQ+ inclusion, community building, and mental health care. Pride Center staff continue to train county staff members about SOGI and LGBTQ+ inclusion. All partners agreed that the Pride Center has increased LGBTQ+ visibility in San Mateo County, ultimately creating a more welcoming and inclusive environment for LGBTQ+ individuals to live and participate in the larger community. As evidence of the changing atmosphere of inclusion, in FY19-20, each of the cities in San Mateo County declared their observance of Pride Month in June and raised the Pride flag.

"The Center has gotten LGBTQ out of the closet [in San Mateo County]."

—Partner Agency

Building a Collaborative Organizational Model

As the Pride Center has continued to operate as a partnership between StarVista, PFS, and ACS, several factors have emerged as core needs for an effective model. Below is a summary of these factors and lessons learned during the Pride Center's operation.



San Mateo County Behavioral Health and Recovery Services

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- **Clarity of roles and responsibilities.** There has not been a shared vision of the intended roles and responsibilities of the partner agencies. Limited clarity about each partner's responsibilities, lines of communication, and decision-making authority remains one of the biggest challenges to operating as a partnership. Partners mentioned a desire to understand how to collaborate and utilize each partner's strengths effectively.
- **Venues for communication.** While there are regular meetings for leadership from partner agencies, there is not always complete attendance. Further, without clear roles, leadership may be unsure how to engage and participate fully. Partner agency staff are invited to attend Pride Center staff meetings, which helps open lines of communication. Pride Center and partner agency staff observed that more opportunities for team building would be beneficial for interagency rapport and collaboration.
- **Organizational culture.** Each partner agency has their own organizational culture. While this not necessarily something negative, considering organizational culture is important when determining procedures such as communication agreements.
- **Leadership support.** The sustainability of the partnership relies in part on support from agency leadership. In the case of one of the partner agencies, when leadership transitioned, the agency left the partnership. Additionally, partners' own capacity to be efficient partners depends in part on their overall funding and resources.
- **Support with administrative requirements.** Pride Center staff have independently navigated administrative requirements to enable the Center to bill Medi-Cal and the Health Plan of San Mateo for clinical services. Without close guidance on federal and County billing requirements, the Center experienced delays in being able to receive federal and County reimbursement for clinical services.
- **Staffing and turnover.** Pride Center receive modest compensation for high-volume, demanding work, which has increased the risk of staff burnout and turnover among the core Pride Center team. In response, in FY2019-20 the Pride Center reduced the breadth of responsibilities for some, so that staff are not stretched so thin. There has also been turnover in some partner agency staff, particularly the youth program, which has led to temporary gaps in programming and loss of institutional knowledge.
- **Funding and sustainability.** The role of partner agencies in supporting fundraising for the ongoing sustainability of the Pride Center has not been clear. Even with a full-time grant writer on staff at the Pride Center, partners raised concerns and a desire for greater strategic support around fundraising for the sustainability of the Pride Center.

"[The partners need an] agreed upon set of expectations and guidelines as to how to operate."

–Partner Agency

Many of the abovementioned challenges have remained consistent over the course of the Pride Center's operation, affirming partners' observations that the Pride Center would benefit from additional support in the governance and operations of the collaborative model. It is important to note that in early 2020, the Pride Center hired a new Program Director, which coincided with the challenges of adapting to COVID-



19 and moving to fully virtual programming. Despite these obstacles, the Program Director has strategized and begun to implement ways to strengthen the collaborative model and build a cohesive and effective team.

Learning Goal 2: Improved Access to Mental Health Services

Learning Goal: Does the Pride Center improve access to behavioral health services for LGBTQ+ individuals at high risk for or with moderate or severe mental health challenges?

Improved Access and Mental Health Outcomes

Over the past three years, the evaluation has demonstrated that the Pride Center has substantially increased access to mental health services for LGBTQ+ individuals. The Pride Center has achieved this by offering in-house therapy services, building a strong referral network with county providers and schools, and improving the capacity of county providers to offer LGBTQ-responsive care. Because the Pride Center has filled a crucial gap in mental health services, the Center has become an established organization within San Mateo County's network of mental health care. On the clinical self-assessment survey, 92% of clinical participants strongly agreed or agreed that they have benefited from services offered to them at the Pride Center. As demonstrated in the Clinical Services Data above, clinical clients have shown improvements in mental health outcomes, including reduced severity of depression and anxiety and improved ability to cope with trauma.

"The impact of the Pride Center is felt across the entire health system."

–Partner Agency

In addition to increasing access to clinical services, the evaluation has consistently found that having a safe space to build community is an important protective factor for both clinical and non-clinical participants. While only a fraction of respondents uses formal therapy services at the Pride Center, many more participants gain benefits to their mental health and wellbeing from the inclusive and supportive space that the Pride Center offers. Numerous participants praised the Pride Center for helping them feel welcome, safe, and comfortable as an LGBTQ+ individual. In this way, participating in the Pride Center can serve as a protective factor that may prevent future mental health challenges. As in previous years, the majority of respondents to the Participant Experience Survey indicated that the Pride Center gives them a sense of community and has improved their mental health.

Clinical Service Capacity and Reach

The Pride Center has continued to strengthen its clinical program by navigating requirements to enable Medi-Cal reimbursement for clients with all levels of mental health need. The Pride Center has hired clinical providers, secured contractors to serve as clinical supervisors, and maintained a consistent caseload of clinical clients. The Center's trainee model offers clinical trainees with an interest in LGBTQ+ mental health the opportunity to serve clients while working toward their clinical hours. The administrative and staffing requirements for Medi-Cal billing are particularly complex for clinical trainees, and the Pride Center is still in the process of ensuring it can receive Medi-Cal reimbursement for clients with serious mental illness (SMI) and mild-to-moderate mental illness.



The Pride Center has developed partnerships with external organizations to extend the county's capacity to provide LGBTQ+ responsive mental health care. The Pride Center alone cannot—and was not intended to—meet the mental health treatment needs of all LGBTQ+ individuals in the county. The Pride Center maintains a full caseload with a waitlist. At the time of the evaluation, ANSA and CANS average domain scores (see Clinical Services Data above) indicated that overall, the Pride Center was serving a population with low to moderate needs. To increase the county's capacity to serve LGBTQ+ clients, particularly those with higher mental health need, the Pride Center has developed relationships with outside providers. For example, the Pride Center has developed a referral pathway with the Felton Institute to deliver psychiatric services for clients with SMI.

The Pride Center has continued to prioritize mental health services for members of underserved and marginalized communities but has struggled to engage Black/African American clients. Participants receiving therapy services at the Pride Center have emphasized the value of having a LGBTQ+ therapist to support their mental health treatment. This year and in previous years, some clinical clients emphasized the value of having a therapist from their same racial or ethnic background. In the ANSA and CANS data, the “cultural identity” item, which can refer to race/ethnicity, religion, and LGBTQ+ identity, saw small improvements in average scores for both adults and children.¹³ At the same time, staff noted that while representation of people of color in the clinical program has overall been strong, Black/African American clients have been the least represented in clinical services. The section below on “Facilitators and Barriers to Access and Engagement” further discusses the Pride Center's engagement with Black, Indigenous, and People of Color (BIPOC).

Facilitators and Barriers to Access and Engagement

This year, the evaluation sought to explore the topic of access with a focus on individuals who have had less engagement with the Pride Center, including those who may choose *not* to engage with the Pride Center. This inquiry was intended to shed light on barriers to access and engagement so that the Pride Center can continue to develop strategies to reach members of the LGBTQ+ community who may be underserved. In previous years, many participants in the evaluation survey and focus groups were already highly engaged in the Pride Center.

The need to adapt the evaluation to the COVID-19 pandemic offered an opportunity to reach individuals with lower levels of engagement with the Pride Center. In the spring of 2020, RDA and the Pride Center strategized and decided to use the county's week-long virtual Pride Week celebration as a forum to outreach for the survey and focus groups. As a result, participants in this year's evaluation were less likely to be highly engaged in the Pride Center. Participant Experience Survey data reflect this to be the case: last year, 70% of respondents participated in the Pride Center at least once a month; this year, only 42% of respondents did.¹⁴ This year, 28% of respondents reported participating a few times a year, and 30%

¹³ Cultural identity refers to an Individual's feelings about her/his cultural identity. This cultural identity may be defined by a number of factors including race, religion, sexual orientation, gender identity, ethnicity, geography or lifestyle. See: http://www.acbhcs.org/providers/CANS/docs/ANSA/ANSA_25_Manual.pdf

¹⁴ The 43 survey respondents were generally reflective of the overall Pride Center participant demographics, with the majority identifying as White, adults ages 26-59, and assigned female at birth.



reported that they have participated only one or two times. Similarly, in this year’s focus groups, a sizeable proportion of participants had participated only one or two times in Pride Center programs and services.

Although it is not possible to conclude definitively, some differences in survey and focus group findings this year may be attributed in part to this shift in representation. For example, in this year’s survey, satisfaction ratings were generally lower than in previous years. With this in mind, the sections below discuss factors that facilitate and hinder participant access and engagement. In this context, *access* refers to individuals’ ability to participate in services, whereas *engagement* refers to their desire to begin or continue participating.

Facilitators of Access. Having information about the Pride Center, whether it be through social media, email lists, word of mouth, referrals is the first step to accessing services. The Pride Center employs a community engagement and outreach specialist and the Center has built a strong referral network with providers, schools, and employers. The Pride Center also offers services at different times of day, including daytime and evening programming. Considering the geographic spread of San Mateo County, the Pride Center has used creative strategies to create groups in North County, South County and Coast areas. In the past year, Coast Pride (another LGBTQ+ organization) has started offering services in Half Moon Bay, which lessens barriers to access for individuals in that part of the county. To address technology barriers to address among older adults, the Pride Center started hosting an “App-y hour” tech workshop for older adults as a collaboration with Peninsula Family Service.

Facilitators of Engagement. Consistent with themes from previous years’ evaluations, a sense of community, enjoyment of services and programs, and rapport with staff were primary facilitators of continued engagement (see text box on the right). Among survey respondents who had engaged less frequently with the Pride Center, nearly three quarters (72%) reported that they plan to continue participating. About one-quarter (24%) responded that they did not know whether they would continue, and only one person (4%) responded that they did not plan to continue.

Top reasons for continuing to participate in the Pride Center:

- Feeling a sense of community at the Pride Center (67%)
- Feeling welcome and safe at the Pride Center (61%)
- Enjoying the services and programs (61%)
- Feeling their identity is affirmed at the Pride Center (50%)

Source: Participant Experience Survey

Barriers to Access. While programming was virtual for much of FY19-20, the Pride Center has continued to contend with barriers to in-person services, including the geographic spread of the county and limited public transportation. Both issues were frequently mentioned by survey and focus group participants. The Pride Center has sought to offer services at different times of day to accommodate different schedules. Some participants shared that evening services may meet the needs of many working adults but may be difficult for older adults who are not comfortable driving at night, as well as youth who rely on public transportation. On the other hand, services for older adults in the daytime may not meet the needs of older adults who work during the day. Additionally, as in previous years, some participants mentioned the physical accessibility of the Pride Center, noting that some areas can only be accessed via stairs. Despite intensive outreach efforts on the part of the Pride Center, a number of participants also expressed that



they had only recently become aware of the Pride Center and perceived that many others in the community are not aware of the available services (see text box below).

Participant Reflections on Outreach

- All participants suggested expanded outreach throughout San Mateo County. Participants suggested partnering with communities of color and non-explicitly LGBTQ+ organizations, such as art spaces, racial/ethnic identity groups, and hospitals. Partner agencies would like to see an increase in funding for advertisements in the forms of newspapers, ads, flyers, etc.
- Older participants find it challenging to stay connected exclusively online. Many said they prefer print advertisement, such as fliers, newspapers, journals, magazines, and places of worship.
- Younger participants mentioned that they would respond well to online outreach in non-traditional venues, such as Instagram and dating apps. They also suggested creating an app for the Pride Center to list upcoming events, programs, etc.

Barriers to Engagement. Survey and focus group participants highlighted two common reasons that they have not engaged or may be hesitant to engage in the Pride Center: 1) they did not feel represented among Pride Center staff and/or participants, or 2) they did not see programming that reflected their identity.

- 1) **Representation among staff and participants.** The Pride Center has espoused a commitment to be an inclusive space for LGBTQ+ community members of color and has continued to offer dedicated programming for people of color. Pride Center staff, partners, and participants alike acknowledged that in large part, being a welcoming and inclusive space necessitates having staff who represent the racial/ethnic and cultural backgrounds of prospective participants. Staff shared that establishing and retaining a racially diverse staff has been a challenge, particularly Black/African American staff. Focus group and survey respondents shared a perception that the staff and clientele of the Pride Center are mostly White. While participant demographic data show that approximately half of all Pride Center participants are non-White, it may be that participation in certain programs is predominantly White.
- 2) **Programming reflecting participants' identity.** Survey and focus group participants shared suggestions for programming focused on BIPOC, including celebrations around food from different cultures, events that are "cross-listed" with other cultural organizations in the county, and additional ways to integrate culture in events and outreach (e.g., including a section in the newsletter that speaks to relevant events in history). One person shared, *"I wish the Center could be more vocal and take a stand against the root causes of our continued oppression: anti-blackness, white supremacy, capitalism, colonization, and militarism. For example, how can the Center honor trans and queer black lives?"*

"I would like to see more POC at events, but we need to have more POC on staff first."

-Partner Agency



The Pride Center has continued to prioritize serving BIPOC residents, including holding events in partnership with the African American Community Initiative (AACI) of San Mateo County. Staff and partners reported challenges specifically around engaging Black/African American individuals. Demographic data from participant sign-in indicate that, proportionally, the Pride Center is serving a higher percentage of Black/African American clients (6%) than the overall San Mateo County population (3%). That said, demographic forms do not contain information about participants' level and consistency of engagement. The abovementioned barriers speak to the context of intense and public racial oppression across the country, which disproportionately impacts queer people of color. Pride Center clinical data also appeared to reflect this reality: in the ANSA and CANS, the "cultural stress" item—which includes circumstances in which an individual's cultural identity is met with hostility—was scored as an area of high need and did not see improvements from baseline to follow-up.

Additional barriers to engagement mentioned by participants and/or staff included: capacity of bilingual staff, who may be the only staff that speak a particular language; stigma among older adults, who may not feel comfortable visiting a center that is prominently LGBTQ+; and some challenges with staff responsiveness. While participants overwhelmingly praised Pride Center staff, some noted that they had occasionally experienced difficulties in reaching staff members. Among survey respondents, 19% indicated that they disagreed or somewhat disagreed that staff are responsive when they have requests.

Impacts of COVID-19

To better understand the impact of COVID-19 on participation, respondents to the Participant Experience Survey were asked to report on their *online* engagement during the pandemic. It is important to note that during the evaluation period, virtual services had only been in operation for a few months (mid-March through mid-June 2020). The Participant Experience Survey was conducted in June 2020, which coincided with the murder of George Floyd and the eruption of racial justice protests around the country. Because of these factors, the Pride Center anticipates that online participation was lower during the FY19-20 period than will be reflected in the FY20-21 data.

Overall, most respondents to the Participant Experience Survey reported being informed about and satisfied with the Pride Center's online services: 58% agreed and 26% somewhat agreed that the Pride Center had informed the community about the online services available. In addition, 51% agreed and 30% somewhat agreed that the Pride Center had offered online options for the services that were most important to them.

- Nearly half (49%) reported that they had not participated in any online services. Of those who did report participating online, over one-quarter (28%) participated in social activities/events online, 16% in peer groups, 12% in community meetings, and 12% in therapy services. Other activities were each selected by fewer than three respondents (7%).
- Of those who participated in online services, most agreed or somewhat agreed that online services have been engaging (90%), have given them a sense of community (87%), and have been easy to access (81%).



Participants and staff shared both benefits and challenges of offering services online. The Pride Center has been able to maintain therapy services through telehealth platforms. Online services have also facilitated access for individuals who have disabilities or chemical sensitivities. Zoom peer support groups have become accessible for people outside of the central San Mateo area and outside of the county itself. The polyamorous support group, for example, regularly has over 20 attendees, including participants from other states and even another county. During Pride Week, at least 9,000 people viewed materials and events, compared to 800 people who participated in last year's in-person Pride celebrations.

“Even though shelter in place is in order and COVID is scary, the Pride Center has helped make me feel like I’m still part of a community, and it means so much to me to not feel as if I’ve been forgotten.”

–Participant

At the same time, staff reported that it has been difficult to maintain engagement in most peer support groups. Some participants noted that they have been disconnected from services during the shelter in place, in some cases because programs did not fit with their schedule and in others because it was harder to feel a sense of personal connection with staff. Online services have increased barriers to participation for older adults, lower income individuals, individuals who are unstably housed, and those living in a hostile environment. In addition, not all clients have access to devices with video calls or a safe place to have private conversations. Despite these challenges, the Pride Center has demonstrated adaptability and dedication to serving the LGBTQ+ community during 2020.

Recommendations

Based on the evaluation findings, below are recommendations to support the Pride Center's operations and programming. Recommendations come from a combination of staff, partner, and participant feedback, as well as the analysis of the evaluation team.

As the Pride Center partnership continues, it will be essential to have systems in place to continually review the partnership model, assess program effectiveness, and make data-driven programmatic decisions. As of the time of this writing (March 2021), the Pride Center had already begun to implement some of these recommendations.

Operations and Governance

- 1) Establish a mutual understanding of roles and responsibilities of partner agencies.** It is clear that there are differences in perspective regarding the desired roles of the partner organizations. It is important that all parties can discuss and affirm shared expectations of each party's primary roles and responsibilities, and their accountability and obligations to each other. Partners' roles should be described in Memoranda of Understanding (MOUs) and partners should periodically assess and revisit their roles and responsibilities.
- 2) Expand opportunities for collaboration and team building among partners.** Partner agencies continue to view themselves as distinct parts, rather than a collaborative whole. There are



opportunities to bolster the capacity of staff and partner agencies through team building, sharing resources, and fostering joint ownership over program development. Recommended actions include:

- a. Facilitating regular attendance of all partner representatives at Pride Center all-staff meetings;
- b. Encouraging participation in each other's trainings;
- c. Holding regular meetings among partner agency managers;
- d. Continuing to host team building activities; and
- e. Developing opportunities for partner agencies to collaborate on program design.

- 3) **Raise awareness about the partnership model among external stakeholders.** Increasing awareness about the partnership model among County and community agencies and with community members can help solidify the partnership structure. Activities may include presentations about the partnership model at external community meetings and increased publicity about joint partner programming.

Programs and Services

- 1) **Consider depth vs. breadth of services.** The Pride Center implements an impressive number of programs and services each year. The volume of programming can create a tradeoff between expanding Pride Center activities and deepening the existing work. Given staff capacity and the risk for burnout, the Pride Center may want to examine the areas of highest demand and success over the past three years and determine ways to narrow their focus. Since staff wear many hats, there may also be opportunities to contract with outside organizations for some services.
- 2) **Formalize partnerships to increase racial, cultural, and linguistic diversity of providers and participants.** The Pride Center has acknowledged challenges in cultivating representation of diverse staff, particularly Black/African American staff, which has impacted BIPOC engagement in the Pride Center. The Pride Center may consider creating MOUs with local BIPOC organizations, either as formal partner agencies with the Pride Center or as "guest" providers who could co-lead certain programs or events.
- 3) **Continue to build the network of LGBTQ+ responsive mental health providers to meet the needs of clients with serious mental illness (SMI).** In order to create a sustainable system of LGBTQ+ affirming mental health services, it will be necessary to coordinate with—and build the capacity of—outside providers. For example, developing referral pathways to LGBTQ+ affirming psychiatrists would enable care coordination for clients who use medication. The Pride Center may also explore ways to enhance its training model to include learning collaboratives and ongoing consultation for providers who serve clients with SMI.
- 4) **Explore new ways to enhance the Pride Center's presence in all parts of the county.** It remains difficult for individuals living outside central San Mateo County to easily access in-person programming. The Pride Center should continue to develop strategies and partnerships that can increase visibility and access, while considering the realities of the Pride Center's staff capacity.



Conclusion

The 2019-20 fiscal year marked the third full year of operation of the San Mateo County Pride Center. In this time, the Pride Center has established a wide array of clinical services and community-oriented programs and has become a recognized community resource. The Center allows participants to access mental health services with LGBTQ+ therapists, which for many participants is a welcome departure from their previous difficulties in finding mental health care providers both knowledgeable and respectful of their sexual orientation and gender identity. In FY2019-20, the Pride Center faced the monumental challenge of transitioning to fully remote service delivery during the COVID-19 shelter in place. The Pride Center was able to successfully offer mental health services, peer groups, and social events online. As the Pride Center progresses and grows, leadership and staff remain committed to their efforts to be a safe and welcoming space for all members of the LGBTQ+ community, particularly BIPOC and low-income individuals.



Appendix A: San Mateo County Pride Center Participant Experience Survey (2020)

1) How many times have you participated in Pride Center programs or services?*

- I have come 1-2 times
- I come a few times a year
- I come at least once a month
- I come at least once a week

2) Do you plan to continue to participate in Pride Center programs or services?

- Yes
- No
- I don't know

3) Why might you not continue to participate in Pride Center programs or services? (Check all that apply)

- I don't feel welcome or safe at the Pride Center
- I don't feel myself represented at the Pride Center
- The times of the events don't work with my schedule
- It is difficult to get to the Pride Center's location
- The Pride Center is not fully accessible for people with disabilities
- I don't feel comfortable going to a visibly LGBTQ center
- Other (Please specify): _____

4) What are the main reasons you want to continue to participate in Pride Center programs or services?

- I feel like my identify is affirmed at the Pride Center
- I feel a sense of community at the Pride Center
- I feel connected to the staff at the Pride Center
- I feel welcome and safe at the Pride Center
- I enjoy the services and programs offered by the Pride Center



Other (Please specify): _____

5) For how long have you been participating in Pride Center programs or services?

- This is my first time
- 0 - 6 months
- 6 months - 1 year
- 1 - 2 years
- Since the Pride Center opened (Summer 2017)

6) Please mark the services you have participated in at the Pride Center. (Check all that apply.)*

- Case Management
- Community Meetings
- Connection to Resources
- Drop-In Center
- Education / Training
- Social Activities / Events
- Therapy Services
- Peer Group (Please specify): _____ *
- Other (Please specify): _____

7) Please mark the services you have participated in at the Pride Center ONLINE during the COVID-19 shelter in place. (Check all that apply.)*

- Case Management
- Community Meetings
- Connection to Resources
- Drop-In Center
- Education / Training
- Social Activities / Events
- Therapy Services
- Peer Group (Please specify): _____ *
- Other (Please specify): _____



I have not participated in any online services

8) Please rate your interactions with the Pride Center's staff.

	Disagree	Somewhat Disagree	Somewhat Agree	Agree
Staff are courteous and friendly.	()	()	()	()
Staff are responsive when I have requests.	()	()	()	()
Staff understand & affirm my sexual orientation.	()	()	()	()
Staff understand & affirm my gender identity.	()	()	()	()
Staff understand & affirm my culture/ethnicity.	()	()	()	()

9) Please rate your experiences with the facility. (Note: please rate based on services at the Pride Center before the COVID-19 shelter in place)

	Disagree	Somewhat Disagree	Somewhat Agree	Agree



The Pride Center is a welcoming & safe environment.	()	()	()	()
The Pride Center gives me a sense of community.	()	()	()	()
The Pride Center is in a convenient location.	()	()	()	()
The hours of the Pride Center work with my schedule.	()	()	()	()

10) Please rate your experience with ONLINE services during the COVID-19 shelter in place.

	Disagree	Somewhat Disagree	Somewhat Agree	Agree
The Pride Center has informed the community about the online services available	()	()	()	()



The Pride Center has offered online options for the services that are most important to me	()	()	()	()
--	-----	-----	-----	-----

11) Please rate your experience with ONLINE services during the COVID-19 shelter in place.

	Disagree	Somewhat Disagree	Somewhat Agree	Agree
Online services at the Pride Center have been engaging	()	()	()	()
Online services at the Pride Center have been easy to access	()	()	()	()
Online services at the Pride Center give me a	()	()	()	()



sense of community				
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12) Please rate your experiences with the services provided at the Pride Center.

	Disagree	Somewhat Disagree	Somewhat Agree	Agree
It's easy to get connected to other services within the Pride Center.	()	()	()	()
It's easy to get connected to other services outside of the Pride Center.	()	()	()	()
The Pride Center staff include me in deciding what services are best for me.	()	()	()	()



The services that I am receiving at the Pride Center are improving my mental health.	()	()	()	()
--	----	----	----	----

Please note any other services or programs to which the Pride Center has connected you. (OPTIONAL)

Please share any positive or negative experiences you have had with the Pride Center, including during the COVID-19 shelter in place. (OPTIONAL)

What is your age category?

- 0 - 15
- 16 - 25
- 26 - 39
- 40 - 59
- 60 & above
- Decline to answer





With which race/ethnicity do you identify? (Check all that apply.)

- American Indian / Native American / Native Alaskan
- Asian / Asian American
- Black / African American
- Hispanic / Latino/a /x
- Native Hawaiian / Pacific Islander
- White
- Other - Write In: _____
- Decline to answer

What was your assigned sex at birth?

- Female
- Male
- Other: _____
- Decline to answer

Do you identify as intersex?

- Yes
- No
- Decline to answer

What is your current gender identity?

- Cisgender Man / Man
- Cisgender Woman / Woman
- Trans Man / Transgender Male / Trans-masculine / Female-to-Male (FTM) / Man
- Trans Woman / Transgender Female / Trans-feminine / Male-to-Female (MTF) / Woman
- Genderqueer / Gender Nonconforming / Neither exclusively male nor female
- Questioning or Unsure of Gender Identity
- Indigenous Gender Identity: _____
- Other Gender Identity: _____
- Decline to answer



How do you identify your sexual orientation?

- Gay or Lesbian
- Heterosexual or Straight
- Bisexual
- Queer
- Pansexual
- Asexual
- Questioning / Unsure of sexual orientation
- Indigenous sexual orientation: _____
- Other sexual orientation: _____
- Decline to answer

Thank You!



Appendix B: ANSA and CANS Instruments

ADULT NEEDS AND STRENGTHS ASSESSMENT(ANSA)				STANDARD VERSION 2.0			
Individual's Name:		DOB:	Gender:	Race/Ethnicity:			
Caregiver(s):	Form Status:		Initial	Subsequent	Annual	Discharge	
	Case Name:						
Case Number:							
Assessor:		Date of Assessment:		m	m	d	d
				y	y		

FUNCTIONING				
0=no evidence	1=history, suspicion			
2= action needed	3= disabling, dangerous, immediate action			
	0	1	2	3
Family Relationships	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical/Medical	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Employment Functioning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Social Functioning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Recreational	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Developmental/intellectual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexual Development	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Living Skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Residential Stability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Legal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Self-Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medication Compliance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Living Situation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
School	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

STRENGTHS				
<i>*Please note only for the Strengths section 3 is "no evidence"</i>				
0=Centerpiece strength	1=Useful strength			
2=Identified strength	3=No evidence			
	0	1	2	3
Family Strengths	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interpersonal/Social Connectedness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Optimism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Educational Setting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Job History	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Talents and interests	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spiritual/Religious	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Community Connection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Natural Supports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Resilience	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Resourcefulness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Volunteering	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vocational	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

CULTURAL FACTORS				
0=no evidence	1=history, suspicion			
2= action needed	3= disabling, dangerous, immediate action			
	0	1	2	3
Language	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cultural Identity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Traditions and Rituals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cultural Stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

BEHAVIORAL/EMOTIONAL NEEDS				
0=no evidence	1=history, suspicion			
2= action needed	3= disabling, dangerous, immediate action			
	0	1	2	3
Psychosis (Thought Disorder)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Impulse Control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interpersonal Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Antisocial Behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Adjustment to Trauma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anger Control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Substance Abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eating Disturbances	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

RISK BEHAVIORS				
0=no evidence	1=history, suspicion			
2= action needed	3= disabling, dangerous, immediate action			
	0	1	2	3
Suicide Risk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-Suicidal Self-Injurious Behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other Self-Harm (Recklessness)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exploitation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Danger to Others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexual Aggression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Criminal Behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

CAREGIVER RESOURCES & NEEDS (OPTIONAL)				
0=no evidence	1=history, suspicion			
2= action needed	3= disabling, dangerous, immediate action			
	0	1	2	3
Physical/Behavioral Health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Involvement in Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knowledge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Social Resources	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Organization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Residential Stability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Substance Use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Developmental	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Standard ANSA 2.0

March 10, 2017,





San Mateo County Behavioral Health and Recovery Services
Pride Center: 2019-20 Annual Report

CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)				STANDARD CANS COMPREHENSIVE			
Child's Name:		DOB:		Gender:		Race/Ethnicity:	
Caregiver(s):			Form Status:	Initial	Subsequent	Annual	Discharge
			Case Name:				
		Case Number:					
Assessor:		Date of Assessment:		m	m	d	d
				y	y		

LIFE DOMAIN FUNCTIONING				
0=no evidence	1=history or suspicion			
2=interferes with functioning; action needed	3=disabling, dangerous; immediate or intensive action needed			
	0	1	2	3
Family Functioning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Living Situation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Social Functioning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Recreational	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Developmental/Intellectual ¹	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Job Functioning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Legal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medical/Physical	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexual Development	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
School Behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
School Attendance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
School Achievement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Decision-Making	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

STRENGTHS DOMAIN				
0=Centerpiece strength	1=Useful strength			
2=Identified strength	3=No evidence			
	0	1	2	3
Family Strengths	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interpersonal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Optimism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Educational Setting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vocational	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Talents/Interests	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spiritual/Religious	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Community Life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Relationship Permanence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Resiliency	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Resourcefulness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cultural Identity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Natural Supports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

CULTURAL FACTORS				
0=no evidence	1=history or suspicion			
2=interferes with functioning; action needed	3=disabling, dangerous; immediate or intensive action needed			
	0	1	2	3
Language	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Traditions and Rituals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cultural Stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

CAREGIVER RESOURCES AND NEEDS				
0=no evidence	1=history or suspicion			
2=interferes with functioning; action needed	3=disabling, dangerous; immediate or intensive action needed			
	0	1	2	3
Supervision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Involvement with Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knowledge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Organization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Social Resources	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Residential Stability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medical/Physical	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental Health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Substance Use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Developmental	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

CHILD BEHAVIORAL/EMOTIONAL NEEDS				
0=no evidence	1=history or suspicion			
2=interferes with functioning; action needed	3=disabling, dangerous; immediate or intensive action needed			
	0	1	2	3
Psychosis (Thought Disorder)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Impulsivity/Hyperactivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Oppositional	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Conduct	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Adjustment to Trauma ²	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Attachment Difficulties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anger Control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Substance Use ³	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

RISK BEHAVIORS				
0=no evidence	1=history or suspicion			
2=interferes with functioning; action needed	3=disabling, dangerous; immediate or intensive action needed			
	0	1	2	3
Suicide Risk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-Suicidal Self-Injurious Behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other Self-Harm (Recklessness)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Danger to Others ⁴	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexual Aggression ⁵	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Runaway ⁶	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Delinquent Behavior ⁷	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fire Setting ⁹	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Intentional Misbehavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





INDIVIDUAL ASSESSMENT MODULES (rate if indicated on prior sheets)	¹ Developmental Disabilities Module
	² Trauma Module
	³ Substance Use Module
	⁴ Violence Module
	⁵ Sexually Aggressive Behaviors Module
	⁶ Runaway Module
	⁷ Juvenile Justice Module
	⁸ Decision Making Module
	⁹ Fire Setting Module

DEVELOPMENTAL DISABILITIES MODULE				
0=no evidence	1=history or suspicion			
2=interferes with functioning; action needed	3=disabling, dangerous; immediate or intensive action needed			
	0	1	2	3
Cognitive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Communication	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Developmental	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Self-Care/Daily Living Skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

TRAUMA MODULE				
No=no evidence of Trauma	Yes=Evidence of Trauma			
	No	Yes		
Sexual Abuse	<input type="radio"/>	<input type="radio"/>		
Physical Abuse	<input type="radio"/>	<input type="radio"/>		
Neglect	<input type="radio"/>	<input type="radio"/>		
Emotional Abuse	<input type="radio"/>	<input type="radio"/>		
Medical Trauma	<input type="radio"/>	<input type="radio"/>		
Natural or Manmade Disaster	<input type="radio"/>	<input type="radio"/>		
Witness to Family Violence	<input type="radio"/>	<input type="radio"/>		
Witness to Community/School Violence	<input type="radio"/>	<input type="radio"/>		
Victim/Witness to Criminal Activity	<input type="radio"/>	<input type="radio"/>		
War/Terrorism Affected	<input type="radio"/>	<input type="radio"/>		
Disruptions in Caregiving/Attachment Losses	<input type="radio"/>	<input type="radio"/>		
Parental Criminal Behavior	<input type="radio"/>	<input type="radio"/>		
If the youth has been sexually abused:				
	0	1	2	3
Emotional Closeness to Perpetrator	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Frequency of Abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Duration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Force	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaction to Disclosure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Traumatic Stress Symptoms:				
	0	1	2	3
Emotional/Physical Dysregulation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Intrusions/Re-Experiencing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hyperarousal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Traumatic Grief/Separation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Numbing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dissociation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SUBSTANCE USE MODULE				
0=no evidence	1=history or suspicion			
2=interferes with functioning; action needed	3=disabling, dangerous; immediate or intensive action needed			
	0	1	2	3
Severity of Use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Duration of Use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stage of Recovery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peer Influences	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parental Influences	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Environmental Influences	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

VIOLENCE MODULE				
0=no evidence	1=history or suspicion			
2=interferes with functioning; action needed	3=disabling, dangerous; immediate or intensive action needed			
	0	1	2	3
Historical risk factors:				
History of Physical Abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
History of Violence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Witness to Domestic Abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Witness to Environmental Violence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emotional/Behavioral Risks:				
Bullying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Frustration Management	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hostility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Paranoid Thinking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Secondary Gains from Anger	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Violent Thinking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Resiliency Factors:				
Aware of Violence Potential	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Response to Consequences	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Commitment to Self-Control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Treatment Involvement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





SEXUALLY AGGRESSIVE BEHAVIORS MODULE				
0=no evidence	1=history or suspicion			
2=interferes with functioning; action needed	3=disabling, dangerous; immediate or intensive action needed			
	0	1	2	3
Relationship	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical Force/Threat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Planning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Age Differential	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Type of Sex Act	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Response to Accusation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Temporal Consistency	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
History of Sexual Abusive Behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Severity of Sexual Abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prior Treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

RUNAWAY MODULE				
0=no evidence	1=history or suspicion			
2=interferes with functioning; action needed	3=disabling, dangerous; immediate or intensive action needed			
	0	1	2	3
Frequency of Running	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Consistency of Destination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Safety of Destination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Involvement in Illegal Acts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Likelihood of Return on Own	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Involvement of Others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Realistic Expectations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Planning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9 - JUVENILE JUSTICE MODULE				
0=no evidence	1=history or suspicion			
2=interferes with functioning; action needed	3=disabling, dangerous; immediate or intensive action needed			
	0	1	2	3
History	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seriousness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Planning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Community Safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peer Influences	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parental Criminal Behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Environmental Influences	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

FIRE SETTING MODULE				
0=no evidence	1=history or suspicion			
2=interferes with functioning; action needed	3=disabling, dangerous; immediate or intensive action needed			
	0	1	2	3
History	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seriousness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Planning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Use of Accelerants	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Intention to Harm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Community Safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Response to Accusation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Remorse				
Likelihood of Future Fire Setting				



Appendix C: Data Tables

Demographic Data

To comply with HIPAA requirements and protect the confidentiality of participating individuals, the tables below only present data for response categories with at least five responses. Where fewer than five responses were received, some categories have been combined. RDA was unable to create a table displaying demographic data on preferred language due to most responses having fewer than five responses. The tables below reflect demographic data from: 1) Fiscal Year 2018-19 and 2) the opening of the Pride Center through Fiscal Year 2018-19, reflected in the tables as “all time periods.”

Table 1. Participants served by age

Age	2019-20 (n=426)		All time periods (n=1,057)	
	Count	Percent	Count	Percent
0-15	28	7%	83	8%
16-25	95	22%	273	26%
26-39	164	38%	339	32%
40-59	98	23%	266	25%
Age 60 and above	41	10%	96	9%

Table 2. Participants served by race¹⁵

Race	2019-20 (n=412)		All time periods (n=1,037)	
	Count	Percent	Count	Percent
White or Caucasian	246	60%	596	57%
Hispanic or Latino/a/x	86	21%	233	22%
Asian or Asian American	71	17%	198	19%
Black or African American	26	6%	59	6%
Native American or Native Alaskan	8	2%	29	3%
Other	12	3%	43	4%
Native Hawaiian or Pacific Islander	10	2%	29	3%

¹⁵ Some participants are counted more than once, as they could mark all categories that apply. Percentages will total greater than 100%.



Table 3. Participants served by ethnicity¹⁶

Ethnicity	2019-20 (n= 377)		All time periods (n=860)	
	Count	Percent	Count	Percent
European	169	45%	347	40%
Mexican/Chicanx/a/o	58	15%	147	17%
Other ¹⁷	48	13%	103	12%
Chinese	31	8%	71	8%
Filipinx/a/o	28	7%	87	10%
Eastern European	25	7%	56	7%
African	14	4%	39	5%
Central American	13	3%	24	3%
Pacific Islander	12	3%	12	1%
South American	11	3%	38	4%
Indigenous Nation	6	2%	6	1%
Japanese	6	2%	22	3%
Middle Eastern	6	2%	21	2%
Puerto Rican	6	2%	16	2%
Vietnamese	6	2%	33	4%

Table 4. Participants served by sex at birth

Sex	2018-19 (n=193)		All time periods (n=601)	
	Count	Percent	Count	Percent
Female	224	55%	433	43%
Male	187	45%	577	57%

¹⁶ Some participants are counted more than once, as they could mark all categories that apply. Percentages will total greater than 100%.

¹⁷ Additional categories written in with fewer than 5 responses are reflected in the Other category.



Table 5. Participants served by gender identity¹⁸

Gender identity	2019-20 (n=400)		All time periods (n=949)	
	Count	Percent	Count	Percent
Cisgender Woman / Woman	156	39%	249	26%
Cisgender Man / Man	121	30%	262	28%
Genderqueer / Gender nonconforming / Neither exclusively male nor female	51	13%	106	11%
Trans Woman / Transgender Female / Trans-feminine / Male-to-Female (MTF) / Woman	37	9%	66	7%
Trans Man / Transgender Male / Trans-masculine / Female-to-Male (FTM) / Man	34	9%	51	5%
Questioning or unsure of gender identity	10	3%	27	3%
Another Gender Identity	8	2%	26	3%
Indigenous gender identity	6	2%	6	1%

Table 6. Participants served by sexual orientation¹⁹

Sexual orientation	2019-20 (n=405)		All time periods (n=996)	
	Count	Percent	Count	Percent
Gay or Lesbian	135	33%	322	32%
Heterosexual or Straight	104	26%	270	27%
Bisexual	73	18%	154	15%
Queer	54	13%	122	12%
Pansexual	43	11%	85	9%
Asexual	25	6%	45	5%
Questioning or unsure of sexual orientation	15	4%	32	3%
Another sexual orientation	7	2%	15	2%

¹⁸ Some participants are counted more than once, as they could mark all categories that apply. Percentages will total greater than 100%.

¹⁹ Some participants are counted more than once, as they could mark all categories that apply. Percentages will total greater than 100%.



Table 7. Participants served by disability status²⁰

Disability Status	2019-20 (n=369)		All time periods (n=903)	
	Count	Percent	Count	Percent
None	214	58%	589	65%
Mental health condition	110	30%	110	12%
Chronic health condition	36	10%	72	8%
Learning disability	27	7%	54	6%
Limited physical mobility	17	5%	37	4%
Difficulty hearing or having speech understood	13	4%	32	4%
Another challenge with communication	13	4%	21	2%
Another disability or condition	11	3%	72	8%
Difficulty seeing	10	3%	37	4%
Developmental disability	8	2%	11	1%

Table 9. Participants served by income²¹

Income	2019-20 (n=329)		All time periods (n=773)	
	Count	Percent	Count	Percent
\$0-\$24,999	100	30%	262	34%
\$25,000-\$50,000	64	19%	158	20%
\$50,001-\$75,000	54	16%	124	16%
\$75,001-\$100,00	38	12%	91	12%
Above \$100,000	73	22%	138	18%

Table 10. Participants served by employment status²²

Employment Status	2019-20 (n=387)		All time periods (n=971)	
	Count	Percent	Count	Percent
Full time employment	224	58%	484	50%
Student	86	22%	209	22%

²⁰ Some participants are counted more than once, as they could mark all categories that apply. Percentages will total greater than 100%.

²¹ Only participants 18 and older were asked to complete this information.

²² Some participants are counted more than once, as they could mark all categories that apply. Percentages will total greater than 100%.



Part time employment	75	19%	166	17%
Retired	19	5%	54	6%
Unemployed and looking for work	17	4%	65	7%
Unemployed and not looking for work	16	4%	43	4%
Unable to work due to disability or illness	15	4%	15	2%

Table 11. Participants served by housing status

Housing status	2019-20 (n=414)		All time periods (n=999)	
	Count	Percent	Count	Percent
Stable housing	353	85%	818	82%
Temporarily staying with friends or family	22	5%	90	9%
Homeless and unsheltered	15	4%	23	2%
Another housing status	13	3%	45	5%
Renting with a subsidy, voucher, or supportive services	9	2%	9	1%



CANS/ANSA Data

ANSA Baseline Data (N=71)

Domain	N	Avg Score
Functioning Domain	70	0.61
Strengths Domain	71	1.74
Cultural Factors	70	0.52
Behavioral/Emotional Needs	70	0.67
Risk Behaviors	71	0.19

Domain/Characteristic	N	Avg Score
Functioning Domain	70	0.61
Family Relationships	70	1.39
Physical/Medical	70	0.60
Employment/Functioning	67	0.75
Social Functioning	70	1.13
Recreational	70	0.47
Developmental/intellectual	70	0.23
Sexual Development	70	0.66
Living Skills	70	0.30
Residential Stability	70	0.67
Legal	70	0.27
Sleep	70	0.63
Self-Care	70	0.70
Medication Compliance	70	0.31
Transportation	70	0.24
Living Situation	70	0.87
School	38	0.55
Strengths Domain	71	1.74
Family Strengths	70	1.87
Interpersonal/Social Connectedness	70	1.56
Optimism	70	1.46
Educational Setting	37	2.46
Job History	70	1.61
Talents and Interests	70	1.60



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Spiritual/Religious	69	2.23
Community Connection	70	1.91
Natural Supports	69	1.83
Resilience	70	0.97
Resourcefulness	71	1.21
Volunteering	69	2.57
Vocational	68	1.65
Cultural Factors	70	0.52
Language	70	0.14
Cultural Identity	56	0.88
Traditions and Rituals	70	0.20
Cultural Stress	70	0.97
Behavioral/Emotional Needs	70	0.67
Psychosis (Thought Disorder)	70	0.34
Impulse Control	68	0.34
Depression	69	1.39
Anxiety	70	1.51
Interpersonal Problems	69	0.80
Antisocial Behavior	69	0.03
Adjustment to Trauma	70	1.20
Anger Control	70	0.27
Substance Abuse	69	0.52
Eating Disturbances	56	0.18
Risk Behaviors	71	0.19
Suicide Risk	71	0.58
Non-Suicidal Self-Injurious Behavior	71	0.20
Other Self-Harm	71	0.27
Exploitation	69	0.30
Danger to Others	71	0.04
Gambling	70	0.01
Sexual Aggression	71	0.00
Criminal Behavior	70	0.11



ANSA Pre/Post Data (N=50)

Domain	N	Baseline Avg Score	Follow-up Avg Score	Avg Change
Functioning Domain	48	0.64	0.59	-0.05
Strengths Domain	49	1.78	1.80	0.02
Cultural Factors	48	0.55	0.51	-0.04
Behavioral/Emotional Needs	49	0.73	0.67	-0.06
Risk Behaviors	48	0.23	0.18	-0.05

Domain/Characteristic	N	Baseline Avg Score	Follow-up Avg Score	Avg Change
Functioning Domain	48	0.64	0.59	-0.05
School	23	0.61	0.30	-0.31
Family Relationships	48	1.44	1.21	-0.23
Sexual Development	48	0.58	0.40	-0.18
Sleep	48	0.77	0.63	-0.14
Self-Care	48	0.81	0.69	-0.12
Social Functioning	47	1.26	1.17	-0.09
Recreational	48	0.50	0.42	-0.08
Medication Compliance	48	0.38	0.31	-0.07
Transportation	48	0.17	0.13	-0.04
Living Situation	48	0.96	0.94	-0.02
Residential Stability	48	0.60	0.58	-0.02
Developmental/intellectual	48	0.27	0.25	-0.02
Legal	48	0.25	0.31	0.06
Living Skills	48	0.31	0.38	0.07
Employment/Functioning	45	0.89	1.00	0.11
Physical/Medical	48	0.56	0.69	0.13
Strengths Domain	49	1.78	1.80	0.02
Spiritual/Religious	47	2.19	1.87	-0.32
Talents and Interests	48	1.56	1.35	-0.21
Resilience	48	1.00	0.79	-0.21
Optimism	48	1.48	1.31	-0.17
Volunteering	47	2.60	2.49	-0.11
Natural Supports	47	1.87	1.85	-0.02
Interpersonal/Social Connectedness	48	1.63	1.63	0.00
Community Connection	48	1.83	1.85	0.02





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Resourcefulness	49	1.20	1.22	0.02
Family Strengths	48	1.92	2.04	0.12
Educational Setting	24	2.42	2.58	0.16
Job History	47	1.70	2.11	0.41
Vocational	46	1.91	2.39	0.48
Cultural Factors	48	0.55	0.51	-0.04
Cultural Identity	33	0.94	0.70	-0.24
Language	48	0.10	0.08	-0.02
Traditions and Rituals	48	0.21	0.19	-0.02
Cultural Stress	48	1.04	1.10	0.06
Behavioral/Emotional Needs	49	0.73	0.67	-0.06
Anxiety	49	1.57	1.31	-0.26
Depression	48	1.54	1.29	-0.25
Adjustment to Trauma	49	1.24	1.00	-0.24
Psychosis (Thought Disorder)	49	0.41	0.33	-0.08
Substance Abuse	48	0.56	0.56	0.00
Interpersonal Problems	48	0.92	0.94	0.02
Antisocial Behavior	48	0.02	0.06	0.04
Eating Disturbances	34	0.18	0.24	0.06
Anger Control	49	0.24	0.37	0.13
Impulse Control	48	0.33	0.50	0.17
Risk Behaviors	48	0.23	0.18	-0.05
Exploitation	46	0.35	0.22	-0.13
Other Self-Harm	48	0.35	0.23	-0.12
Suicide Risk	48	0.67	0.56	-0.11
Gambling	47	0.02	0.00	-0.02
Criminal Behavior	47	0.15	0.13	-0.02
Non-Suicidal Self-Injurious Behavior	48	0.25	0.25	0.00
Sexual Aggression	48	0.00	0.00	0.00
Danger to Others	48	0.02	0.06	0.04



CANS Baseline Data (N=16)

Domain	N	Avg Score
Functioning Domain	16	0.56
Strengths Domain	16	1.46
Cultural Factors	16	0.50
Caregiver Resources and Needs	16	0.37
Child Behavioral/Emotional Needs	16	0.48
Risk Behaviors	16	0.12

Domain/Characteristic	N	Avg Score
Functioning Domain	16	0.56
Family Functioning	16	0.94
Living Situation	16	0.56
Social Functioning	16	1.00
Recreational	16	0.56
Developmental/intellectual	16	0.19
Job Functioning	13	0.15
Legal	16	0.06
Medical/Physical	16	0.50
Sexual Development	16	0.81
Sleep	16	0.81
School Behavior	16	0.56
School Attendance	16	0.31
School Achievement	16	0.63
Decision-making	16	0.63
Strengths Domain	16	1.46
Family Strengths	16	0.88
Interpersonal/Social Connectedness	16	1.44
Optimism	16	1.25
Educational Setting	16	1.44
Vocational	12	2.25
Talents and Interests	16	1.13
Spiritual/Religious	16	2.44
Community Life	16	1.81
Relationship Permanence	16	1.25
Resiliency	16	0.81
Resourcefulness	16	1.44
Cultural Identity	16	1.75



Natural Supports	16	1.25
Cultural Factors	16	0.50
Language	16	0.19
Traditions and Rituals	16	0.13
Cultural Stress	16	1.19
Caregiver Resources and Needs	16	0.37
Supervision	16	0.25
Involvement with Care	16	0.56
Knowledge	16	1.00
Organization	16	0.25
Social Resources	16	0.75
Residential Stability	16	0.25
Medical/Physical	16	0.13
Mental Health	16	0.44
Substance Abuse	16	0.25
Developmental	16	0.06
Safety	16	0.13
Child Behavioral/Emotional Needs	16	0.48
Psychosis (Thought Disorder)	16	0.06
Impulsivity/Hyperactivity	16	0.25
Depression	16	1.13
Anxiety	16	1.31
Oppositional	16	0.19
Conduct	16	0.06
Adjustment to Trauma	16	0.56
Attachment Difficulties	16	0.63
Anger Control	16	0.44
Substance Use	16	0.19
Risk Behaviors	16	0.12
Suicide Risk	16	0.50
Non-Suicidal Self-Injurious Behavior	16	0.19
Other Self-Harm	16	0.19
Danger to Others	16	0.00
Sexual Aggression	16	0.00
Runaway	16	0.06
Delinquent Behavior	16	0.13



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Fire Setting	16	0.00
Intentional Misbehavior	16	0.00

CANS Pre/Post Data (N=8)

Domain	N	Baseline Avg Score	Follow-up Avg Score	Avg Change
Functioning Domain	8	0.50	0.39	-0.11
Strengths Domain	8	1.75	1.30	-0.45
Cultural Factors	8	0.54	0.42	-0.12
Caregiver Resources and Needs	8	0.35	0.34	-0.01
Child Behavioral/Emotional Needs	8	0.44	0.39	-0.05
Risk Behaviors	8	0.11	0.14	0.03

Domain/Characteristic	N	Baseline Avg Score	Follow-up Avg Score	Avg Change
Functioning Domain	8	0.50	0.39	-0.11
Recreational	7	0.57	0.14	-0.43
Decision-making	8	0.50	0.25	-0.25
Sexual Development	8	1.13	0.88	-0.25
Social Functioning	8	0.88	0.75	-0.13
Sleep	8	0.88	0.75	-0.13
Medical/Physical	8	0.63	0.50	-0.13
Living Situation	8	0.38	0.25	-0.13
School Achievement	8	0.50	0.38	-0.12
Developmental/intellectual	8	0.25	0.13	-0.12
School Behavior	8	0.25	0.13	-0.12
Job Functioning	6	0.17	0.17	0.00
Legal	8	0.00	0.00	0.00
Family Functioning	8	0.75	0.88	0.13
School Attendance	8	0.00	0.13	0.13
Strengths Domain	8	1.75	1.30	-0.45
Interpersonal/Social Connectedness	8	1.88	0.88	-1.00
Natural Supports	8	1.63	0.75	-0.88
Cultural Identity	8	2.12	1.25	-0.87
Resourcefulness	8	2.13	1.38	-0.75





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Optimism	8	1.50	0.75	-0.75
Community Life	8	2.38	2.00	-0.38
Family Strengths	8	1.00	0.63	-0.37
Educational Setting	8	1.75	1.50	-0.25
Talents and Interests	8	1.38	1.13	-0.25
Relationship Permanence	8	1.25	1.00	-0.25
Vocational	4	2.75	2.75	0.00
Spiritual/Religious	8	2.75	2.75	0.00
Resiliency	8	0.88	0.88	0.00
Cultural Factors	8	0.54	0.42	-0.12
Language	8	0.38	0.13	-0.25
Traditions and Rituals	8	0.13	0.00	-0.13
Cultural Stress	8	1.13	1.13	0.00
Caregiver Resources and Needs	8	0.35	0.34	-0.01
Social Resources	8	0.75	0.38	-0.37
Organization	8	0.38	0.25	-0.13
Residential Stability	8	0.25	0.13	-0.12
Knowledge	8	1.00	1.00	0.00
Involvement with Care	8	0.50	0.50	0.00
Mental Health	8	0.38	0.38	0.00
Substance Abuse	8	0.25	0.25	0.00
Safety	8	0.13	0.13	0.00
Supervision	8	0.25	0.38	0.13
Developmental	8	0.00	0.13	0.13
Medical/Physical	8	0.00	0.25	0.25
Child Behavioral/Emotional Needs	8	0.44	0.39	-0.05
Anxiety	8	1.50	0.88	-0.62
Adjustment to Trauma	8	0.63	0.38	-0.25
Depression	8	1.00	0.88	-0.12
Anger Control	8	0.25	0.13	-0.12
Substance Use	8	0.25	0.25	0.00
Oppositional	8	0.13	0.13	0.00
Psychosis (Thought Disorder)	8	0.00	0.00	0.00
Impulsivity/Hyperactivity	8	0.00	0.13	0.13
Conduct	8	0.00	0.13	0.13
Attachment Difficulties	8	0.63	1.00	0.37



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Risk Behaviors	8	0.11	0.14	0.03
Other Self-Harm	8	0.25	0.13	-0.12
Suicide Risk	8	0.63	0.63	0.00
Non-Suicidal Self-Injurious Behavior	8	0.13	0.13	0.00
Sexual Aggression	8	0.00	0.00	0.00
Runaway	8	0.00	0.00	0.00
Fire Setting	8	0.00	0.00	0.00
Danger to Others	8	0.00	0.13	0.13
Delinquent Behavior	8	0.00	0.13	0.13
Intentional Misbehavior	8	0.00	0.13	0.13



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MHSA Innovation Final Evaluation Report: Health Ambassador Program – Youth (HAP-Y)

San Mateo County Health Ambassador Program–Youth Final Evaluation Report, 2016-20

A Mental Health Services Act Innovation Project



Prepared by:

Resource Development Associates

December 2020





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From HAP-Y Program Coordinator, Brenda Nuñez:

We cannot express enough gratitude to our partners throughout San Mateo County who contributed to the efforts and mission of the Health Ambassador Program for Youth (HAP-Y). Over the last four years, HAP-Y has touched the lives of so many. This program would not have been possible without the advocacy, support, and dedication of the following stakeholders in particular:

- **The Crisis Intervention & Suicide Prevention Center staff** for support in implementation and program planning, including Program Directors Narges Dillon, Islam Hassanein, and Zena Andreani. Additionally, to the CISPC staff who were also a part of program and training facilitation, including Brook Pollard, who delivered important educational presentations for HAP-Y, and Karina Chapa and Vero Polanco, who were both essential parts of programming as facilitators for the WRAP and Photovoice workshop experiences.
- **Community agency and service partners** including Behavioral Health and Recovery Services and the staff at the Office of Diversity and Equity, who provided critical funding, guidance, and support. To other community partners who were essential in programming, including Waynette from Copeland Center, who led the WRAP workshops and reminded participants that they are more than their diagnosis; Claudia Saggese and Karina Marwan, who both served as NAMI Family-to-Family facilitators and did so in such a passionate and empathetic manner; Siavash Zohoory, who facilitated workshops that provided participants the opportunity to explore and understand the power behind their own lived experiences; and Lisa M. Vasquez, for their continued support with outreach and participant recruitment.
- **Educational partners**, including Aspire East Palo Alto Phoenix Academy, Aragon High School, Jefferson High School, Fair Oaks Community Center, and ALAS for granting us space at their locations to host full 14-week programming.
- The team at **Resource Development Associates**, who has collaborated with everyone during this project and also worked directly with HAP-Y participants. Their engagement and communication with us has been exceptional.
- The **Youth Ambassadors**, who are most important of all, and who made this program such a wonderful and empowering experience for all involved. The ambassadors have been amazing leaders in their communities, and it has truly been a privilege to have been part of this journey with them.

A special statement of gratitude to all of the HAP-Y program graduates:

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Introduction

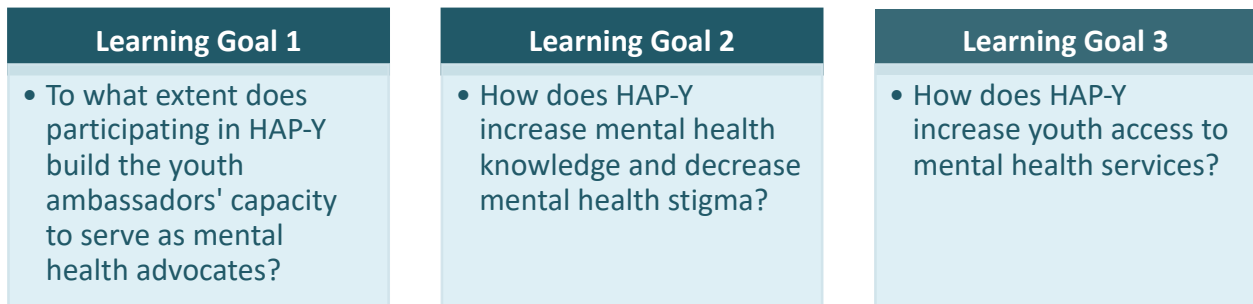
Project Overview and Learning Goals

The Health Ambassador Program-Youth (HAP-Y) was an Innovation (INN) program under the Mental Health Services Act (MHSA). San Mateo County Behavioral Health Recovery Services (BHRS) funded HAP-Y. StarVista, a nonprofit mental health organization based in San Mateo County, administered the program.

- **MHSA INN Project Category:** Makes a change to an existing mental health practice that has not yet proven to be effective.
- **MHSA Primary Purpose:** Increase access to mental health services.
- **Project Innovation:** HAP-Y served as a youth-led initiative where young adults acted as mental health ambassadors to promote awareness of mental health, reduce mental health stigma, and increase access to mental health services among young people. The HAP-Y Innovation project was the first to offer formal evaluation of a program designed for youth peer educators.

In accordance with the requirements for MHSA INN programs, BHRS selected three Learning Goals as priorities for the HAP-Y program. Figure 1 introduces these Learning Goals.

Figure 1: HAP-Y Learning Goals



The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the project on July 28, 2016, and BHRS contracted with StarVista in December 2016. In 2017, BHRS selected Resource Development Associates (RDA) to serve as the evaluation team for three MHSA Innovation Projects, including HAP-Y.

This final report follows three previous annual evaluation reports (2016-17, 2017-18, and 2018-19) that presented year-to-year accounts of HAP-Y program development, program outcomes, and participant experiences. This cumulative evaluation presents cross-cutting findings and “lessons learned” from across the nine cohorts held during the evaluation period.



Project Description

HAP-Y engaged, trained, and empowered TAY as youth ambassadors to promote awareness of mental health, educate their peers about mental health resources, and increase the likelihood that young people in San Mateo County are knowledgeable and comfortable enough to seek out mental health services. Each cohort of youth ambassadors underwent a 14-week psychoeducational training program designed to enhance their knowledge of mental health, communicative best practices, and advocacy skills. Following the training program, the ambassadors engaged in outreach and peer education activities in school- and community-based venues. Most ambassadors conducted their presentations with high school students in classroom settings, but HAP-Y participants also completed their presentations by speaking on discussion panels or serving in other public speaking roles.

StarVista, which provides counseling, prevention, early intervention, and education services for San Mateo County residents, served as the lead agency for HAP-Y. For over 30 years, StarVista has offered mental health services and resources to more than 40,000 people from diverse communities throughout San Mateo County. StarVista was selected through a Request for Proposal (RFP) process to implement and manage the HAP-Y project, including program administration, participant recruitment, and data collection efforts.

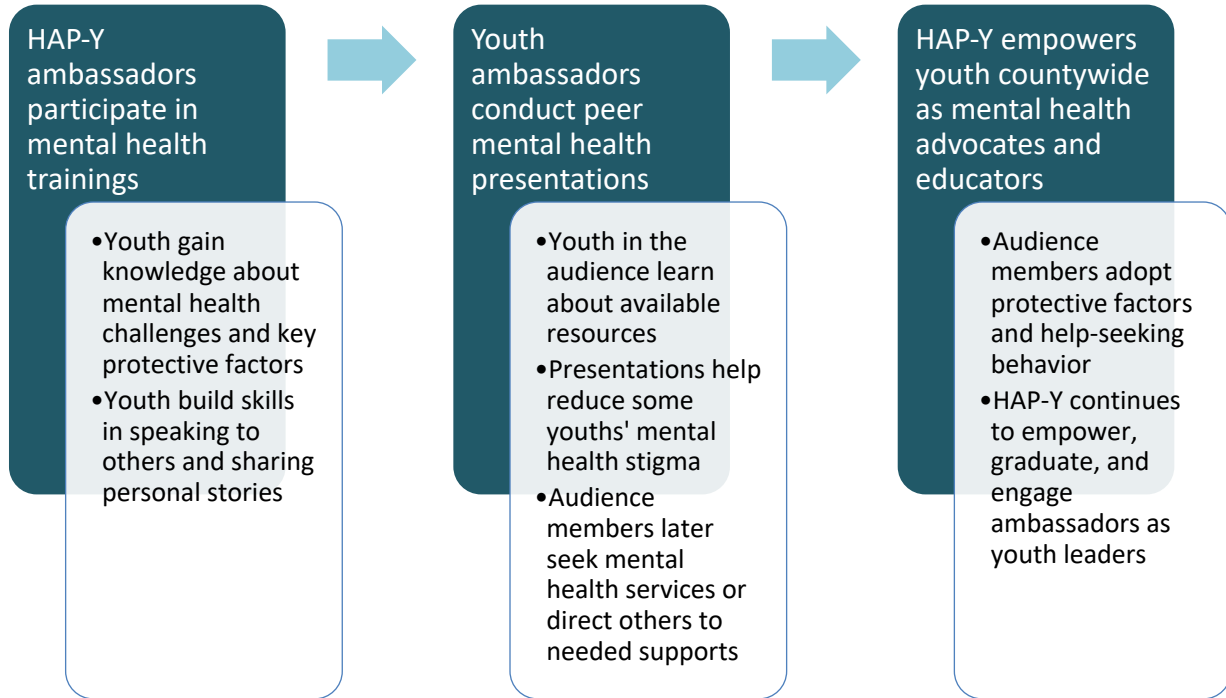
StarVista staff were responsible for providing training, collaborating with outside agencies to provide additional training, and arranging and supporting public presentations for Youth Ambassadors. StarVista also provided transportation and stipends for youth to attend the trainings.

HAP-Y Theory of Change

As is illustrated in the Theory of Change below, HAP-Y was developed to educate and empower youth ambassadors, inform young people across the county, and enhance the county's mental health system in its ability to serve youth. The program design expects that youth audiences are more likely to access mental health services and resources when receiving the information from peers. StarVista staff worked closely with the ambassadors to cultivate their knowledge of mental health, their public presentation skills, and their capacity to serve as community advocates. As such, HAP-Y was meant to create lasting change for individuals who directly engaged with the program, while improving mental health access among young people in the community at large.



Figure 2: HAP-Y Theory of Change



HAP-Y Program Model

1. StarVista conducted outreach for HAP-Y through schools, community-based organizations, social media platforms, and general outreach in the community.
2. Youth who showed interest in HAP-Y participation were asked to submit an application and go through a formal interview process conducted by StarVista staff. StarVista's key criteria for selecting ambassadors included youth who have lived experiences with mental health challenges, as well as youth who were able to commit to the full training program. StarVista staff convened different cohorts in different parts of the county, to ensure a wider geographic and demographic representation of youth ambassadors.
3. Cohorts received 14 weeks of training and then had three months following their training to conduct a minimum of three community presentations. StarVista partnered with youth to identify a location and supported the training by either co-presenting or providing individual preparation support.

See Appendices A and B for the HAP-Y youth application and StarVista youth interview protocol.

HAP-Y Training Curriculum

Over the 14-week training program, StarVista staff presented and coordinated an array of different mental health and suicide prevention trainings for the youth ambassadors. Together, these trainings prepared participants to:



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- Present psychoeducational information to youth in school- and community-based settings;
- Facilitate discussions about mental health care, suicide, and mental health challenges;
- Provide their peers and loved ones with mental health resources;
- Encourage others to seek formal support for mental health challenges; and
- Build confidence and grow their skills in leadership, advocacy, and public speaking.

Across the nine cohorts occurring during the evaluation period, StarVista staff incorporated ambassador feedback into curricular and program planning. For example, during the 2019-20 program year, StarVista discontinued its use of the National Alliance on Mental Illness (NAMI) training based on participant feedback.

HAP-Y Response to COVID-19

HAP-Y pivoted to a virtual training model in the spring of 2020 in response to COVID-19. HAP-Y trainings were conducted remotely, and ambassadors delivered presentations to audiences virtually when possible. With classroom-based audiences not readily accessible, some youth opted to present to smaller groups of family or friends. Overall, limited opportunities for presentations led to program graduates in cohort 9 completing fewer presentations than in past years.

Evaluation Overview

In 2017, BHRS contracted Resource Development Associates (RDA) to carry out the evaluation of HAP-Y's implementation and program outcomes. RDA is an Oakland-based public systems consulting firm that has conducted evaluations of MHSA Innovation Projects in multiple counties throughout California.

HAP-Y's three Learning Goals, introduced in the previous section, provided the core framework for the evaluation. Within this framework, the two major components to the evaluation are as follows:

- The **process evaluation** concerns the implementation of HAP-Y: the extent to which the program operated according to plan, any challenges with implementation, and any major changes to program operations. Lessons from the process evaluation enabled BHRS and StarVista to make real-time adjustments to improve program delivery.
- The **outcome evaluation** component assesses the extent to which HAP-Y activities produced the intended outcomes as outlined in the Learning Goals: building the leadership capacity of youth ambassadors, enhancing youth knowledge and decreasing mental health stigma, and increasing youth access to mental health services.

RDA worked with StarVista and BHRS to launch the HAP-Y evaluation using a Participatory Action Research (PAR) framework. During the first year of the program, HAP-Y youth ambassadors were instrumental in the development of the evaluation plan, and helped to design some of the major evaluation tools. StarVista staff, with support from RDA, introduced each new cohort to the importance of program evaluation during the training sessions. Youth ambassadors continued to serve a critical role in the





evaluation process: they conducted data collection with their peer education audiences and offered insight and reflections to the evaluation team following program completion.

The PAR framework enhanced the cultural competency of data collection methods employed for this evaluation. RDA centers a trauma-informed, culturally sensitive approach to engaging with and gathering information from program participants, particularly with youth-centered or youth-led programs. Our interviewers and facilitators are trained to bring an awareness of their own positionality and biases, as well as to ask questions in a sensitive and trauma-informed manner that gives participants voice and choice. Collaborating with HAP-Y ambassadors and program staff elevated participant voice, with participant input shaping data collection strategies over time.

Data Collection

In order to assess HAP-Y's progress toward its three learning goals, the evaluation team used a mixed-methods approach to program evaluation. This approach includes tracking quantitative measures of impact from the educational presentations, as well as qualitative assessments of youth ambassadors' experiences and the program's major successes and challenges. Using multiple methods also enables a more robust comparison of findings across the different data sources.

This final evaluation report also includes a unique data source: a retrospective survey offered to all HAP-Y program graduates. Respondents included youth ambassadors from each of the first eight HAP-Y cohorts, who graciously shared their perspectives on HAP-Y's longer-term impact as well as recommendations for program improvement as the HAP-Y program continues with other funding sources.

The types of data collection used for the evaluation are briefly described below. They include demographic reporting, the Self-Determination Survey, the Audience Survey, ambassador focus groups, and the HAP-Y Graduate Survey.

Demographic Reporting

The MHSOAC mandates that MHSA Innovation Projects collect data on the demographic backgrounds of program participants, and has a required list of demographic categories that the survey process must include. HAP-Y ambassadors completed a demographic survey at the start of the training program, which a StarVista staff member subsequently uploaded onto a HIPAA-compliant survey platform. Beyond the MHSOAC requirements, the demographic survey included an expanded list of options for sexual orientation and gender identity (SOGI), in order to accommodate a wider range of youth who identify as LGBTQ+. With these revisions, the demographic survey aligned with BHRS' agency-wide initiative to revise its SOGI questions on health intake forms. For a copy of the demographic survey, please see Appendix C.

HAP-Y Self-Determination Survey (Pre/Post)

RDA developed the Self-Determination Survey for the youth ambassadors, who take the same survey at the start of the program and after completing their time with the program. The survey, which was anonymous, required the ambassadors to assess their skills and beliefs in three domains: mental health



advocacy, leadership, and teamwork. Administering the survey at the start and end of the program (“pre” and “post” tests) helped to track how, on average, ambassadors’ self-perceptions changed over the course of their time with HAP-Y. For a copy of the Self-Determination Survey, please see Appendix D.

Audience Survey

To assess the impact of the ambassadors’ peer mental health presentations, a group of youth ambassadors worked with RDA to develop the Audience Survey in the first year of HAP-Y. The ambassadors administered the survey to their audience members following their presentations. This survey used a “post-pre” format: it asked audience members to recall their knowledge and beliefs about mental health before attending the presentation, and compare it to their knowledge after having witnessed the presentation. In addition, the Audience Survey included an option for respondents to leave their contact information if they are experiencing mental health challenges and wanted follow-up contact from StarVista. For a copy of the Audience Survey, please see Appendix E.

Focus Groups with HAP-Y Ambassadors

RDA conducted eight focus groups with current and former HAP-Y youth ambassadors throughout the evaluation period. In addition to cohort-specific focus groups, RDA facilitated two focus groups with HAP-Y graduates. While the evaluation team conducted pre/post focus groups with the majority of cohorts, the evaluation team did not conduct a focus group with participants from cohorts 5 or 7. Several alumni from these cohorts participated in a graduate focus group.

The focus group discussions enabled the evaluation team to gather in-depth information from HAP-Y’s participants, and provide the ambassadors a space to reflect on their experiences following the end of the program. For a copy of the focus group questions, please see Appendix F.

HAP-Y Graduate Survey

This final evaluation report also includes a retrospective survey offered to HAP-Y program graduates. Respondents included youth ambassadors from each of the first eight HAP-Y cohorts, who graciously shared their perspectives on HAP-Y’s longer-term impact as well as recommendations for program improvement as the HAP-Y program continues with other funding sources.

Intended as a complement to the Self-Determination Survey, the Graduate Survey asks about the longer-term impacts of HAP-Y participation, from multiple months to multiple years post-program. For a copy of the Graduate Survey, please see Appendix E.

Data Analysis

To analyze quantitative data from the survey tools, RDA examined frequencies, averages, and ranges of survey responses. To analyze qualitative data, RDA transcribed focus group and interview responses, and analyzed these transcripts to identify major themes, significant outliers, and notable perspectives across participants’ experiences. RDA then synthesized these quantitative and qualitative analyses in accordance with the three Learning Goals that guide the evaluation plan.





Data Limitations

Small sample sizes for “post” Self-Determination Surveys. Logistical difficulties prevented the administration of the Self-Determination Survey to certain cohorts at the close of their respective programs. While some former ambassadors maintained contact with StarVista, others were harder to reach after the end of the program. As such, the number of ambassadors who completed the “post” survey (26) is fewer than half of the number who completed the “pre” survey (78).

Difficulty of surveying audience members in non-school settings. HAP-Y ambassadors participated in a number of presentations, speakers’ panels, and other events in community-based settings outside of school. However, ambassadors were often unable to administer the Audience Survey in these settings. As such, the number of Audience Surveys is an undercount of the total number of people the HAP-Y ambassadors reached during their peer education efforts.

Ambiguous or confusing wording for some Audience Survey questions. The data from 2017-18 suggested that following the presentations, attendees were more likely to report feeling uncomfortable discussing mental health challenges, and more likely to believe that people with mental health challenges were unstable. These results appeared counterintuitive, as HAP-Y was designed to normalize open discussions about mental health challenges. In response, the evaluation team worked with StarVista and a group of former HAP-Y participants to revise the wording to these questions. In February 2019, StarVista staff presented these unexpected survey results to program alumni. These alumni discussed revisions to the audience survey, and recommended rewording these two questions to match the positive framing of the rest of the survey. Cohort 6 was the first group of ambassadors to use the new survey. The results of Cohort 6’s Audience Surveys are more aligned with program expectations—that audience members would feel more comfortable talking about mental health, and be more likely to believe that people with mental health challenges can lead healthy lives. The differences in survey results before and after this change suggests that the previous wording may have skewed the results.

In 2018-19, data analysis revealed that another survey question may have garnered unintended results. The survey asks audience members to check off any issues they have experienced in trying to access mental health care, but leaves no box or option to indicate that the survey-taker has never attempted to access mental health care. As such, it is possible that people in this position would have marked one of the answers, “I did not qualify for services,” understanding that to mean that they did not qualify because they did not need any services. It is thus unclear whether the number of people who indicated that they had experienced this challenge with eligibility is an accurate headcount. This survey question was changed for 2019-20.

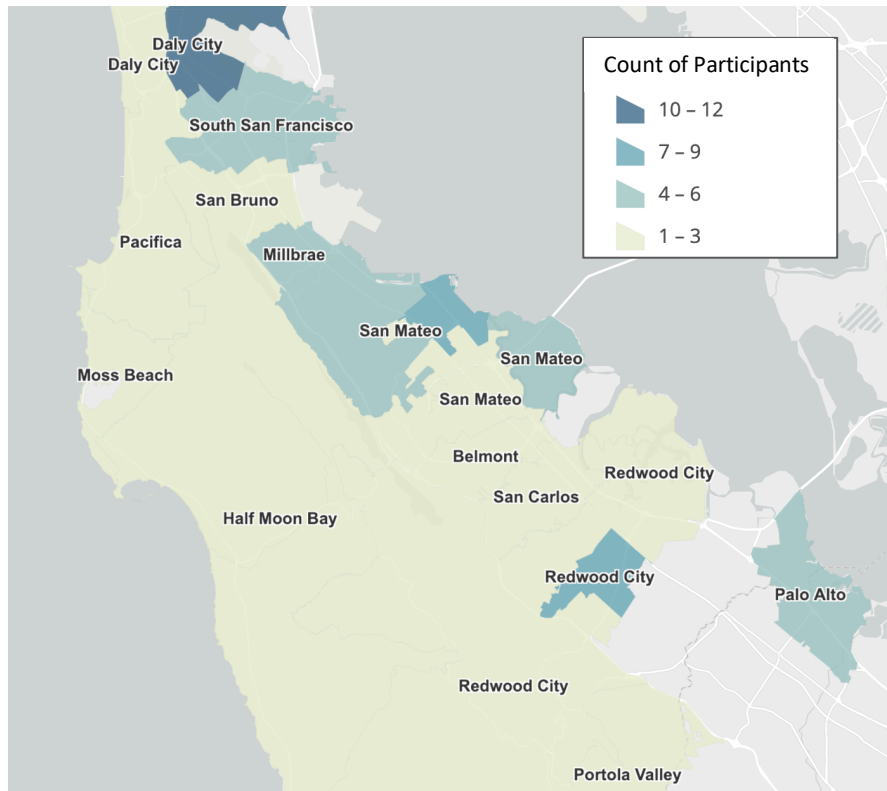


Program Reach and Participants

Geographic Reach

HAP-Y engaged nearly 100 youth ambassadors (n=98) over the course of the multiyear program. Youth enrolling in HAP-Y originated from across San Mateo County, with Figure 3 below showing HAP-Y participation by the zip code of youth ambassadors. Communities shown in darker blue, e.g., Daly City, west San Mateo, and Redwood City, had a higher number of youth participating in HAP-Y.

Figure 3. HAP-Y Participation by Zip Code, 2017-2020 (n=75)¹



Over the course of the project, StarVista expanded HAP-Y into different areas of San Mateo County, achieving a wider geographic representation of young people in the program. For example, in the program’s second year, StarVista’s emphasis on geographic diversity also overlapped with a goal of incorporating youth from historically marginalized communities. Except for cohorts 3, 6, and 9, all cohorts were majority Latinx. In focus groups, several Latinx youth noted the cultural and social barriers in their families that made mental health a taboo topic.

Multiple members of Cohort 6, which was centered in San Mateo, learned about HAP-Y through their participation in LGBTQ+ student organizations or the San Mateo County Pride Center.² For cohorts 7-9,

¹ While most youth did provide their zip code, 23 youth did not provide this information.

² The Pride Center is another MHSA Innovation Project.



HAP-Y engaged youth from across San Mateo County and from the Daly City and South San Francisco regions in particular.

Program Retention

Of the 98 youth who completed a demographic survey and attended an initial training session, 89 went on to complete the full course of HAP-Y training and 69 completed at least one presentation. Table 1 below shows the total number of youth engaged by HAP-Y (“HAP-Y Participants”) and demonstrates program retention as measured by the number of youth who completed the program (“Youth Completing HAP-Y Training”). Table 1 also shows survey completion rates across cohorts as measured by the number of youth who completed a pre-survey, both a pre- and post-survey, and the number of ambassadors who completed the graduate survey.

Table 1. HAP-Y Training and Survey Participation by Cohort³

Cohort	HAP-Y Participants	Youth Completing HAP-Y Training	Youth Completing Pre-Survey	Youth Completing Pre & Post Survey	Youth Completing HAP-Y Graduate Survey
1	11	10	-	-	10
2	10	9	10	-	5
3	13	11	13	6	6
4	13	12	4	4	4
5	7	7	7	4	5
6	13	11	13	8	5
7	9	9	9	1	7
8	16	14	16	-	4
9	6	6	6	3	-
TOTAL	98	89	78	26	46

³ “Participants” refers to the number of youth who completed an anonymous demographic survey during training. Only youth who completed both a pre- and a post- Self-Determination Survey are included. Cohort 9 participants had not completed the program at the time the Graduate Survey was administered.



Participant Characteristics

HAP-Y ambassadors reported diverse identities and backgrounds. Table 2 below describes the demographic characteristics of HAP-Y participants across age, race/ethnicity, sex, gender identity, sexual orientation, health and housing, language preference, education, employment, and income.

Table 2: HAP-Y Ambassador Demographics (n=98)⁴

Age: 100% of ambassadors were 24 or younger at the time of survey, with nearly all participants between the ages of 16 and 24.

Language: Almost all (95%) of ambassadors listed English as their primary language, or listed English along with another language.

Race: Roughly 58% of participants identified as Latinx, and 26% identified as white. Except for cohorts 3, 6, and 9, all cohorts were majority Latinx. A slight majority of cohort 3 participants were Asian, a slight majority cohort 6 participants were white, and a majority of cohort 9 participants were non-white.

Ethnicity: A majority of ambassadors (62%) were Mexican/Mexican American/Chicanx, Central or South American, including nearly all of Cohorts 4 and 5. Roughly 12% of participants reported European ethnicity and 9% reported Chinese ethnicity, with the remainder reporting Filipino, African, Korean, Middle Eastern, Native American, or other ethnicity.

Sex at Birth: 73% of ambassadors indicated that they were female at birth. Others were male at birth or declined to answer.

Gender Identity: The majority of ambassadors (69%) identified as cisgender women at the time of survey.

Sexual Orientation: About two-thirds (69%) of ambassadors identified as heterosexual or straight, and 13% identified as bisexual. The other 18% identified as questioning, pansexual, queer, gay/lesbian, or declined to answer.

Education: Most (87%) participants were in high school at the time of survey, including all members of Cohorts 4 and 5. This number may be underreported, as some ambassadors declined to respond.

Health Conditions: 74% of ambassadors reported having no major health issues or declined to answer. The most common reported condition was difficulty seeing.

Employment: 70% of youth reported being students, and one-third (32%) had a part-time or full-time job. A few selected multiple categories.

Housing Status: Nearly all ambassadors indicated that they have stable housing, or are living with friends or family members.

Income: Only 16% of participants answered this question, with all reporting an annual income of \$50,000 or less.

⁴ To comply with HIPAA requirements and to protect the confidentiality of participants, the demographic analysis below only lists categories where there were at least five responses. Some categories have been combined in cases where there were fewer than five responses.



Presentations and Audience Engagement

Table 3 presents key metrics related to HAP-Y audience engagement over the course of the project.⁵ Among the 89 participants who completed the full course of HAP-Y training, **69** youth delivered **229** mental health-focused presentations in their schools and communities. These presentations reached over **3,800** individuals countywide.

HAP-Y ambassadors in cohorts 1-8 delivered in-person presentations to classroom and community audiences. Youth in cohort 9 delivered virtual presentations due to the lockdown directives in San Mateo County in response to the COVID-19 pandemic.

Table 3. HAP-Y Audience Presentations and Surveys by Cohort

Cohort	Youth Completing Presentations	Presentations	Audience Surveys
1	9	9	287
2	9	23	365
3	10	32	822
4	8	41	594
5	5	18	278
6	8	41	459
7	8	29	475
8	6	16	341
9	6	20	267
TOTAL	69	229	3,888

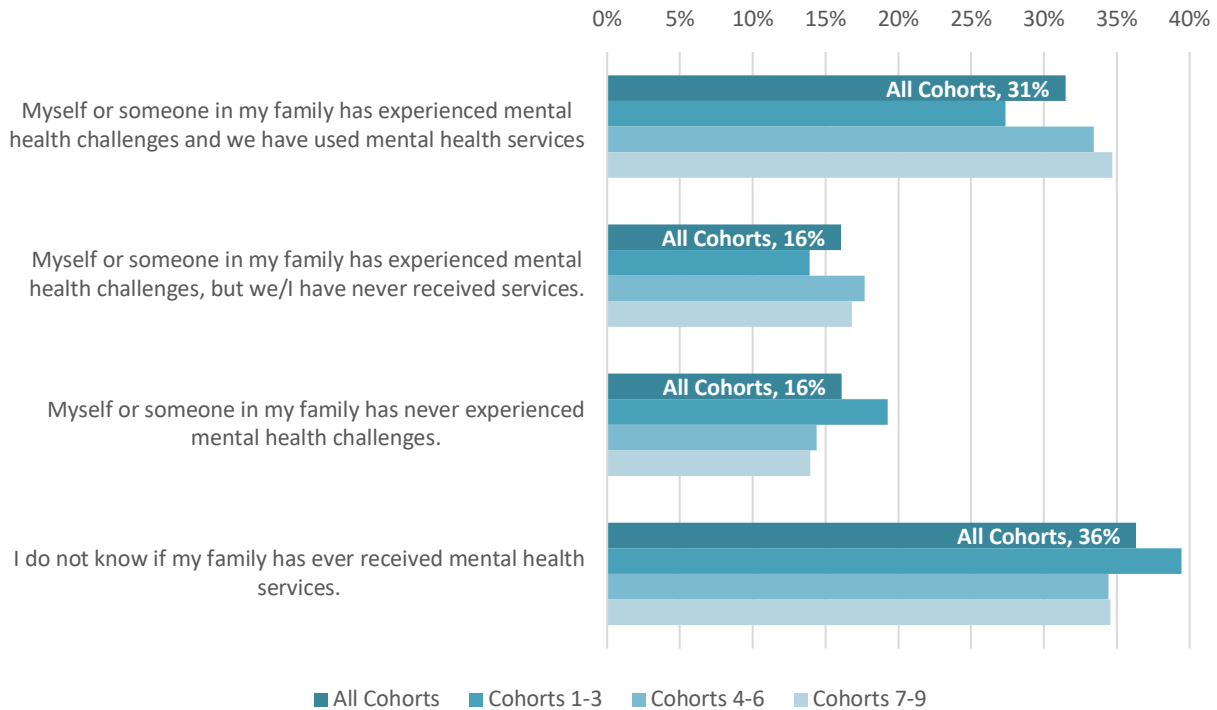
⁵ The total count of completed audience surveys is likely an undercount of the total audience engagement, as not all audience members completed a survey. Additionally, due to the impact of COVID-19, there was a decline in the number of presentations delivered and audience surveys completed in cohort 9.



Audience Lived Experiences

While the audience survey did not solicit any demographic information from respondents, one question asked about the audience member’s personal or familial experience with mental health challenges and mental health services. Figure 4 shows audience responses to this question were generally consistent across cohorts.

Figure 4: Audience Members’ Prior History of Mental Health Challenges and Services (n=3,888)



Nearly half of audience members reported some personal experience with mental health challenges. Across cohorts, 47% of survey respondents indicated that either they or a family member had experienced mental health challenges. Among that subset of respondents, roughly one-third had not received any mental health services in response.

Over one-third of audience members (36%) did not know whether any family members had received mental health services before. This proportion was more than twice the percentage of audience members who responded that neither they nor any family members had ever accessed mental health services (16%). The fact that so many audience members were uncertain about their family’s mental health histories suggests that mental health challenges and mental health care may not have been a common topic of discussion at home for these students.



Final Progress Toward Learning Goals

This section presents the key evaluation findings across the first nine HAP-Y cohorts, separated by the three Learning Goals. A summary of key findings is included below.

Learning Goal 1: Building Youth Capacity

Mental Health Leadership and Advocacy. Participating in HAP-Y provided ambassadors with concrete tools and knowledge to effectively advocate for mental health awareness, contribute to others' learning, and support their own mental health and wellbeing.

Improved Self-Confidence. Youth who participated in HAP-Y reported higher self-confidence, including in measures describing resilience and attitudes about self, after participating in the program.

Community as a Protective Factor. HAP-Y helped foster a sense of community and reduced the isolation that some ambassadors reported feeling, especially those with lived experiences of depression or other mental health challenges.

Mental Health Career Pathways. For many ambassadors, participating in HAP-Y affirmed or inspired their desire to pursue a career in the mental health field, or to integrate mental health concerns into their other career aspirations.

Long-Term Ripple Effects. Ambassadors reported that their participation in HAP-Y has continued to positively impact their own lives and the lives of those around them months, and even years, after program completion.

Learning Goal 2: Enhancing Mental Health Knowledge & Decreasing Stigma

Knowledge about Mental Health and Resources. Across cohorts, the most salient takeaways for audience members were understanding the signs of depression and anxiety and learning that there are helplines and other services available 24/7 to assist individuals who are experiencing mental health crises.

Addressing Stigma. HAP-Y presentations appeared to decrease audience members' stigma around mental health. At the same time, it is still likely that stigma remains an issue for some audience members.



Learning Goal 3: Increasing Youth Access to Mental Health Services

Access to Resources. Many HAP-Y audience members indicated that the presentation had provided them with resources they could use in the future to seek support for themselves, family members, and/or friends.

Long-Term Ripple Effects. Beyond the required presentations, HAP-Y ambassadors shared the knowledge and skills gained from the program with family, friends, and community members. Ambassadors described myriad post-program interactions ranging from educating family members to connecting peers to mental health resources, including peers who disclosed suicide or self-harm ideation.

Learning Goal 1: Building Youth Capacity

Mental Health Leadership and Advocacy

Participating in HAP-Y provided ambassadors with concrete tools and knowledge to effectively advocate for mental health awareness, contribute to others' learning, and support their own mental health and wellbeing. As Figure 5 shows, HAP-Y ambassadors reported an improved sense of efficacy regarding mental health advocacy and leadership, with the figure illustrating ambassadors' self-reported change between the pre- and post-program Self-Determination Survey. Notably, the two indicators that saw the largest increase between the pre- and post-survey relate to advocacy for self and others. Both of these indicators ("I am comfortable speaking up"; "I can speak up for myself in a group") increased by eleven percentage points when analyzing cohort results collectively.

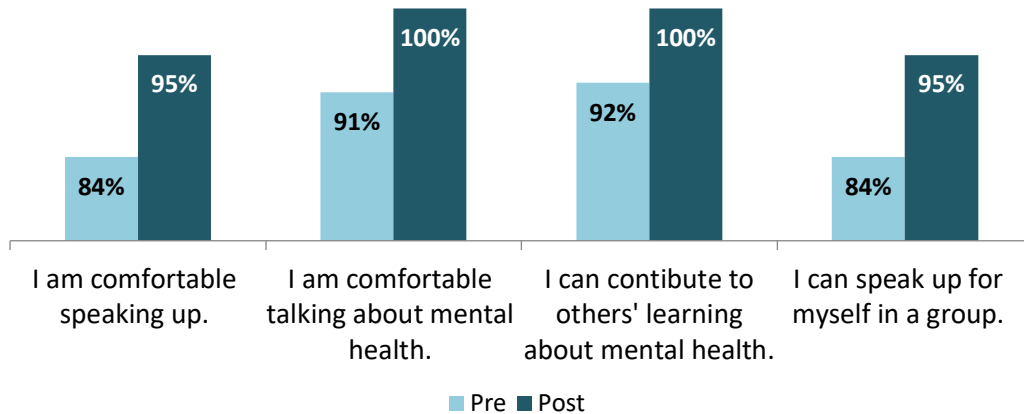
This increase corresponds to the ways in which HAP-Y graduates talked about how the program prepared them to engage proactively as mental health educators and advocates with their families, friends, and broader social networks. For example, one HAP-Y graduate shared that the experience "helped me give advice about what therapy means [to] my dad. Sometimes older men think that therapy means that something is bad, but I can talk about it in a way [that normalizes it]."

Because many HAP-Y ambassadors had lived experiences of mental health challenges, the program also helped participants build resilience and practices around self-care. For example, several participants noted how they had found the training on Wellness Recovery Action Plans (WRAPs) useful for the general stresses in their own lives. One former ambassador noted that they had created a WRAP when working on their college applications, as they had found the experience to be incredibly burdensome. Several ambassadors also appreciated the emphasis on self-care during the training sessions, which covered



difficult and sensitive topics. This focus on emotional self-awareness made ambassadors more cognizant of their own stress levels and the need to advocate for their own wellbeing on a regular basis.

Figure 5. Pre/Post Changes in Participants’ Self-Reported Mental Health Advocacy Skills (n=26)
(Percentage of ambassadors who responded “mostly true” or “very true”)



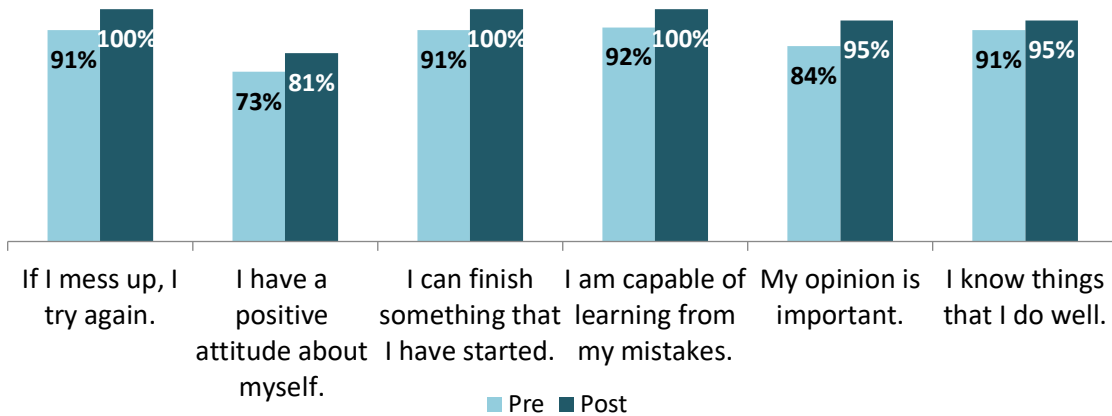
Improved Self-Confidence

Youth who participated in HAP-Y reported higher self-confidence, including in measures describing resilience and attitudes about self, after participating in the program. Figure 6 below describes the areas where these increases were observed. While ambassadors generally reported in the pre-survey that they had high perceptions of self-confidence (e.g., “My opinion is important”; “I know things that I do well”) and self-efficacy (e.g., “I can finish something that I have started”; “I am capable of learning from my mistakes”), it is notable that each of these indicators increased between the pre- and post-surveys across cohorts as a whole.

Increased levels of confidence helped HAP-Y alumni to continue advocating for the importance of mental health awareness even after they completed their presentations. Several ambassadors noted that by the end of the program, they felt knowledgeable and confident enough to challenge their friends and relatives who hold misconceptions about mental health, or who say things that could be taken as insensitive. Importantly, these ambassadors also noted the importance of having empathy when challenging others: the goal was not to belittle the other person, but to share helpful knowledge and prevent the spread of potentially harmful beliefs.



Figure 6. Pre/Post Changes in Participants’ Self-Confidence/Self-Efficacy (n=26)
 (Percentage of ambassadors who responded “mostly true” or “very true”)



Community as a Protective Factor

“The biggest thing that has stayed with me is having a support system. [HAP-Y] made me realize how important that is.”

–HAP-Y Graduate

HAP-Y helped reduce the isolation that some ambassadors reported feeling, especially those with lived experiences of depression or other mental health challenges. HAP-Y participants noted that cohorts often became close-knit over the course of the program, and that many ambassadors developed bonds with one another. Some ambassadors described that they had not previously had an opportunity to discuss their own mental health challenges with peers, and discovered through HAP-Y that they were not the only ones experiencing those struggles.

Notably, one of the largest pre/post increases across the Self-Determination Survey was observed in the indicator that asked participants about their sense of belonging to a community. There was an increase of 11 percentage points in youth who agreed that they are a part of a community. Powerfully, the largest shift came from those who reported that this was “very true.” The number of youth who agreed that this was “very true” increased from 48% to 76%.⁶

⁶ The overall pre/post change remains 11 percentage points, as it includes those who responded “mostly true” or “very true” in both the pre- and post-surveys.



Mental Health Career Pathways

For many ambassadors, participating in HAP-Y affirmed or inspired their desire to pursue a career in the mental health field, or to integrate mental health concerns into their other career aspirations. While BHRS and StarVista did not plan for this as a program goal, many HAP-Y participants exited the program with goals to pursue careers as mental health practitioners, social workers, service providers, or similar professions. Some of these ambassadors started the program with some interest in a career in mental health, which strengthened over the course of the program; others discovered a newfound passion in HAP-Y that they wish to keep pursuing in the future.

Measuring Impact

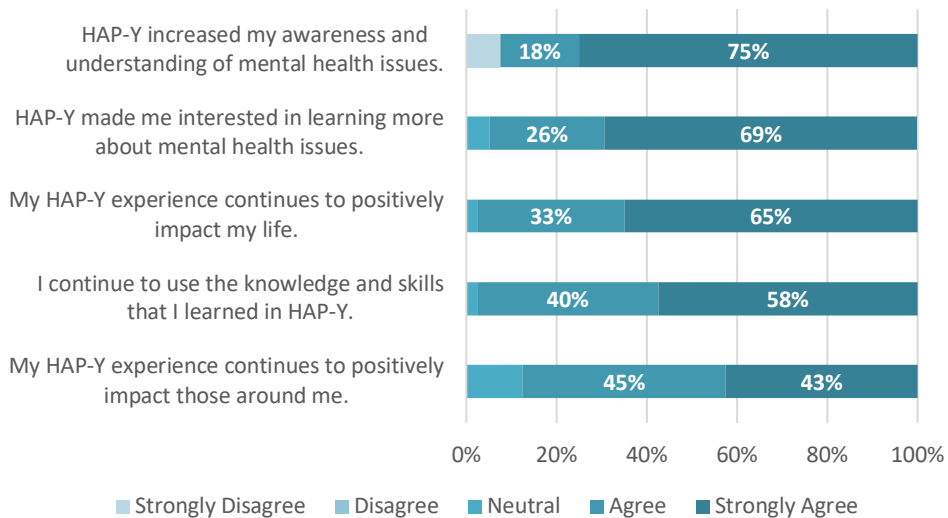
58% of ambassadors said that they are considering a mental health-related career as a result of their participation in HAP-Y in San Mateo County.

Over half (58%) of program graduates agreed that they are considering a mental health-related career because of HAP-Y. Of those who reported that HAP-Y influenced them to pursue a mental health-related career pathway, 71% said they are considering a career in psychology or psychiatry, 64% a career in social work, and 57% a career as a therapist.⁷

Long-Term Ripple Effects

Ambassadors reported that their participation in HAP-Y has continued to positively impact their own lives and the lives of those around them for months, and even years, after program completion. Figure 7 below describes the responses of HAP-Y graduates when asked about the longer-term impacts of program participation on their understanding of and interest in mental health issues, the ongoing application of the knowledge and skills they learned in HAP-Y, and any perceived positive impact(s) that their participation in HAP-Y continues to have in their own lives or in the lives of friends or family.

Figure 7. HAP-Y Graduate Survey Responses (n=46)



⁷ Respondents were able to select multiple options.





Learning Goal 2: Enhancing Mental Health Knowledge and Decreasing Stigma

Knowledge about Mental Health and Resources

Across cohorts, the most salient takeaways for audience members were understanding the signs of depression and anxiety and learning that there are helplines and other services available 24/7 to assist individuals who are experiencing mental health crises. Most audience members found the HAP-Y presentations useful and expressed high levels of satisfaction with both the presentation and the presenters. Across all cohorts, 88% of audience members indicated that they had found the presentation useful.

“I have depression and [the presentation] made me feel like I wasn’t alone. I learned more about services I can access.”

–HAP-Y Audience Member

Despite the impact of COVID-19 on the ability of ambassadors in cohorts 8 and 9 to deliver presentations, audience members for cohorts 7, 8, and 9 shared positive feedback in line with audience members of the first six cohorts. For example, audience members who completed an Audience Survey for cohort 8’s presentations reported that they found the presentations helpful particularly for the insights around how to talk with friends or family members who have suicidal or self-harm ideation. One audience member writes, “[I learned] the signs of a person who is trying to harm or kill themselves.” Others expressed new learnings around common mental health challenges, including depression and anxiety. Another audience member shared that “I honestly didn’t know what anxiety really was” and that the presentation “helped me learn about the symptoms.”

Addressing Stigma

Measuring Impact

After attending a HAP-Y presentation, **74% of audience members** reported that they would feel comfortable seeking mental health services.

Only half (51%) reported feeling comfortable seeking services prior to the presentation.

HAP-Y presentations appeared to decrease audience members’ stigma around mental health. Audience members reported that after attending the presentation, they would feel more comfortable seeking out mental health services. Several audience members wrote in the open-ended comments that by learning more about mental health and mental illness, they were more informed and less likely to pass judgment on individuals who may be struggling with mental health challenges.

At the same time, it is likely that stigma remains an issue for some audience members. After the presentation, nearly all audience members reported that they knew where to get support for mental health challenges (94%). However, fewer audience members indicated that they felt *comfortable* seeking mental health resources (74%), even though audience members’

comfort levels rose on average after the presentation. While these figures represent a sizeable majority of audience members, it is still noteworthy that more audience members felt knowledgeable about available mental health resources than those that would feel comfortable accessing those same resources or services. These data suggest that stigma around mental health may remain a challenge for some students in San Mateo County, including those who otherwise found the presentation to be informative.



Learning Goal 3: Increasing Youth Access to Mental Health Services

Access to Resources

Many HAP-Y audience members indicated that the presentation had provided them with resources they could use in the future to seek support for themselves, family members, and/or friends. As mentioned in the previous section, many audience members noted that they appreciated how ambassadors shared specific resources that were easy and free to access, such as crisis hotline numbers and a peer-run youth chatroom. These resources could serve as points of entry for youth to seek out longer-term mental health services.

A small portion of Audience Survey respondents indicated that they were experiencing a mental health challenge, and requested individual follow-up support from StarVista. StarVista staff noted that most students who do leave their contact information ultimately do not respond to StarVista’s efforts to contact them. Moreover, StarVista was not able to track the completion rate of follow up contacts, or whether a follow up call results in the student being connected to mental health supports. As such, it is difficult to gauge accurately how many of these survey requests result in access to formal services.

Long-Term Ripple Effects

Beyond the required presentations, HAP-Y ambassadors shared the knowledge and skills gained from the program with family, friends, and community members. Ambassadors described myriad post-program interactions ranging from educating family members to connecting peers to mental health resources, including peers who disclosed suicide or self-harm ideation. Among those who completed the HAP-Y Graduate Survey—which included a cross-sample of participants from the first eight cohorts—88% of respondents agreed that their participation in HAP-Y continues to positively impact those around them.

Measuring Impact

Of the 88% of HAP-Y graduates who agreed that their participation in HAP-Y “continues to positively impact those around me,” 90% shared a personal anecdote describing how they continue to share the knowledge and resources they learned from HAP-Y.

Most of those ambassadors shared personal anecdotes describing how they continue to share the knowledge and resources from HAP-Y with the people in their lives, including teachers, parents, friends, and classmates. The majority of graduates shared that they use the knowledge they learned to dismantle stigma or negative attitudes about mental health with the people in their lives. Others described how they are able to support their siblings’ or friends’ management of mental health challenges. One ambassador discussed being able to support her friend who was experiencing a panic attack by using one of the breathing techniques she learned in HAP-Y. Overall, HAP-Y ambassadors continue in their role long after they graduate from the program, showing up as mental health leaders and ambassadors who promote self-care and community care information and strategies.



Conclusion

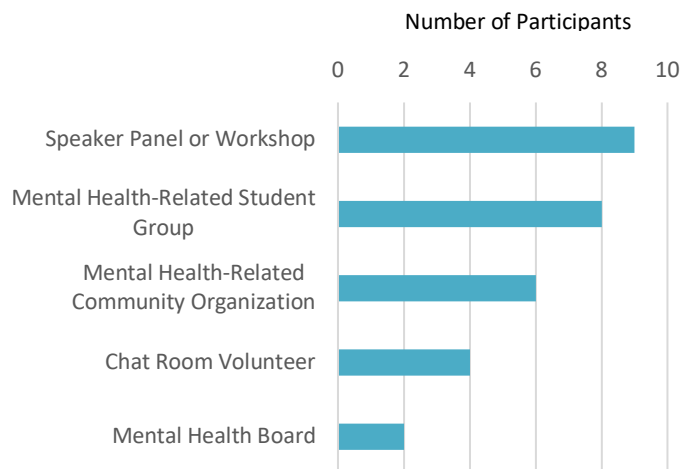
Across all HAP-Y cohorts, ambassadors provided input and feedback via cohort focus groups, reunion focus groups, and surveys. True to the purpose of MHSA Innovation projects—providing funding to incubate novel behavioral health strategies and approaches—the following are the guiding “lessons learned” culled from the multi-year San Mateo County HAP-Y pilot. These lessons illustrate the relational impact of the Innovation project and provide insights for ongoing program adjustments moving forward.

Lesson 1. Training youth as mental health advocates and leaders in San Mateo County resulted in a multiplier effect: participants continued to initiate mental health conversations even after they completed the program. These conversations crossed generational and cultural boundaries and occurred at the individual, family, and community levels.

Not only did HAP-Y empower ambassadors to lead and engage in a greater number of mental health-focused conversations, it shaped the quality and content of those conversations. As one HAP-Y graduate shared, “HAPY continues **to influence the language I use when speaking about mental illness** around others, as I have learned how to speak compassionately and respectfully about mental health issues.” Another participant described how HAP-Y empowered them to support and educate both friends and family: “My friend one day had suicidal thoughts and I knew to provide him lots of support, motivational thoughts, but **most importantly I knew that I needed to [connect him to] a professional.** Together, we were able to find a therapist he could talk [to at] his school’s health center. I’m also now able to educate my Latino family on mental health which they weren’t so open to before.”

In addition to informal, interpersonal conversations on mental health, some ambassadors continued to engage in mental health conversations in formal spaces in their communities. Figure 8 illustrates ways in which HAP-Y graduates continued to engage in mental health-focused spaces in their schools and communities.

Figure 8. Post-Program Community Involvement



Lesson 2. Youth participating in an evidence-based mental health training program can apply the tools and strategies they learn to their own mental wellbeing and self-care praxis.

A vignette shared time and again by HAP-Y ambassadors over the course of the evaluation period was how often they used the knowledge and skills they gleaned from HAP-Y in their day-to-day interactions, including self-care activities. Multiple program graduates reported that **they apply self-care frameworks**



from HAP-Y in their personal lives, such as by practicing journaling, establishing relational boundaries, or engaging in mindfulness activities.

Collectively, ambassadors’ personal reflections underscore **heightened resilience, self-awareness, and an understanding of the critical nature of self-care**. For example, one ambassador shared that “I’ve learned to notice the signs of when I might be entering a moment of crisis.” Another added, “I have been able to take care of my mental health better. HAP-Y taught me coping skills for anxiety and depression and ways to care for myself. I usually take out the binder I was given and read through some of the lessons we went through on mental health.”

These individual anecdotes are reflected in the data: 98% of HAP-Y graduates who completed the graduate survey reported that their participation in the program continues to positively impact them. In both the surveys and focus groups, graduates provided an abundance of examples of how they put HAP-Y training concepts into practice. Whether these examples discuss mental health, self-appreciation, or conflict resolution, HAP-Y ambassadors demonstrated that self-care strategies bolster mental wellbeing and enhance resilience. Finally, the insights and experiences shared by participants emphasize a greater takeaway, which is that evidence-based mental health educational programs for youth can yield long-term dividends by modeling and normalizing tools for self-care praxis.

“HAP-Y taught me about self-worth. I now know that focusing on myself is just as important as caring for others. I am in a healthier state of mind.”

–HAP-Y Graduate

“I love how much we talk about self-care as a serious topic rather than a hot buzzword. Making me think in each session about what I will do for self-care has helped me to continue to practice that in my own life.”

–HAP-Y Graduate

Program and Funding Continuation

San Mateo County BHRS presented interim HAP-Y outcomes to stakeholders, the MHSA Steering Committee, and the MHSARC in 2019. During this meeting, BHRS provided an update on progress toward program learning goals, client outcomes, and a proposed sustainability plan. The sustainability plan included a request of \$250,000 ongoing MHSA funds, beginning in FY 2020-21. An estimated 40 members of the public attended the presentation and had the opportunity to ask questions and provide public comment.

The MHSA Steering Committee made a motion to approve a one-year no cost extension of HAP-Y for FY 2019-20. Additionally, the idea to fund HAP-Y using MHSA one-time unspent funds as an interim solution was presented at this meeting, with the intention to incorporate the ongoing project sustainability into the FY 2020-23 MHSA Three-Year Plan Community Program Planning process. The Plan to Spend was developed in collaboration with stakeholders during two MHSA Steering Committee meetings and input sessions with the MHSARC Older Adult, Adult, and Youth Committees, as well as the Contractor’s Association, the Office of Consumer and Family Affairs/Lived Experience Workgroup and the Peer Recovery Collaborative.



San Mateo County Behavioral Health and Recovery Services

MHSA Innovation Final Evaluation Report: Health Ambassador Program – Youth (HAP-Y)

In October 2019, the MHSA Steering Committee reviewed the draft Plan to Spend and provided comments. In November, the MHSARC held a public hearing, closed the 30-day public comment period, reviewed the public comments, and subsequently voted to submit the plan to the Board of Supervisors for approval. The final Plan to Spend was submitted and approved by our Board of Supervisors in April 2020.

During the FY 2020-23 MHSA Three-Year Plan Community Program Planning process, the COVID-19 pandemic transpired. Given the significant revenue decrease projections expected due to the pandemic, it is unlikely that San Mateo County will be able to fund any new programs or expansions, including HAP-Y past FY 2021-22. At the MHSA Steering Committee in February 2021, BHRS will work with stakeholders on a plan to utilize reserves for possible sustainability of this and other programs.

As mentioned above, preliminary project outcomes were presented to stakeholders, the MHSA Steering Committee and the MHSARC in 2019. The final report will be presented to these same groups in May 2021 as part of the FY 2020-21 MHSA Annual Update, posted on the San Mateo County MHSA website, BHRS blog and disseminated to the over 2,000 local MHSA subscribers. There are no current plans to present to other counties but BHRS is open to this possibility.

Finally, StarVista and BHRS worked with RDA to identify and develop infrastructure for ongoing reporting purposes. These conversations engaged stakeholders in program sustainability planning to ensure HAP-Y's ongoing compliance with County and State reporting requirements.



Appendix A: HAP-Y Application



STAR VISTA Health Ambassador Program for Youth

DESCRIPTION:

Health Ambassador Program-Youth (HAP-Y) is a new program established by StarVista. We are looking for youth health ambassadors who are passionate about serving communities that have been affected by mental health challenges, interested in raising awareness, and increase access to behavioral health services. Interested youth will participate in trainings focusing on mental wellness. After completion of training, Health Ambassadors will be community agents ready to help others in the community through information sharing or providing referrals when appropriate. Stipend of up to \$700 will be provided for youth who complete the training program. Public transportation passes and child care are available upon request. **People who have family, communities or they themselves have been affected by mental health challenges are highly encouraged to participate.**

REQUIREMENTS:

Be between the ages of 16 to 24.
Able to commit to 70+ hours of training.
Participation in community events.

GENERAL RESPONSIBILITIES:

Training

Participate in the entire training program. Training will be focused on topics of mental wellness. Some of the trainings cover the common challenges in mental wellness, learning the signs and risks of suicide, suicide prevention, and information on access to mental health services. Snacks and light refreshments will be provided at each training.

Community Involvement

After completing required training, health ambassadors will have the opportunity to represent HAP-Y in community events such as health fairs, outreach events, and trainings. Opportunities to receive pay will be available.

PLEASE EMAIL APPLICATION TO: hapy@star-vista.org

OR

PLEASE MAIL APPLICATION TO:

StarVista Crisis Center, Attn: HAP-Y
610 Elm Street, Suite 212
San Carlos, CA 94070

Please submit applications by 12/14. Selected applicants will be contacted for interview. Any applications received after this date will be considered for the next round.





PERSONAL INFORMATION:

NAME:

DATE OF BIRTH:

AGE:

GENDER IDENTITY:

ADDRESS:

PHONE NUMBER:

EMAIL ADDRESS:

DO YOU PREFER TO BE CONTACTED BY PHONE, TEXT OR EMAIL?

SCHOOL (IF APPLICABLE):

NOTE: PARENTAL PERMISSION REQUIRED FOR PARTICIPATION FOR THOSE UNDER 18.

BACKGROUND INFORMATION:

1. List any jobs or extracurricular activities that you are currently involved in or participated in previously.

Job/Activity	Description of involvement	How long have you been or were you involved?

1. What language(s) other than English do you speak? Would you need interpretation services to participate in the program?
2. Our next training program will be in San Mateo, Does this location work for you? If no, please enter most convenient location for you.
3. What qualities do you possess that will make you successful as a Health Ambassador?
4. How have you, your family, or your community been affected by mental health and behavioral health challenges?
5. How does becoming a health ambassador fit with your personal and professional goals?



Appendix B: StarVista HAP-Y Interview Protocol

Start by describing the program (combination of trainings and outreach)

Applicant Name:

Interviewer:

1. Tell us a little about yourself and why you are interested in participating in a program focusing on mental health?
2. What is something you hope to get out of participating in this program?
3. How do you feel about representing the program at community events like health fairs or in classroom presentations?
4. Tell us about a time you worked in a team: what were some challenges and what were some things that made is successful?
5. How do you think this will fit with your other commitments? How will you manage your time?
6. Our meetings would be in the afternoon starting at 4:30 starting in September lasting for 13 weeks. Do you expect any challenges to regular participation in the program? (For example: do you have transportation, any scheduling conflicts? Will you need vouchers?)
7. If you are under 18, have you discussed this program with your parents? Are they supportive? Would it be ok for us to contact them?
8. How did you hear about the program?
9. What do you think are your strengths and areas you are working to improve?
10. Why do you think it's important for young people to learn more about mental health?
11. Think about a teacher you liked, what made them effective?
12. What are you most proud of?
13. How would your friends describe you? (If more experienced, how would your supervisor describe you)?
14. What 3 words would you choose to describe yourself?



Appendix C: HAP-Y Demographic Form

Thank you for joining the Health Ambassador Program for Youth. This form will help us understand who is attending the trainings and part of the program. The questions are voluntary. Thank you for your time!

Team Member First and Last Initial & DOB:	
Zip code:	

1. What is your age category?

- 0-15
- 16-25
- 26-39
- 40-59
- Age 60 and above
- Decline to answer

2. What is your preferred language?

- English
- Spanish
- Mandarin
- Cantonese
- Russian
- Vietnamese
- Tagalog
- Hindi
- Farsi
- American Sign Language
- Other: _____
- Decline to answer

3. How do you define your race? (check all that apply)

- American Indian/Native Alaskan
- Asian
- Black or African American
- Hispanic or Latino/a/x
- Native Hawaiian or other Pacific Islander
- White/Caucasian
- Other: _____
- Decline to answer

4. How do you define your ethnicity? (check all that apply)

Hispanic Ethnicity:

- Caribbean
- Central American: _____
- Mexican/Mexican-American/Chicano/a/x
- Puerto Rican
- El Salvadorian
- South American: _____

Non-Hispanic Ethnicity:

- African
- Asian Indian/South Asian
- Cambodian
- Chinese
- Eastern European
- European
- Filipino
- Middle Eastern
- Vietnamese
- Japanese
- Korean
- Other: _____
- Decline to answer



5. What is your assigned sex at birth?

- Male
- Female
- Intersex
- Decline to answer

6. What is your current gender identity?

- Cisgender Man
- Cisgender Woman
- Trans Man
- Trans Woman
- Genderqueer
- Two-Spirited
- Questioning or unsure of gender identity
- Another gender identity: _____
- Decline to answer

7. How do you identify your sexual orientation?

- Gay or Lesbian
- Heterosexual or Straight
- Bisexual
- Questioning or unsure of sexual orientation
- Queer
- Pansexual
- Asexual
- Two-Spirited
- Another sexual orientation: _____
- Decline to answer

8. Do you have any of the following disabilities or health conditions? (check all that apply)

A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness.

- Difficulty seeing
- Difficulty hearing, or having speech understood
- Other communication challenges: _____
- Limited physical mobility
- Learning disability
- Developmental disability
- Dementia
- Chronic health condition
- Other disability or health condition: _____
- None
- Decline to answer

9. What is your highest level of education?

- Less than high school diploma
- High school diploma or GED
- Some college
- Vocational or trade certificate
- Associate's Degree
- Bachelor's Degree
- Graduate Degree
- Decline to answer

10. What is your current employment status?

- Full time employment
- Part time employment
- Unemployed and looking for work
- Unemployed and not looking for work
- Retired
- Student
- Decline to answer

11. What is your current housing status?

- I have stable housing
- I am staying with friends or family
- I am living in a shelter or transitional housing
- I am homeless
- Other housing status: _____
- Decline to answer

Complete questions 12 & 13 if you are 18 years old and over

12. What is your individual annual income?

- 0-\$24,999
- \$25,000- \$50,000
- \$50,001- \$75,000
- \$75,001- \$100,000
- Above \$100,000
- Decline to answer

13. Are you a veteran?

- Yes, I am a veteran
- No, I am not a veteran
- Decline to answer



Appendix D: HAP-Y Self-Determination Survey

In your opinion, how true are these things? Please mark the box that matches with how true each statement is to you.

Mental Health Advocacy	Not at all true	A little bit true	Mostly true	Very true
I am comfortable talking about mental health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am interested in learning more about mental health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have a positive attitude about myself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have the courage to say difficult things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My involvement in this project is important.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that I am part of a community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can contribute to other people’s learning about mental health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Leadership	Not at all true	A little bit true	Mostly true	Very true
I know things that I do well.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My opinion is important.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am comfortable speaking up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am capable of learning from my mistakes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If I mess up, I try again.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can gain professional skills from this project.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am able to make a plan to achieve my goals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can finish something that I have started.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Teamwork	Not at all true	A little bit true	Mostly true	Very true
I work well on my own.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I work well with others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I aim to understand the other person’s point of view.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I listen to other people’s opinions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I support team members to participate and contribute.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can make decisions as part of a group.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can speak up for myself in a group.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am willing to learn from others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I follow through commitments to my teammates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Appendix E: Health Ambassador Program Youth Audience survey

Thank you for listening to our presentation today! Please use the scale below to rate your level of knowledge before and after the presentation:

1 = No	2 = Sometimes	3 = Most of the time	4 = All of the Time	NA = Not Applicable						
		For the check boxes in the left column, please rate your knowledge/feelings Before Presentation:	For the check boxes in the left column, please rate your knowledge/feelings After Presentation:							
I know where to go to get support if I am emotionally struggling.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> NA	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> NA
I know who to call or access online if I need mental health services.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> NA	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> NA
I know of services that are available evenings and weekends.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> NA	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> NA
I can get services that I need.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> NA	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> NA
I'm uncomfortable discussing topics related to mental health challenges.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> NA	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> NA
I think people with mental health challenges are unstable.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> NA	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> NA
I feel comfortable seeking mental health services.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> NA	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> NA

Which of the following statements about what your family/loved ones has experienced is true? *Select one*

- Myself or someone in my family has experienced mental health challenges and we have used mental health services.
- Myself or someone in my family has experienced mental health challenges, but we/I have never received services.
- Myself or someone in my family has never experienced mental health challenges.
- I do not know if my family has ever received mental health services.

If you've ever attempted to get mental health services: – *Select multiple*

- I did not qualify for any services
- It took too long to be seen after I had a crisis
- The hours of services do not match with my schedule
- The appointments are always full
- There were not enough services available
- I had no problems getting into services
- Other _____ (please write in)



Was this presentation helpful for you?

Yes No

If yes, please share why: _____

What is something we could do better?

What do you need more information about?

Please use the following scale to rate your level of satisfaction.

1 = Poor

2 = Fair

3 = Good

4 = Very Good

5 = Excellent

How would you rate the effectiveness 1 2 3 4 5
of this presentation?

How would you rate the effectiveness 1 2 3 4 5
of the presenters?

Overall, my experience with the 1 2 3 4 5
presentation was:

Are you experiencing a mental health problem? Would like a follow up call, text, or email about getting mental health support? If so, please provide the appropriate information below, and someone from our team will follow up with you.

Name: _____

Phone Number: _____

Email Address: _____

Please contact me by:

Text Message Email Phone Call



Appendix F: Focus Group Protocol

County of San Mateo BHRS Innovation HAP-Y / Focus Group Protocol

Date	
FG Type/Size	
Location	
Facilitator	

Introduction

Thanks for making the time to join us today. My name is _____ and this is _____. We are with a consulting firm called Resource Development Associates and we are here to help the County of San Mateo Behavioral Health and Recovery Services Department with the Health Ambassador Program – Youth. I will be facilitating our talk today and _____ will take notes, but we won’t use your name unless we specifically ask if we can use your comment as a quote.

The purpose of these projects is to learn more about your experience in the program. This is **your** process and **your** opportunity to make your voice heard about your experience.

This is your conversation, but part of my job as facilitator is to help it go smoothly and make sure that everyone has a chance to say what’s on their mind in a respectful way. We have a few guidelines to help us do that. Please:

- Put your phone on silent and don’t text
- Engage in the conversation – this is your meeting!
- Limit “side conversations” or “cross talk” so that everyone can hear what is being said
- And remember, there are no “wrong” or “right” opinions: please share your opinions honestly and listen with curiosity to understand the perspective of others

Does anyone have any questions before we begin? **Raise your hand if you’ve ever been part of a focus group.**

Introductions

1. How did you learn about HAP-Y?
2. By joining HAP-Y, what impact are you hoping to have on the community? What impact are you hoping that HAP-Y has on you?

Skills and training

3. What skills/knowledge do you **currently** have that you think will help you with the HAP-Y program? (prompt: public speaking, leadership, knowledge of mental health)
4. What skills/knowledge **are you hoping to gain** that will help you with the HAP-Y program? (prompt: public speaking, leadership, knowledge of mental health)



Stigma

5. When you think of mental health, what words come to mind?
6. Do you feel comfortable talking about mental health with friends and family?

Knowledge

7. If you or a friend was experiencing a mental health challenge, what would you do? Who would you talk to? Where would you go?
8. Is evaluation important? Why or why not?



Appendix G: HAP-Y Graduate Survey

1) Please select your Cohort from the options below.

2) Please select your response to each statement below (respondents select from “strongly disagree,” “disagree,” “neutral,” “agree,” or “strongly agree.”

- Participating in HAP-Y increased my awareness and understanding of mental health issues.
- I am interested in learning more about mental health issues because of my experience with HAP-Y.
- My participation in HAP-Y continues to positively impact my life.
- My participation in HAP-Y continues to positively impact those around me.
- I continue to use the knowledge and skills that I learned in HAP-Y.
- I am considering a career in a mental health-related field because of my participation in HAP-Y.

3) In what ways has your participation in HAP-Y continued to positively impact your life? Please provide 1-2 specific examples.

4) In what ways has your participation in HAP-Y continued to positively impact those around you (e.g. parents, friends, siblings, classmates, or others)?

5) In what ways do you continue to use what you learned in HAP-Y?

6) Which of the following mental health-related careers are you considering? Please select all that you are considering as a result of your HAP-Y experience.

Case Manager

Clinician

Psychologist/Psychiatrist

Social Worker

Therapist

Other (please list):: _____

7) Since participating in HAP-Y, how have you continued to be involved with mental health issues in your community? Please select each group or activity you have participated in.

Mental Health Board/Other Mental Health Advisory Board

Mental Health-Related Student Group/Club

Mental Health-Related Community Organization

Chat Room Volunteer (e.g. On Your Mind)

Speaker Panel or Workshop (e.g. delivered an additional mental health-related presentation)

Other (please list):: _____

8) What suggestions do you have for improving the topics and trainings you participated in during HAP-Y?

9) Do you have any suggestions for additional topics or trainings that HAP-Y could offer to participants?

10) Is there anything else you would like to share about your experience with HAP-Y?

San Mateo County Adult NMT Pilot Final Evaluation Report, 2016-2020

A Mental Health Services Act Innovation Project



Prepared by:

Resource Development Associates

December 2020





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Introduction

Project Overview and Learning Goals

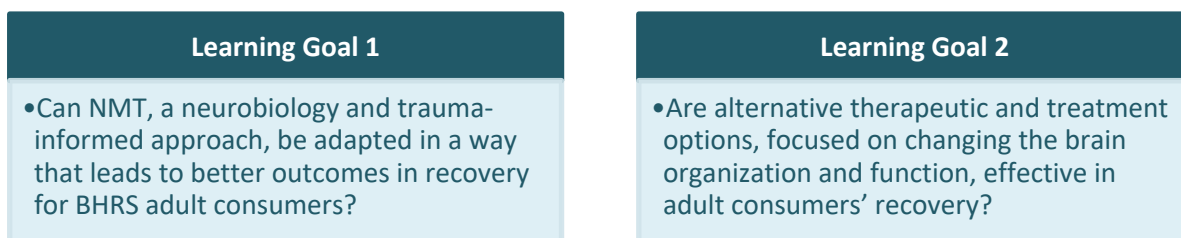
San Mateo Behavioral Health and Recovery Services (BHRS) implemented the Neurosequential Model of Therapeutics© (NMT) within the Adult System of Care as part of the three-year Mental Health Services Act (MHSA) Innovation (INN) plan. The MHSA INN project category and primary purpose of the NMT pilot project are as follows:

- **MHSA INN Project Category:** Makes a change to an existing mental health practice that has not yet been demonstrated to be effective.
- **MHSA Primary Purpose:** Increase quality of mental health services, including measurable outcomes.
- **Project Innovation:** While NMT has been integrated into a variety of settings serving infants through young adults, there is no literature or research of NMT in a strictly adult setting or population. BHRS intends to adapt, pilot, and evaluate the application of the NMT approach to an adult population with a history of trauma. This expansion to and evaluation of NMT in an adult system of care is the first of its kind.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the project on July 28, 2016 and BHRS began implementation in September 2016. In 2017, BHRS contracted Resource Development Associates (RDA) to evaluate the adult NMT pilot project.

BHRS developed two learning goals to guide the NMT pilot and assess the extent to which the program is meeting its intended MHSA objectives—to increase the quality of services and consumer outcomes. The learning goals are outlined in Figure 1 below. The first learning goal pertains to the adaptation and implementation of the NMT approach in the adult consumer population, while the second learning goal pertains to the effectiveness and impact of the NMT approach in improving recovery outcomes.

Figure 1. NMT Pilot Project Learning Goals



This final report follows three previous annual evaluation reports (2016-17, 2017-18, and 2018-19) that presented year-to-year accounts of the NMT adult pilot program development outcomes. This cumulative evaluation report presents cross-cutting findings and “lessons learned” during the evaluation period.



Project Need

Through the MHSA Community Planning Process in San Mateo, BHRS and community stakeholders identified the need to provide alternative treatment options to broaden and deepen the focus on trauma informed care and provide better outcomes in recovery for adult BHRS consumers. To address this need, BHRS proposed implementing the NMT approach within the BHRS Adult System of Care. NMT is an innovative approach to treating trauma that is grounded in neurodevelopment and neurobiology. Subsequent sections provide a more in-depth description of NMT and its application to adults.

NMT Background

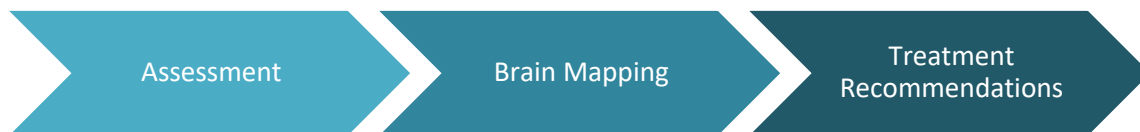
The Child Trauma Academy (CTA) developed NMT as an alternative approach to addressing trauma, typically used with children, that is grounded in neurodevelopment and neurobiology. NMT is not a single therapeutic technique or intervention. Rather, NMT uses assessments to guide the selection and sequence of a set of highly individualized therapeutic interventions (e.g., therapeutic massage, drumming, yoga, expressive arts, etc.) that best match each NMT consumer’s unique strengths and neurodevelopmental needs.¹

NMT is guided by the principle that trauma during brain development can lead to dysfunctional organization of neural networks and impaired neurodevelopment. The selected set of therapeutic interventions intends to help change and reorganize the neural systems to replicate the normal sequence of brain and functional development. Selected interventions first target the lowest, most abnormally functioning parts of the brain. Then, as consumers experience functional improvements, interventions are selected that target the next, higher brain region. The sequence of interventions aims to help consumers better cope, self-regulate, and progress in their recovery.

NMT Processes and Activities

As depicted in Figure 2, the NMT process consists of three main phases: 1) assessment, 2) brain mapping, and 3) the development of individualized treatment recommendations. These phases are briefly described below.

Figure 2. Key phases of the NMT Process



¹Perry, B.D. & Hambrick, E. (2008) The Neurosequential Model of Therapeutics. *Reclaiming Children and Youth*, 17(3), 38-43.



Assessment. NMT-trained providers collect information pertaining to the consumer’s history of adverse experiences—including their timing, nature, and severity—as well as any protective factors. This information is used to estimate the risk and timing of potential developmental impairment. The assessment also includes an examination of current functioning and relationship quality (e.g., with parents, family, peers, community, etc.).

Brain Mapping. NMT-trained providers enter assessment data into a web-based tool designed by the CTA, which uses assessment data to generate a brain map illustrating the brain regions most affected by developmental impairment. Through this “mapping” process, scores are calculated in four functional domains: 1) Sensory integration, 2) Self-regulation, 3) Relational, and 4) Cognitive. The functional domain values are compared with age typical domain values to assess the degree of developmental impairment and identify the consumer’s functional strengths and challenges.

Treatment Recommendations. Therapeutic interventions are identified that address the consumer’s needs in the four functional domains, first targeting the lowest brain regions with most severe impairment. Throughout treatment, assessments and brain mapping are performed at regular intervals to evaluate any changes in functional domains, and treatment recommendations are adapted as appropriate.

NMT Training

CTA offers two levels of training: Phase I NMT Certification training, and Phase II “Train-the-Trainer” training for providers already certified in NMT. The NMT training model, for both Phase I and Phase II trainings, relies on a case conference or group supervision approach with intensive self-study. To conduct their self-study, providers receive a detailed training syllabus with a variety of web-based training materials and resources—including videos, lectures, recordings, readings, and case studies—allowing providers to work through the content at their own pace.

Providers must also participate in a monthly meeting, or case conference, wherein providers discuss real-life cases. These group discussions are the foundation for supervision of NMT implementation, provide opportunities for clinicians to refine their knowledge and skills, and allow for fidelity monitoring. Throughout the course of the training, trainees are also expected to conduct NMT assessments and interventions.

Certified NMT providers must then complete fidelity assessments annually, wherein providers evaluate the same client data and inter-rater reliability scores are calculated. NMT training is designed to be completed over the course of approximately one year, although the self-directed nature of the training allows the training to be extended as needed.



The Phase I and Phase II training structure is briefly described below:

- **Phase I training:** The Phase I training providers attend an initial in-person training that teaches the core principles of NMT. After this initial training, providers begin conducting their self-study and implementing NMT, often with the support of an NMT mentor. Throughout the training, trainees also participate in NMT study groups and learning communities. To graduate the training, providers must complete at least 10 NMT assessments.
- **Phase II training:** The Phase II training to prepare NMT clinicians to become NMT trainers or mentors. The structure and format of the Phase II training is similar to Phase I, and includes a combination of self-study, monthly meetings, and conducting NMT assessments. However, the Phase II training examines NMT principles in greater depth. Like the Phase I training, Phase II clinicians must conduct at least 10 NMT assessments. By the end of the Phase II training, providers are expected to be able to lead the core principles training and mentor providers in the Phase I training.

Application of NMT to Adults

Since its development, NMT has been most widely used with children who experienced maltreatment and/or trauma, and BHRS has been using the NMT approach with children since 2012. However, the use of NMT with adults is limited. Given the high prevalence of trauma among adult behavioral health consumers and the relationship between childhood trauma and behavioral health issues in adulthood, there is a strong theoretical basis to predict that adult mental health consumers could benefit from the NMT approach.^{2,3}

Nevertheless, NMT's effectiveness in the adult population is unknown. As mentioned, NMT has not been formally implemented into an adult system of care, and no outcome studies have been conducted to evaluate NMT in an adult population. BHRS is adapting, piloting, and evaluating the application of the NMT approach to an adult population with hopes of increasing the quality of mental health services and improving recovery outcomes for adult mental health consumers with a history of trauma.

²It is estimated that 40-80% of adults with mental illness and/or substance use issues also have experiences of trauma.

Source: Missouri Institute of Mental Health. (2004). Trauma among people with mental illness, substance use disorders and/or developmental disabilities. *MIMH Fact Sheet, January 2004*. Retrieved from:
<https://dmh.mo.gov/docs/mentalillness/traumafactsheet2004.pdf>

³Anda, R.F., Felitti, V.J., Bremner, J.D., Walker, J.D., Whitfield, C., Perry, B.D., ... Giles, W.H. (2006). The enduring effects of abuse and related adverse experiences in childhood: a convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience*, 256(3), 174-186.



Project Description and Timeline

BHRS NMT Pilot Project

NMT Providers

As mentioned, BHRS has been using the NMT approach with youth since 2012. Prior to beginning the NMT adult pilot, 30 clinical staff in the BHRS Child and Youth System of Care and 10 clinical staff from community-based partner agencies received training through CTA. In addition, 10 BHRS providers became certified NMT trainers, and certify other providers in NMT through the CTA training. These trainers serve as mentors to NMT trainees and teach NMT principles and provide consultation to other providers. To expand NMT to the adult population, BHRS began training providers within the Adult System of Care in January 2017. The providers work in a variety of settings, including BHRS specialty mental health or regional clinics and programs serving consumers re-entering the community following incarceration.

Target Population

BHRS estimates that the adult NMT pilot project will serve approximately 75 to 100 adult consumers annually once the BHRS providers in the Adult System of Care are fully trained. Providers refer existing BHRS consumers from their caseloads to NMT, targeting three adult mental health populations:

- General adult consumers (ages 26+) receiving specialty mental health services;
- Transition age youth (TAY) consumers (ages 16-25); and
- Criminal justice-involved consumers re-entering the community following incarceration.

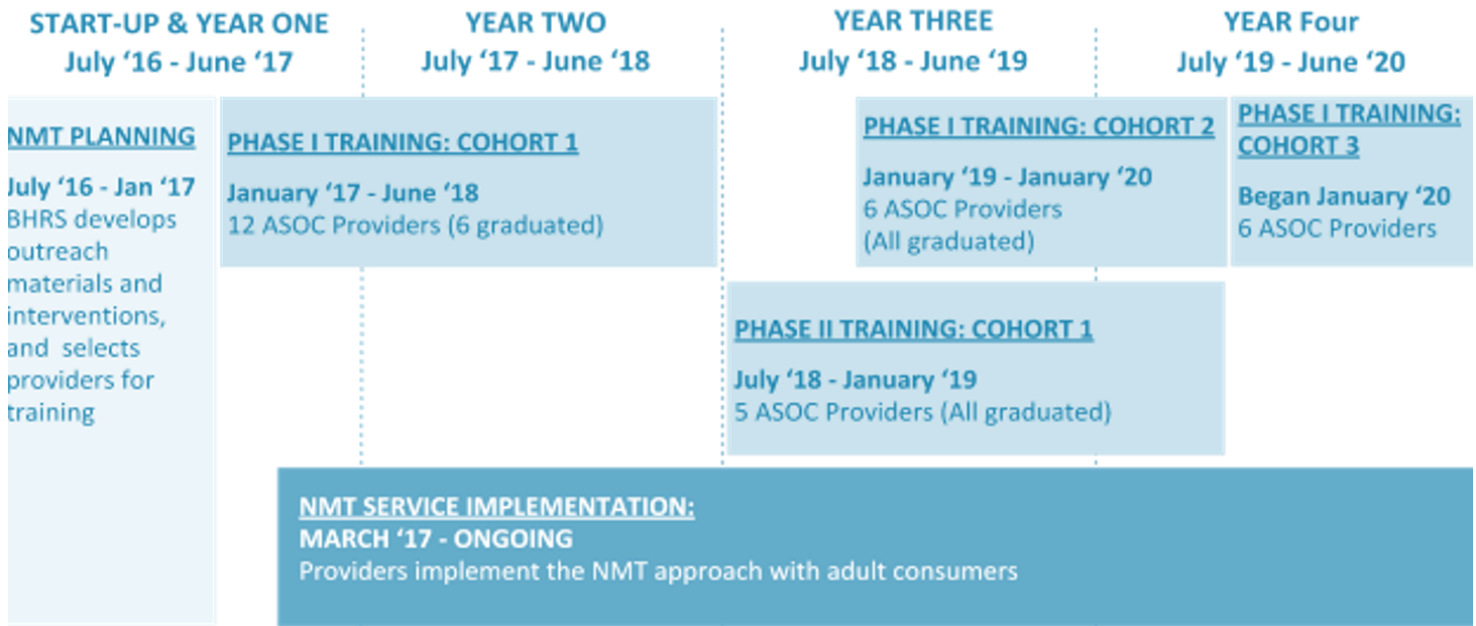
The three target populations likely have different experiences, needs, and coping skills and, as a result, could respond to NMT differently. For example, TAY are still undergoing brain development and therefore may be more responsive to neurodevelopmental treatment approaches such as NMT. In addition, the re-entry population might have different coping mechanisms than the general adult and TAY consumer populations, such as engaging in high-risk behaviors that might lead to incarceration. For the re-entry population, the experience of incarceration could also further contribute to trauma.



Implementation Timeline

Figure 3 illustrates the key activities that took place during the NMT adult pilot project.

Figure 3. NMT Implementation Timeline



Impact of COVID-19 on NMT Adult Pilot Project

NMT pivoted to a virtual service model in the spring of 2020 in response to COVID-19. NMT provider training as well as NMT assessments and interventions with consumers were conducted remotely, with services predominantly provided over the phone or through video conferencing. Only consumers with severe needs or who were receiving treatment in residential placements continued to receive services in-person. Additionally, the Phase I training that began in January 2020 was extended from 12 to 18 months, ending in June 2021 rather than December 2020, to give trainees more time to complete training requirements during the pandemic.

Some consumers did not have the appropriate equipment or technology for video conferencing, while others had limited or unreliable access to phones. Some consumers also found it more challenging or were less willing to engage in remote services. Given the difficulty in engaging some consumers, BHRS opened fewer new consumers to NMT services during shelter-in-place. When possible, providers continued to provide NMT interventions and follow-up assessments with existing consumers.



Evaluation Overview

As mentioned, BHRS contracted RDA to evaluate the pilot and support project learning. In order to maximize RDA's role as research partners, RDA collaborated with BHRS and CTA when planning the evaluation—including identifying evaluation goals, validating the theory of change for NMT specific to the adult population, identifying the types of variables that may support or complicate outcomes in adults, and developing data collection tools to measure program implementation and consumer outcomes.

To guide the NMT evaluation, RDA developed evaluation sub-questions associated with each learning goal. The evaluation questions (EQ) are listed below. To the extent possible, the evaluation examined implementation and outcome differences across the three target populations to identify how BHRS could adapt the NMT approach to best meet each population's unique needs.

Learning Goal 1: Can NMT, a neurobiology and trauma-informed approach, be adapted in a way that leads to better outcomes in recovery for BHRS adult consumers?

EQ 1.1. How is the NMT approach being adapted to serve an adult population?

EQ 1.2. Who is being served by the adult NMT project, what types of NMT-based services are consumers receiving, and with what duration and frequency?

Learning Goal 2: Are alternative therapeutic and treatment options, focused on changing the brain organization and function, effective in adult consumers' recovery?

EQ 2.1. To what extent is the NMT approach supporting improvement in adult consumers' functional outcomes and overall recovery and wellbeing?

EQ 2.2. To what extent is the experience of care with the NMT approach different from consumers' previous care experiences?

The evaluation examines both Learning Goals to: 1) identify how NMT implementation progressed as the program matured and 2) examine changes in consumers' functional and recovery outcomes as consumers participated in NMT.



Evaluation Methods

Data Collection

RDA employed a mixed-methods evaluation approach (i.e., using both qualitative and quantitative data) to identify who participated in NMT, how BHRS is adapted the NMT approach for the adult population, and preliminary consumer outcomes. This report includes information about NMT implementation as well as consumer outcomes for adults who were open to NMT services during the evaluation period—September 2016 through June 2020. RDA worked closely with BHRS to identify and obtain appropriate outcome measures and data sources to address the evaluation questions. Table 1 outlines the outcome data available for this report as well as the respective data sources.

Table 1. Measurable Outcomes and Data Sources

Outcome Type	Outcome Measures	Data Sources
Process Outcomes	Number of consumers participating in NMT services	Electronic Health Records
	Characteristics of NMT consumers	Electronic Health Records
	Provider experience of NMT training and NMT implementation with the adult population	Provider Focus Groups
	Types of recommended NMT interventions	Consumer and Provider Focus Groups and NMT Database
Consumer Outcomes	Changes in brain map and functional domain scores	NMT Database
	Perceived impact of NMT services on consumer functional and recovery outcomes	Consumer and Provider Focus Groups
	Consumer experience of NMT services	Consumer Focus Group

Quantitative data: RDA collected quantitative data about NMT consumers from two main sources: 1) BHRS’s Electronic Health Record (EHR) system, Avatar, and 2) the NMT Database operated by CTA, which includes brain map and functional domain scores and recommended NMT interventions.

Qualitative data: RDA also collected qualitative data through discussions with BHRS NMT providers, non-NMT trained BHRS providers, and NMT consumers. Throughout the evaluation period, RDA conducted a total of 10 focus groups, including the following:⁴

- 5 focus group discussions with BHRS providers participating in NMT training (37 total participants)
- 1 focus group discussion with non-NMT-trained BHRS providers (5 total participants)
- 4 focus group discussions with NMT consumers (13 total participants)

Focus groups with BHRS providers centered on providers’ experience of NMT training, how they adapted the NMT approach with the adult population, and implementation successes and challenges. Discussions with consumers focused on their experience with NMT services, how NMT services differed from other mental health services received, and the perceived impacts of NMT on their wellness and recovery.

⁴ The number of focus group participants are not unique participants as some individuals participated in more than one focus group throughout the evaluation period.



RDA employed a trauma-informed, culturally sensitive approach when engaging with and gathering information from NMT consumers, as RDA recognizes that most NMT consumers have experienced multiple forms of trauma. Our interviewers and facilitators were trained to bring an awareness of their own positionality and biases, as well as to ask questions in a sensitive and trauma-informed manner that gives participants voice and choice to share their stories and experiences.

Data Analysis

To analyze the quantitative data (e.g., consumer characteristics and service utilization), RDA used descriptive statistics to examine frequencies and ranges. When the sample size was large enough, RDA also explored differences in outcomes across different sub-populations (e.g., adults, TAY, criminal justice involved adults, etc.). To analyze qualitative data, RDA transcribed focus group participants' responses to appropriately capture the responses and reactions of participants. RDA then thematically analyzed responses from participants to identify commonalities and differences in participant experiences.

Data Limitations

NMT service duration and frequency. As part of NMT pilot implementation, BHRS created an NMT episode code to identify consumers who received NMT assessments and participated in NMT-based services. However, an NMT service code could not be created as NMT is an approach to therapy rather than a specific service. Without an NMT service code, it was difficult to determine the duration and frequency of NMT services. This limited analyses and the ability to quantitatively determine whether individuals who participated in NMT-based services more frequently or for a longer duration had improved outcomes compared to those who engaged in NMT less frequently or for a shorter time period.

NMT follow-up assessments. Follow-up assessment data were available for half of consumers. To calculate the change in assessment metrics, RDA used the most current metric compared to the consumers' baseline metric. However, the time between consumers' baseline and most current metric varied widely, from 4 months to approximately 4 years. Given the relatively small number of consumers with follow-up assessments and the varying length of time between assessments, NMT assessment findings should be considered exploratory.



Program Reach

Over the course of the NMT adult pilot project, the volume of adult consumers participating in NMT services grew each year. During year 1, 20 adult consumers participated in NMT services, compared to 40 consumers in Year 2, 77 consumers in Year 3, and 90 consumers in Year 4. Additionally, as the pilot progressed, providers completed more follow-up assessments to assess changes in functional outcomes. During the first year, no follow-up assessments had been completed, while 11 follow-up assessments were completed in year 2, 28 were completed in year 3, and 46 were completed as of the end of year 4. As mentioned, the volume of new consumers served in Year 4 was slightly lower than in previous years due to COVID-19.

Through the NMT adult pilot project, a total of 29 providers within the Adult System of Care participated in NMT training. BHRS conducted three cohorts of Phase I NMT certification training. Twelve providers in the Adult System of Care participated in the first cohort, with six completing the training. In the second cohort, 6 ASOC providers enrolled in and completed the training, and six additional ASOC providers began the third training cohort. The third cohort was still participating in the Phase I training as of the end of the pilot period; trainees are expected to complete the training in June 2021. In addition to the three cohorts of Phase I training, BHRS also conducted a Phase II Train-the-Trainer training. Five providers in the Adult System of Care enrolled in and completed the Phase II training, and became NMT trainers and mentors to Phase I trainees.



NMT Consumer Profile

The following section describes the consumer population that participated in NMT services throughout the pilot project period, including demographic information, behavioral health diagnoses, behavioral health service utilization, and baseline NMT assessment information.

Demographic Information

As mentioned previously, BHRS aimed to serve three adult populations through the NMT pilot project: adult consumers (ages 26+) receiving specialty mental health services, TAY (ages 16-25) receiving mental health services, and criminal justice-involved consumers re-entering the community following incarceration.

Throughout the adult NMT pilot project, 90 adult consumers received NMT services, all of whom reflect the intended target population. Overall, the average age of consumers was 34, with ages ranging from 17 to 70. Most consumers (n=61, 68%) were adults ages 26 and older, while 29 consumers (32%) were TAY. In addition, at least 33 consumers (37%) were also part of the re-entry population, almost all of whom were adults ages 26 and older (85%, n=28).⁵

Figure 4. NMT Consumer Population, N=90



Table 2 describes the demographic characteristics of the NMT consumers.⁶ Two-thirds of consumers reported they were female (n=58, 64%) and one-third reported they were male (n=32, 36%); no consumers reported a different sex.⁷ Although the largest racial group was White (n=26, 29%), approximately a quarter of consumers each reported they were two or more races (n=21, 23%) or reported their race as Other (n=24, 27%). A smaller proportion of consumers reported their race as Black or African American (n=6, 7%) or Asian/Pacific Islander (n=5, 6%). Nearly half of consumers also reported their ethnicity as Hispanic/Latino (n=39, 43%). Race was unknown or unreported for 8 consumers, and ethnicity was not reported for 10 consumers.

⁵Consumers were identified as part of the criminal justice/re-entry population if they received behavioral health services in custody, services through the BHRS mental health court, or services through a provider aimed at serving the re-entry population (e.g., Service Connect).

⁶In accordance with HIPAA, demographic categories comprised of fewer than five consumers were aggregated to protect consumer privacy.

⁷Information regarding gender identity was not available for this report.



The majority of consumers (n=73, 81%) reporting speaking English only, while 16% of consumers reported speaking Spanish (n=14), and 3% reported another language (n=3). Most consumers reported they were heterosexual (n=61, 68%), while 13% (n=12) reported they were another sexual orientation. One consumer declined to state their sexual orientation, while sexual orientation was unknown or unreported for 16 consumers. Two-thirds of consumers (n=60, 67%) had a known disability. No consumers reported that they were a veteran.

Table 2. Demographic Characteristics of Consumers (N=90)

Characteristic	Consumers	% of Total
Age		
Ages 16 to 25	29	68%
Ages 26+	61	32%
Gender		
Female	58	64%
Male	32	36%
Race		
White	26	29%
Black or African American	6	7%
Asian/Pacific Islander	5	6%
Other Race	24	27%
Two or More Races	21	23%
Unknown/ Not Reported	8	9%
Ethnicity		
Hispanic/Latino	39	43%
Not Hispanic/Latino	41	46%
Unknown/ Not Reported	10	11%
Primary Language		
English	73	81%
Spanish	14	16%
Other	3	3%
Sexual Orientation		
Heterosexual	61	68%
LGBTQ+ ⁸	12	13%
Declined to State	1	1%
Unknown/ Not Reported	16	18%
Disability		
Any Disability	60	67%
No Known Disability	30	33%

⁸LGBTQ+ refers to lesbian, gay, bisexual, transgender, questioning or gender queer, intersex, asexual, or other sexual orientations.



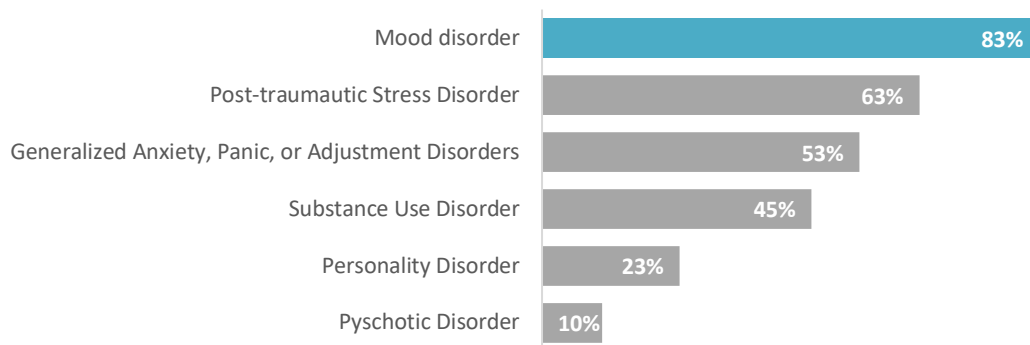
Behavioral Health Diagnoses

Consumers who participated in NMT had a variety of mental health diagnoses. Typically, the majority of adult consumers receiving specialty mental health services within adult systems of care have been diagnosed with a psychotic disorder (e.g., schizophrenia or schizoaffective disorder) or a mood disorder (e.g., bipolar or major depressive disorders). However, as shown in Figure 5, the NMT population served had a wider variety of behavioral health diagnoses. Consumers may have more than one behavioral health diagnosis; as a result, percentages add to greater than 100%.

The most common diagnosis was a mood disorder; 83% (n=75) of consumers were diagnosed with a depressive or bipolar disorder. Of those, most were diagnosed with a major depressive disorder while a smaller subset was diagnosed with bipolar disorder or an unspecified mood disorder. Nearly two-thirds of consumers (63%, n=57) were diagnosed with a posttraumatic stress disorder (PTSD), and half (53%, n=48) were diagnosed with a generalized anxiety, panic, or adjustment disorder. Only 10% of consumers (n=9) were diagnosed with a psychotic disorder. In addition to these mental health diagnoses, 23% (n=21) also had a diagnosed personality disorder.

Substance use is also prevalent among the population served, wherein nearly half of consumers (n=41, 45%) had a documented co-occurring substance use disorder. Of these consumers, most reported using several substances, while some were diagnosed with specific cannabis, alcohol, opioid, stimulant, or other substance use disorders. Most consumers with documented substance use disorders were also part of the criminal justice re-entry population.

Figure 5. Behavioral Health Diagnoses of NMT Consumers, N=90



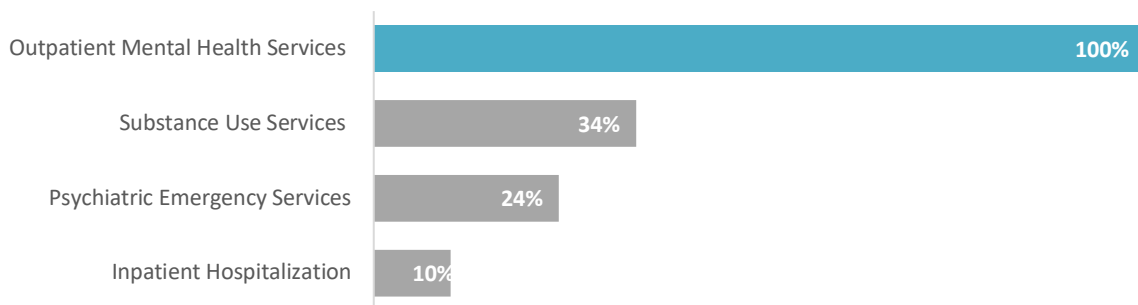
The breadth of diagnoses aligns with some of the diagnostic challenges that arise when working with individuals who have experienced significant trauma. Adults who have experienced trauma often have a more complex clinical presentation, frequently characterized by symptoms of anxiety, depression, and other mood fluctuations as well as substance misuse. Symptoms reflective of trauma may not clearly align to any one diagnosis within the existing diagnostic classification systems (e.g., DSM-IV TR or DSM-V). The relatively high prevalence of documented personality disorders may also be indicative of pervasive childhood trauma.



Behavioral Health Service Utilization

All consumers who received NMT services were enrolled in and receiving outpatient mental health services, which aligns with the model of integrating NMT within existing mental health services rather than creating a stand-alone program. In addition to outpatient mental health services, one-third of consumers (n=31, 34%) also participated in outpatient and/or residential substance use services. Of these consumers, seven also participated in detoxification services in the year prior to enrollment. Additionally, one-quarter of consumers (n=22, 24%) experienced a mental health crisis that required psychiatric emergency services, and 10% of consumers experienced inpatient hospitalizations in the year prior to enrollment.

Figure 6. Behavioral Health Service Utilization, N=90



Baseline NMT Assessments

Baseline Brain Map and Functional Domain Scores

As mentioned previously, NMT-trained providers enter assessment data into a web-based tool designed by CTA that uses the assessment data to generate a brain map illustrating the brain regions most likely to be affected by developmental impairment. Through this mapping process, scores are calculated in four functional domains: 1) Sensory integration, 2) Self-regulation, 3) Relational, and 4) Cognitive. The brain map and functional domain values can then be compared with age typical values to assess the degree of developmental impairment and identify the consumer's functional strengths and challenges.

These functional domains are defined as follows:

- **Sensory Integration** refers to a set of functions that integrate, process, store, and act on sensory input from outside (e.g., visual, auditory) and inside (e.g., metabolic) the body.
- **Self-Regulation** refers to a broad set of functions that modulate and regulate the activity of other key systems in other parts of the body and brain, such somatosensory and emotional regulation.
- **Relational** refers to the complex set of relationship-related functions such as bonding, attachment, attunement, reward, empathy, and related emotional functions.
- **Cognitive** refers to the myriad functions involved in complex sensory processing, speech, language, abstract cognition, reading, future planning, perspective-taking, moral reasoning, and similar cognitive capabilities.



As of the end of the reporting period, baseline assessment data were completed and available for 82 consumers. Of these 82 consumers, 67% were adults (n=55) and 33% were TAY (n=27). Additionally, 39% (n=32) were part of the reentry population.

For each consumer, functional domain values were compared with age typical values to calculate the percent of age typical functional domain score. A score of 100% indicates normal functioning with respect to a person’s age. A score lower than 100% indicates some degree of impairment, wherein lower scores correspond to greater impairment. For example, a functional domain score of 70% indicates greater impairment than a score of 80%. The average baseline scores for the total brain map and each of the functional domains are illustrated in Figure 7.

Consumers’ average baseline brain map score was 77%. However, the values ranged widely from 29% (indicating a high degree of impairment) to 100% (indicating normal functioning). Consumers appeared to have relatively high functioning in the sensory integration and cognitive domains at baseline, while baseline functioning in the self-regulation and relational domains tended to be slightly lower. For both the sensory integration score and cognitive domains, the average score was approximately 81% (sensory integration range: 38% to 100%, cognitive range: 15% to 100%). In comparison, for both self-regulation and relational domains, the average score was approximately 71% (self-regulation range: 34% to 100%, relational range: 27% to 100%).

Figure 7. Average Baseline Brain Map and Functional Domain Scores, N=82



Level of NMT Recommended Interventions

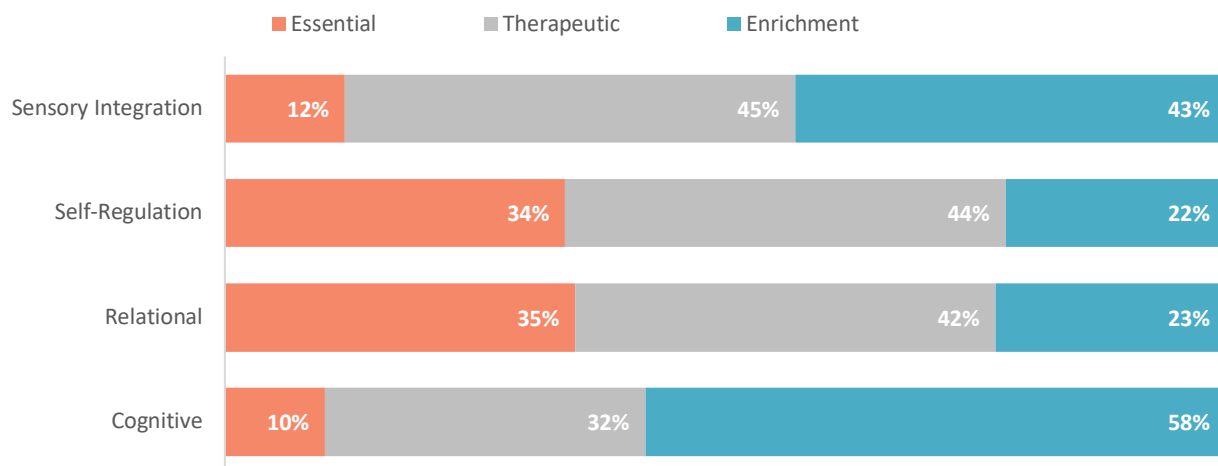
As discussed, brain map and functional domain scores are used to highlight the consumers’ functional strengths and needs. This information can then be used to develop broad recommendations for the types and intensity of NMT interventions that consumers should receive to promote growth and recovery. To guide treatment planning, CTA developed cut-off scores to indicate whether interventions targeting each of the functional domain areas are recommended as essential, therapeutic, or enrichment. These recommendation categories, or levels, are described in greater detail below:



- **Essential:** Functional domain score is <65% of age typical. At the essential level, activities are considered crucial for future growth in the given domain. If functioning in the essential area is not increased, the individual will lack the foundation for future growth and development in this and other areas.
- **Therapeutic:** Functional domain score is 65-85% of age typical. At the therapeutic level, activities are aimed at building strength and growth in the particular area. Therapeutic activities are viewed as important for continued growth and development.
- **Enrichment:** Functional domain score is >85% of age typical. At the enrichment level, activities provide positive, valuable experiences that continue to build capacity in the given area.

The recommended level of interventions reflects the relatively high functioning of consumers in the cognitive and sensory integration domains, compared to the self-regulation and relational domains (Figure 8). In both the sensory integration and cognitive domains, interventions for approximately half of consumers were recommended as enrichment, whereas interventions were recommended as essential for only 10% of consumers. In comparison, for the self-regulation and relational domains, only 20% of consumers had interventions recommended as enrichment while over 30% had interventions recommended as essential.

Figure 8. NMT Recommendation Categories across Functional Domains, N=82



Differences Across Target Populations

Overall, there were no significant differences between adults and TAY in the baseline functional domain scores and the recommended level of NMT interventions. Although, adults appeared to have a slightly wider range in functional domain scores. Additionally, baseline values were similar among adults in the re-entry population and adults who were not criminal justice involved. Baseline functional domain scores and baseline recommended level of interventions information for each of the target populations are available in Appendix I.



Final Progress Toward Learning Goals

Summary of Key Findings

This section discusses the progress that the BHRS NMT Pilot has made toward achieving its two learning goals. Key findings are summarized below, followed by a detailed discussion of each learning goal.

Learning Goal 1: NMT Implementation and Adaptation

NMT Capacity in Adult System of Care. BHRS expanded NMT capacity by training clinicians and supervisors throughout the Adult System of Care. BHRS selected NMT trainees to fill gaps in adult outpatient clinics and programs; however, some providers experienced challenges in getting buy-in for NMT among providers in their clinic or program who were not NMT-certified.

NMT Training Support. BHRS implemented a number of strategies to better prepare and support providers through the intensive NMT training. These improvements helped providers stay motivated and complete the training. However, the training is still time intensive and providers continued to face challenges balancing NMT training with caseload and productivity demands.

Adaptations to Adults. Although NMT assessments took longer and were more complex with adults than children, NMT providers developed effective strategies to adapt the NMT approach to adults. As providers became more confident in the NMT approach and assessment process, providers implemented NMT with a broader adult population.

Provider Skill Development. The NMT training increased providers' knowledge and ability to respond to consumers with a history of trauma. Learning the NMT approach helped providers bring creativity to their work and sharpened providers' clinical skills, which may be encouraging providers to stay at BHRS.

Learning Goal 2: NMT Outcomes

Improved Consumer Functional Domain Scores. Consumers appeared to benefit from NMT services, as indicated by increased functional domain scores. However, the magnitude of change varied widely across consumers, and preliminary data demonstrated greater and more consistent improvement among transition age youth compared to adults.

Improved Consumer Recovery and Experience of Care. NMT appeared to enhance the consumer experience of care and helped consumers progress in their recovery. Prior to NMT, most consumers had only engaged in more traditional approaches to treatment. Consumers appreciated the individualized approach of NMT, the alternative interventions, and working with providers in a new way. For some consumers, the NMT approach made it easier to engage in therapy.

Trauma-Informed Approach to Care. NMT training and implementation supported NMT clinicians—and, in turn, other providers who work with NMT clinicians—to implement a more trauma-informed approach to care with their caseloads and in their clinics overall.



Learning Goal 1: NMT Implementation and Adaptation

The following section describes key successes and challenges in implementing and adapting NMT to the adult population. The section includes discussion of the selection of providers in the adult system of care, NMT training, the NMT assessment process, and NMT interventions.

NMT Provider Selection

As the NMT pilot progressed, BHRS selected providers to fill NMT gaps throughout the Adult System of Care. Both the NMT Phase I and Phase II trainings were voluntary and available to BHRS master’s level clinicians, although staff had to apply to participate in the training. At the beginning of the pilot, BHRS providers were selected largely due to providers’ interest and availability to participate. However, as NMT became more widely implemented within BHRS and providers’ interest in NMT grew, BHRS received a greater volume of applications from providers in both the Adult and Children’s Systems of Care. When selecting providers to participate, BHRS aimed to fill gaps in the system of care and prioritized clinics or programs that did not have any or had only one NMT-certified clinician. This strategy helped ensure there are NMT-trained clinicians throughout the Adult System of Care—including in BHRS clinics as well as residential placements. To continue expanding NMT services and buy-in within the Adult System of Care, BHRS should continue prioritizing training providers at sites or programs where there are no or only one NMT trained clinician.

Providers participated in NMT training to strengthen their ability to serve consumers with a history of trauma. Throughout the evaluation period, 24 ASOC clinicians participated in the Phase I NMT training, and 5 providers participated in the Phase II “Train-the-Trainer” trainings. Providers received information about NMT and the NMT training opportunity from supervisors, team members, and training announcements circulated by BHRS.

There were three people going through training program [at my clinic], and they would come back and share what they were learning and the changes and progress they were making...I also heard NMT referenced through other trainings I was part of. When the opportunity came to do the training myself, I was on board.

– NMT Provider

Most providers shared that prior to the NMT training, they were working with individuals with a history of trauma and wanted to strengthen their abilities to respond to and treat the impact of trauma. Some learned about NMT through the six core principles training and wanted to participate in the training to learn more about the impact of trauma on neurodevelopment. Other providers were already familiar with the NMT approach—either from attending other trainings or conferences where NMT was discussed or working with other NMT-trained clinicians—and were eager to participate in the training themselves.

Providers participating in the Phase II training wanted to deepen their understanding of NMT principles learned in the Phase I training. In some cases, providers completed the Phase I training several years earlier and wanted to refresh and strengthen their training. Others had just completed the Phase I training



and wanted to continue to build upon the foundations and skills learned to strengthen their own abilities as well as educate others on NMT principles.

NMT Training

BHRS created and filled a Mental Health Program Specialist position to support NMT training. As NMT continued to expand within the BHRS systems of care, BHRS developed a Mental Health Program Specialist role in the third year of the pilot. This role was instrumental in supporting the organization and coordination of the NMT program. The Mental Health Program Specialist is a certified NMT clinician and trainer within BHRS and acted as an important resource and mentor for NMT trainees.

BHRS implemented a number of strategies to support providers to stay on track with the intensive NMT training obligations. NMT training requires significant time and dedication. Providers from the first cohort of trainees in the Adult System of Care shared that the training was more demanding and time consuming than expected. Translating NMT tools from the child to adult population also intensified the time spent during training. Additionally, providers noted that the training website was difficult to navigate, posing impediments to accessing the self-study materials.

[My mentor] provides a lot of positive feedback, modeling a lot of what we are learning. She's attentive and doesn't seem to miss a thing which helps me feel more engaged. It's like going through school again, but when you're engaged and you see progress and you see changes in your clients, then it feels worth it.

– NMT Provider

To address some of these challenges, BHRS implemented several strategies throughout the pilot to better support trainees, including:

- 1) **Setting clearer expectations about NMT training demands.** During the training outreach and selection process, BHRS was clear with potential trainees as well as supervisors about the NMT training requirements to help ensure providers and their supervisors better understood the demands prior to beginning the training.
- 2) **Compiling and organizing training materials for providers.** Each month the BHRS' Mental Health Program Specialist for the NMT program created a zip file with all of the self-study materials along with a checklist or instructions for training activities and expectations for that month. Providers shared that these emails helped keep providers organized, motivated, and engaged.
- 3) **Providing greater mentorship throughout the training.** The first cohort of trainees expressed a need for more one-on-one mentorship throughout the training process. For subsequent cohorts, BHRS ensured all trainees were assigned a mentor at the beginning of the training period. Additionally, BHRS implemented the Phase II training to grow the number of NMT-trained providers who could serve as mentors for subsequent cohorts. Mentors worked with trainees on a biweekly or monthly basis (depending on the trainee's needs) to help trainees better understand and integrate NMT principles. This often included reviewing and discussing self-study materials, reviewing cases, and co-leading or supporting trainees during assessments and intervention planning. Many providers shared that the mentorship was the most helpful aspect of the training.



- 4) **Granting trainees compensatory time for NMT training and self-study.** To help ease the burden of participating in NMT training on top of existing work and caseloads, BHRS granted all trainees four hours of compensatory time (i.e., comp time) each week. This time was intended to help trainees set aside time for self-study and other training requirements.
- 5) **Reducing the number of NMT assessments required to complete the NMT training.** With the complexity of adult cases, some providers noted that the Phase I training requirement of 10 completed assessments was too demanding in the adult population as it often took a longer time to conduct assessments with adults. Given this challenge, BHRS worked with CTA to modify the training requirements to allow providers within the adult system of care to complete 7 rather than 10 NMT assessments.
- 6) **Creating flexibility in the training schedule during the COVID-19 pandemic.** The third cohort of Phase I training began in January 2020, and was therefore impacted by COVID-19 and shelter-in-place restrictions. Although the Phase I training was intended to last 12 months, BHRS extended the third cohort's training to 18 months (ending in June 2021) to help alleviate NMT training demands as providers personally coped with the impacts of the pandemic and adjusted to providing services in a remote environment. Although providers noted that the training was still intensive, extending the training helped relieve providers' anxiety about keeping up with training requirements and made the training experience more enjoyable.

Additionally, as NMT was more widely implemented within BHRS, more trainees were exposed to NMT before beginning the formal training by working with other NMT-trained clinicians. In many cases, NMT-trained clinicians conducted assessments with individuals on other non-NMT trained clinicians' caseloads. Some of these non-NMT trained clinicians then opted to participate in the Phase I training, or expressed a desire to participate in the training at a later time, to learn more about NMT and conduct the assessments themselves. Providers' base level of knowledge and familiarity with NMT and the assessment process before starting the training may have better prepared providers in later training cohorts.

Having sufficient time to complete training requirements was a persistent barrier for trainees.

In the first year of NMT training with adult clinicians, only half successfully completed the training. In subsequent cohorts, all ASOC clinicians successfully completed the training, in large part due to the strategies implemented to better support and retain providers throughout the training. Nevertheless, having sufficient time to complete training requirements remained a persistent challenge for providers throughout the pilot period. Some non-NMT trained providers shared that although they were interested in the formal NMT training, they opted not to participate as the time commitment seemed daunting.

Time is a challenge in general, and the productivity index is a pressure as well. Yeah, we can use comp time, but I still need to reach a level of productivity.

– NMT Provider

Although the allocated comp time helped providers meet training requirements, the comp time was not enough at the beginning of the training when providers were familiarizing themselves with the materials and/or were learning NMT principles for the first time. Additionally, the approval of comp time was inconsistent across sites and supervisors, and providers were sometimes unsure of when to use or how



to submit comp time. In particular, Phase II providers shared that they needed time to practice teaching and presenting on NMT modules but were unclear if comp time could be used. Several trainees shared that even with comp time, they still felt pressure to meet productivity targets and ended up needing to work additional hours to keep up with the training. As a result, some providers fell behind on training requirements. Moving forward, BHRS should continue exploring and implementing strategies to help alleviate the time burden of NMT training.

The NMT training increased providers’ knowledge and ability to respond to consumers with a history of trauma. Overall, providers found the NMT training useful and interesting and enjoyed learning about the neurobiology and impact of trauma. For many of the providers, the NMT training provided an opportunity for more advanced training in brain development and neuropsychology related to trauma. For Phase I trainees in particular, their increased knowledge and understanding about the impact of trauma helped them better understand the behaviors and presentation of consumers. For Phase II trainees, the training helped them understand NMT principles more deeply. Phase II providers improved their ability to identify and integrate appropriate interventions (particularly the use of sensory tools) into therapy, as well as apply and explain NMT principles to consumers and other providers.

Learning the NMT approach helped some providers bring creativity to their clinical work, which may also support provider retention at BHRS. NMT enabled providers to “think outside the box” when identifying interventions to best meet each consumer’s unique needs. In some cases, providers shared that the ability to be creative in their clinical work as a result of NMT helped keep them at BHRS. NMT trainers and supervisors also observed these changes among providers and noted that the training sharpened providers’ clinical skills. Given these benefits, several providers shared that all clinicians should receive some training in the NMT principles and the impact of trauma on neurodevelopment in order to improve service delivery to the entire adult consumer population.

NMT Assessment Process

Providers implemented strategies to streamline the assessment process. The NMT assessment process is fairly intensive and includes a number of detailed questions to understand a consumer’s developmental history and past experiences of trauma. For all new NMT trainees—in both adult and youth systems of care—it takes time for providers to learn and gain comfort with the assessment tool. Providers in adult systems typically had a steeper learning curve as they do not regularly conduct developmental histories with adult consumers with the level of detail required for the NMT assessment.

At first, I tried to run the NMT assessment like a regular BHRS assessment, and I realized some of the questions are really intense for adults that are going through a lot of trauma. Now, I give clients lots of space to talk, and I don’t put a limit on the number of sessions to complete the assessment. My mentor has given me many tips on how to go through the assessment.

– NMT Provider

As NMT trainees first learned the assessment questions and process, they often administered the assessment in a direct way, going question by question. This approach took longer and risked re-traumatizing consumers—particularly adults—who were not



accustomed to these types of questions. As providers progressed through the training and became more confident with the assessment tool, they typically learned and implemented strategies to make the assessment process smoother and minimize the risk of re-traumatization. These strategies included:

- 1) **Explaining the process and providing some psychoeducation to consumers** to help consumers understand why the providers are asking about their childhood and adolescence;
- 2) **Asking broader questions or combining questions** to make the assessment more conversational, less burdensome, and less-time consuming as well as to reduce the risk of re-traumatization;
- 3) **Breaking up the assessment over multiple visits** if the consumer had reactions to the questions or struggled to focus long enough to complete the assessment;
- 4) **Reaching out to additional respondents who may have information about the consumer**, such as another provider who is familiar with the consumer’s history;
- 5) **Examining existing health records** for clients who have been open to BHRS to learn more about the consumer’s history; and
- 6) **Closing an assessment session with mindfulness exercises, meditation, or other interventions** to help soothe or stabilize consumers after discussing difficult topics.

Mentors also helped shorten the assessment learning curve and helped trainees learn and implement some of the strategies more quickly. In addition to discussing the assessment process with trainees, mentors also often conducted the first assessments with trainees. During these co-assessments, mentors modeled these strategies or gave feedback to trainees about how to make the assessment process easier.

During shelter-in-place, NMT providers transitioned to conducting assessments over the phone or through video conferencing. Providers found that some consumers were more difficult to engage through remote services due to technology limitations or unreliable access to phones. Other consumers—particularly TAY—were uncomfortable with telehealth services and had anxiety about talking over the phone or through video conferencing. Some parents had less time or less privacy to participate in NMT sessions due to family obligations. Rather than spending an hour and a half with consumers, some consumers were only able to engage with providers for 15 or 30 minutes at a time. Additionally, BHRS providers initially had more difficulty accessing electronic health records through their home laptops to gather historical information. Given these limitations, several providers found it particularly important to pace the assessment questions and implement strategies to ease the assessment process on consumers.

On the other hand, some providers found it easier to engage other consumers through remote services. In some cases, consumers found it difficult to sit still or engage in services in an office environment. However, when talking over the phone, consumers were free to walk around which helped them stay engaged and better communicate. In other cases, providers had more access to family members who could provide historical information during the assessment process.

Assessments were more time consuming and challenging to complete with the adult population compared to children. Although providers implemented different strategies to make the assessment process less burdensome, implementing NMT assessments was more time consuming and challenging with adults than with children. Some reasons the assessment process was often longer for adults were:



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- With adults, the NMT assessment collects information for a consumers’ entire developmental history—fetal stages through adulthood. In contrast, the assessment is shorter for children as it only collects information through the child’s current developmental stage.
- The assessments can be more time consuming for adults if consumers cannot recall information, and/or if consumers need to take breaks or stop the assessment if it brings up difficult experiences.
- Compared to children, adult consumers may have fewer collateral contacts that the providers or consumers can work with in order to fill in information gaps of the assessment.
- Adult consumers may be less likely to regularly participate in NMT services due to the severity of mental illness, substance use, homelessness, incarceration, or other barriers to consistently accessing or engaging in services.

Given these challenges, providers experienced difficulty completing assessments when consumers stopped regularly attending mental health service appointments or were incarcerated, hospitalized, or otherwise unavailable to continue. Although completing the assessments was a challenge for many providers throughout the NMT adult pilot, NMT providers began implementing the NMT approach with consumers before the assessment was completed. Providers found that implementing NMT interventions helped some

consumers better understand the NMT approach and built buy-in for continuing the assessment process. For some consumers, engaging in NMT interventions also helped consumers feel more comfortable sharing information, which helped facilitate the assessment process.

Providers expanded NMT selection criteria to include consumers with greater mental health needs. In the earlier stages of NMT training, providers were often conservative in determining which consumers to refer to NMT. Providers were mindful of the risk of the assessment process and effectiveness of interventions based upon consumers’ level of functioning, coping skills, and ability to self-regulate as well as providers’ experience with the assessment tool. At the beginning of the pilot, several providers mentioned that they typically only referred higher functioning consumers.

As providers gained more experience and confidence with NMT and the assessment process, providers’ perception of the adult population that could benefit from NMT evolved, and providers’ selection criteria expanded. Providers still considered the risks of engaging in the assessment with the potential benefits of NMT and strove to build rapport with consumers before beginning the assessment process. However, providers noted the most important selection criteria for NMT are:

- Consumer has a history of trauma;
- Consumer is willing to participate in NMT and regularly attends appointments; and
- Consumer is stable enough to recall information and provide realistic responses.

It is easier to complete an NMT metric with children than adults. It’s geared toward kids and it’s a much shorter history. They take a lot more time to do with adults and it’s definitely an investment, 3-4 sessions for an assessment at least.

– NMT Provider



Throughout the pilot, NMT providers also began to see the potential for NMT among consumers where more traditional approaches to treatment had not worked. Providers saw NMT as an opportunity to try something different. As NMT expanded throughout the BHRS System of Care as implementation of the NMT pilot progressed, providers also identified other populations that could benefit from NMT—such as parents of children in the youth system of care, mothers who were experiencing post-partum depression, and individuals with more severe mental health needs who were receiving treatment at residential placements.

Those that are actively psychotic are really difficult to do in person. It's not as linear or black and white, but you can often get answers just being with them and building rapport. You can also provide what you think the NMT intervention is first, rather than waiting for the assessment to be complete.

– NMT Provider

Providers shared that it was most challenging to conduct assessments with individuals who were actively abusing substances, were experiencing psychosis, or had developmental disabilities. These factors influenced consumers' ability or willingness to respond to assessment questions and/or regularly participate in NMT services. However, if it was apparent that the individual could benefit from NMT services, providers implemented the NMT approach and interventions with these clients even if a formal assessment could not be completed.

NMT Interventions

Throughout the pilot, BHRS expanded the NMT resources and interventions available to consumers in the Adult System of Care. At the beginning of the NMT adult pilot, the resources for NMT interventions was somewhat limited. Providers noted that many children's clinics already had tools and resources that could be used for NMT interventions, such as weighted blankets or sensory tools. In comparison, the Adult System of Care is more heavily focused on medication management and talk therapy. As a result, adult providers initially had less access to tools and resources for NMT interventions.

Throughout the pilot period, BHRS focused efforts on expanding resources and establishing new interventions—such as YMCA memberships, animal-assisted therapy, therapeutic massage, and the “Art of Yoga” therapeutic yoga sessions for NMT consumers. All NMT providers were also equipped with a basket of sensory tools (e.g., fidget spinners, stress balls, play doh, sensory brushes, pipe cleaners, etc.) to keep in their office for consumers to use. In addition to these tools, BHRS allowed BHRS providers to request specific resources or interventions to best meet their clients' needs (e.g., rocking chair, weighted blankets, coloring books, sketch pads, etc.). Beyond providing resources directly for interventions, NMT providers also received training in implementing sensory profiles to better understand consumers' sensory preferences and behaviors. This information was used to further inform appropriate therapeutic strategies and interventions.



Providers tailored NMT interventions to each consumer’s specific interests and needs.

The assessment recommendations serve to guide the types of interventions that consumers may need and that providers should prioritize. However, the specific interventions that providers selected were tailored to what each individual was interested in and willing to do. As mentioned, compared to the Youth System of Care, the Adult System of Care is more heavily focused on medication management and talk therapy. As a result, adults were typically unaccustomed to participating in the types of alternative interventions recommended by NMT. Providers found that compared to children, some adults were less willing to try new and different types of activities.

[My provider] has a box of squishy things, as well as a sand tray. [The interventions] offer a different way to express yourself, rather than talking it out.

– NMT Consumer

Providers aimed to learn about consumers’ hobbies and interests and suggested activities that aligned with the recommended interventions but that may also be more familiar—such as deep breathing, counting, going for walks, and mindfulness exercises. Providers observed that the sensory tool baskets also served as a conversation starter and were a good mechanism to communicate NMT principles. As providers built rapport with consumers and learned more about consumers’ specific goals and needs, providers suggested new or additional activities that consumers might enjoy or benefit from—such as yoga, massage therapy, animal assisted therapy, drumming, or spinning clay. In some cases, providers also engaged in these activities alongside consumers, which helped develop trust with the NMT provider as well as built buy-in for the interventions.

Providers also encouraged consumers to suggest new activities that consumers wanted to try—including building models, calligraphy, or using essential oils. Consumers appreciated having a variety of activities to choose from and tools to use to best meet their needs in different situations. This flexible and individualized approach helped consumers feel supported and engaged, and increased the likelihood that they would implement the interventions independently.

During shelter-in-place, providers identified strategies to adapt NMT interventions to a remote environment. During shelter-in-place, providers identified interventions that consumers could implement and work on in their own living environments. In some cases, providers mailed or dropped off tools or resources—such as sensory tools, weighted blankets, yoga mats, coloring books, etc.—at consumers’ homes. During video sessions, NMT providers found ways to engage in interventions with consumers—such as each going for a walk while they were together on the phone, coaching consumers through an activity like gardening or molding clay, or watching YouTube videos together.

Nevertheless, as described previously, providers also found it challenging to engage some consumers. For individuals who were uncomfortable with telehealth or video conferencing, providers began by engaging consumers in 10-15 minute sessions and gradually built up to longer meetings. Some providers also began NMT sessions the same way each time (e.g., practicing the same bilateral movements) to help ground consumers in the session and what they were doing together. Other consumers did not have access to video conferencing technology. Although providers were still able to engage some consumers over the



phone, they noted it was more challenging to work with some consumers—particularly TAY who were often less communicative—without being able to see their reactions or body language. For consumers without reliable access to phones, it was particularly challenging to participate in virtual services. Some consumers also mentioned they missed the in-person interaction, and suggested it would be helpful to meet with providers in outdoor spaces (wearing masks and practicing social distancing) when possible.

Support and resources from BHRS helped providers implement the various NMT interventions.

Some providers shared that prior to the NMT pilot, they were used to purchasing materials or tools for their offices out-of-pocket. With the NMT pilot, providers were able to request tools and resources for the NMT interventions through County funds, which helped providers expand the interventions available to better meet each consumer’s unique interests and needs. Nevertheless, some providers noted that insufficient space or poor office configuration was a constraint for effectively implementing some NMT interventions. Some providers noted that it was challenging to find instructors or providers to lead some group NMT interventions—such as yoga or gardening—due to providers’ workload constraints. Additionally, some providers were unsure what types of tools and resources they could request and provide to NMT consumers during shelter-in-place.

We have funds to support NMT interventions, like getting a rocking chair for one of our clients. This is the first time I’ve gotten supplies with County support.

– NMT Provider

Learning Goal 2: NMT Outcomes

The following section describes individual-level outcomes of adult consumers who participated in NMT services—including changes in assessment scores and recovery outcomes—as well as larger systems-level changes in providers’ approach to care as a result of NMT implementation in the adult system.

Changes in Brain Map and Functional Domain Scores

At the time of this report, follow-up assessment data were available for 46 consumers (51%). Providers conducted follow-up NMT assessments with consumers to evaluate consumers’ progress as well as update consumers’ treatment plans if necessary. On average, there were 12 months between the baseline and most recent follow-up assessments, although the time interval ranged from 4 months to nearly 2.5 years.

Among consumers with follow-up assessments, 24 were adults (52%) and 22 were TAY (48%). Additionally, 13 consumers (28%) were part of the reentry population, all of whom were adults. The evaluation examined changes in assessment scores overall as well as across sub-populations—including a comparison of adults to TAY, and a comparison of reentry and non-reentry adults. However, given the small number of individuals with follow-up data available, assessment findings should be considered exploratory.

The relatively small number of individuals with follow-up assessments and the varying length of time between assessments may partially reflect the challenges in completing assessments and inconsistent participation in services among the adult population. In some cases, programs are designed to be short-



term and consumers may graduate or move on to other services before a follow-up assessment is completed.

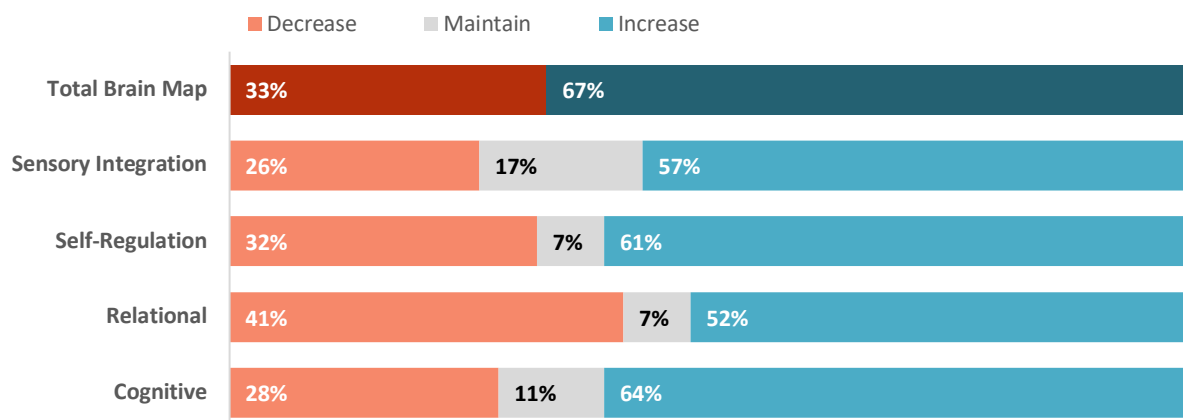
For the 46 consumers with follow-up data available for this report, baseline and follow-up assessment data were examined to identify changes in consumers’ brain map and functional domain scores as consumers participated in NMT services. Brain map and functional domain changes are defined as follows:

- **Increase:** any positive change in a score from baseline to follow-up (follow-up – baseline > 0),
- **Decrease:** any negative change in scores from baseline to follow-up (follow-up – baseline < 0).
- **Maintain:** no change in the score from baseline to follow-up (follow-up – baseline = 0)

Increases in brain map values suggest improvement (progress toward age typical functioning), while decreases in brain map values suggest further impairment (movement away from age typical functioning).

Although the magnitude of change varies, approximately two-thirds of consumers showed increases in their assessment scores, suggesting functional improvements. As shown in Figure 9, 67% of consumers (n=31) showed increases in their total brain map scores, while 33% (n=15) showed a decrease.⁹ Across the self-regulation and cognitive domains, approximately two-thirds of consumers showed increases in domain scores and one-quarter to one-third showed decreased scores. Fewer consumers—slightly more than half—showed increases in the sensory integration and relational domains. A quarter of consumers showed decreased sensory integration scores while 41% showed decreased relational scores. Across the self-regulation, relational, and cognitive domains, roughly 10% of consumers showed no change in scores. A larger proportion, 17%, showed no change in their sensory integration scores.

Figure 9. Percentage of Consumers with Increased and Decreased Assessment Scores from Baseline to Follow-up, N=46



Overall, the average change in consumers’ brain map was +3%, while the average change in functional domain values was +2% to +5% depending on the specific domain (Table 3).

⁹Although consumers may not have showed changes in one or more of the functional domain scores from baseline to follow-up (i.e., scores were maintained), all consumers showed some change (i.e., increase or decrease) in their overall brain map scores.



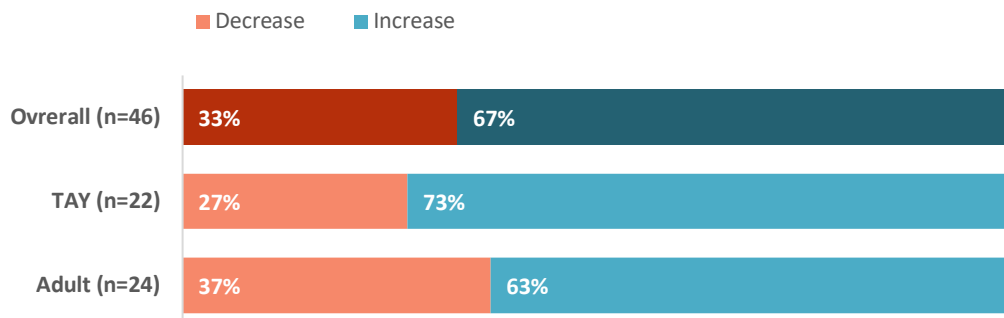
Table 3. Average Change in Assessment Scores from Baseline to Follow-Up, N=46

	Average Change in Scores	Range of Change in Scores
Total Brain Map	+3%	-13% to +25%
Sensory Integration	+3%	-10% to +25%
Self-Regulation	+5%	-11% to +30%
Relational	+4%	-14% to +30%
Cognitive	+2%	-26% to +25%

Providers noted that consumers who had large increases in assessment scores responded particularly well to the selected NMT interventions and consistently engaged in NMT services. These consumers regularly engaged in the recommended activities and/or practiced various self-soothing or calming techniques on a day-to-day basis. However, in other cases, providers noted that some consumers showed great progress in their recovery, but the change in assessment scores was minor. In contrast, providers noted that individuals who showed decreases in assessment scores tended not to engage regularly in NMT services and may have had more active substance use and/or psychosis. Additionally, providers noted that many consumers experienced increased anxiety and isolation during the COVID-19 pandemic, which contributed to decreases in brain map and functional domain scores.

Compared to adults, TAY generally showed greater and more consistent improvement in functional domain scores from baseline to follow-up. As mentioned, differences in the change in functional domain scores were examined across sub-populations. Overall, there were no significant differences between adults who were and were not part of the reentry population, and changes in brain map and functional domain scores were similar. Although there also were no statistically significant differences between TAY and the adult population, TAY tended to show greater improvements in brain map and functional domain scores.¹⁰ As shown in Figure 10, 73% of TAY showed increases in their overall brain map scores compared to 63% of adults.

Figure 10. Percentage of Adults and TAY with Increased and Decreased Brain Map Scores from Baseline to Follow-up, N=46



On average, the magnitude of change in assessment scores also tended to be larger among TAY. Among TAY, brain map scores increased by an average of 5%, while brain map scores increased by an average of

¹⁰ Additional data regarding changes in functional domain scores across subpopulations is available in Appendix II.



2% among adults. These trends continued across each of the functional domains, wherein a greater proportion of TAY had increased scores and the change in scores was larger compared to adults. The larger and more consistent increases among TAY may reflect greater neuroplasticity among TAY compared to adults as they are still undergoing brain development. Additionally, TAY were less likely to have co-occurring substance use disorders and/or psychotic disorders. TAY also tend to have fewer years of heavy psychiatric medication. All of these factors may help TAY more consistently engage in and be more responsive to NMT interventions compared to adults.

Table 4. Average Change in Functional Domain Scores among Adults and TAY (N=28)

Functional Domain	Adult (N=24)	TAY (N=22)
	Average Change (Range)	Average Change (Range)
Total Brain Map	2% (-13 to +23%)	5% (-9 to +25%)
Sensory Integration	3% (-7 to +25%)	3% (-10 to +22%)
Self-Regulation	3% (-11 to +28%)	6% (-8 to +30%)
Relational	3% (-14 to +30%)	5% (-9 to +30%)
Cognitive	0% (-26 to +13%)	4% (-9 to +25%)

No significant differences were found across groups using t-test.

In previous years, the change in brain map and functional domain values among TAY was larger compared to TAY who had their follow-up assessment during FY19-20. Between FY16-17 to FY18-19, TAY showed an average change of +9% in brain map scores. However, when including the most recent follow-up assessments conducted during FY19-20, the average change in total brain map scores was only +5%.

In part, the smaller increase in brain map scores during FY19-20 among TAY may reflect changes in service engagement as well as increased stress and anxiety during the COVID-19 pandemic. Among the 22 TAY with follow-up assessments, 73% (n=16) had their most recent follow-up assessment conducted during shelter-in-place (i.e., after March 15, 2020). Additionally, all TAY that showed decreases in brain map scores (n=6) had their follow-up assessment during shelter-in-place. In comparison, 33% of adults (n=8) had their most recent follow-up assessment conducted during shelter-in-place, nearly all of whom showed improvements in brain map or functional domain scores.

In alignment with these findings, providers observed greater decompensation among TAY during shelter-in-place. As mentioned previously, some TAY had more difficulty engaging and communicating in remote services during shelter-in-place due to anxiety around talking on the phone or over video. Additionally, providers reported that TAY were feeling more isolated without school or other activities and the stress of the pandemic strained family relationships in some households. Half of TAY (n=8, 50%) who completed follow-up assessments during shelter-in-place showed decreases in relational scores compared to only one TAY (17%) who completed a follow-up assessment before shelter-in-place.

Providers noted that many adults also struggled with increased anxiety and isolation during shelter-in-place as well. However, most adults who completed assessments during shelter-in-place showed improvements in functional domain scores. While some adults were also more challenging to engage in remote services, adults who completed assessments during shelter-in-place may have been higher



functioning and/or more willing and able to participate in telehealth compared to those who did not complete assessments during shelter-in-place. As a result, adult consumers' who were high functioning enough to complete assessments during shelter-in-place may have been more likely to improve or maintain scores. Additionally, given TAY experience more neuroplasticity than adults, TAY may be more receptive to changes in their environment—both positive and negative—which may be reflected by greater changes in functional domain scores. Moving forward, BHRS may wish to continue examining differences between TAY and adults in order to tailor intervention strategies for each population.

Changes in functional scores may also be reflective of providers' as well as consumers' increasing experience and comfort with NMT and the assessment process. Providers observed that consumers were forthcoming about their history or experiences as they built rapport with providers and began to see the benefits of NMT. As a result, more accurate information was often available for follow-up assessments, which may have changed assessment scores. In some cases, individuals shared information that resulted in lower assessment scores. Additionally, providers generally completed baseline assessments earlier in their NMT training, whereas follow-up assessments were completed later when providers had more practice and training. As providers gained more experience with the assessments, they sometimes scored criteria slightly differently. For example, some providers noted that when they were first learning the tool, they were more likely score a given criterion neutrally. However, as they became more comfortable with the tool and/or they learned more about the consumer, they were able to score criteria more accurately—which resulted in a higher or lower score.

NMT Consumer Recovery and Experience of Care

NMT helped some consumers progress in their recovery.

Aside from changes in assessment scores, all focus group participants (including providers and consumers) pointed to benefits consumers experienced as a result of participating in NMT interventions. Consumers frequently discussed how the NMT interventions helped them feel less anxious, more relaxed, and more in control. Concentrating on an activity—such as coloring or origami—helped consumers “get out of their head,” while techniques such as deep breathing, meditation, yoga, or the use of sensory tools helped consumers stay centered and calm. As one consumer shared, “If there’s something on my mind and I do origami, my focus is on the origami. After I’m done with the origami, the stuff I was worried about isn’t too much to worry about anymore.”

Evaluating situations and making better choices has been a significant improvement. Now I think about options to handle a situation, rather than just reacting to a negative stimulus. Now, I also think about the association of things. I think I would have handled issues with my family differently before. Now I have empathy and think about how they got to be that way.

– NMT Consumer

In several cases, consumers felt NMT helped improve their quality of life and shared that they had a renewed interest in hobbies, reaching their goals, and spending time with family or friends. Other changes noted by consumers and providers included better communication, improved ability to manage emotions or stress, and being better equipped to recognize and manage triggers. Other consumers reported that



the NMT-based techniques and activities helped consumers decrease substance use as well as reduce or avoid medication to cope with depression and anxiety.

For some consumers, the assessment process and NMT interventions helped them process their experiences to develop better insight and understand the impact that trauma had on their current behaviors as well as behaviors of others. Consumers talked about how the interventions created a safe space for them to address and rewrite their history. Providers also shared that some consumers began to use NMT and trauma-informed language when discussing their experiences and recovery.

NMT offers an alternative approach to treatment that many consumers had never experienced. For some consumers, the NMT approach made it easier for consumers to engage in therapy. Consumers shared that NMT felt different from other mental health services they had received. In many cases, consumers were accustomed to more traditional talk therapy, which

[NMT interventions] like the sand tray, or sketching, or writing offer a different way to express yourself, rather than talking it out.

– NMT Consumer

often left them feeling emotional and fatigued after sessions. In other cases, consumers talked about how other services they had received felt “one size fits all” and that previous providers did not try to get to know or understand them as individuals. Some consumers also felt that other providers were more focused on identifying a diagnosis and the appropriate medication. In contrast, the individualized approach of NMT helped consumers feel respected and heard. One consumer shared,

“[My NMT provider] and I were able to develop a relationship where we could talk. We realized that even though we had philosophical differences we respected each other. [My NMT provider] took time to understand where I was coming from. Others in the past were in a rush to make an opinion or put down a diagnosis. Whereas [my NMT provider] would ask if I thought it was the correct assessment and would allow me to make clarifications. I knew he was paying attention because he would ask questions based on what I said. I appreciated that.”

Several consumers observed that it was easier for them to discuss their feelings and trauma when engaging in the activities and that it helped them feel safe. Several consumers described feeling “refreshed” or “light” after NMT activities. Consumers appreciated that providers tailored activities to consumers’ specific interests, and providers’ willingness to participate in the activities with consumers helped build rapport and trust.

“I’ve worked with [my NMT provider] longer than anyone else in the past. Past therapists would try to diagnose me, and then give me some form of medication to ‘treat’ me. I don’t think that actually addressed any of my issues... I’ve never had a therapist that’s like let’s do yoga, I’ll do it with you. Let’s do meditation, or this Qigong video together. Sometimes we do sit down and have a serious conversation. But I think developing a bond through doing activities like yoga made me feel more comfortable. [My NMT provider] is very relatable.”



Several consumers mentioned that no other providers had worked with them in this way before and that with NMT they look forward to their next sessions. As mentioned previously, in several cases, NMT consumers also implement NMT interventions on their own in between sessions.

Provider Approach to Care

NMT implementation helped some clinics and programs be more trauma-informed. As mentioned, providers reported that being trained in NMT and the neurodevelopmental impacts of trauma changed the way they approach care with all consumers. Additionally, providing NMT services in the Adult System of Care appeared to support non-NMT providers to employ a more trauma-informed approach when working with both NMT and non-NMT clients.

Since I've been in a leadership role [at my clinic], NMT has been a constant part of agenda. At least once a month, I'm presenting on something on NMT and trauma-informed care...We want to get to a point where [non-NMT trained] supervisors can tell when a person needs a metric.

– NMT Provider

Non-NMT trained providers shared that the NMT assessment process can provide more comprehensive information about a consumers' history than they might have otherwise obtained. The assessment also helped non-NMT providers to identify and implement other types of interventions that the consumer may respond well to. Non-NMT providers shared that the assessment process helped them better understand consumers, and in some cases they were able to work with consumers or their families differently. For example, NMT-trained clinicians conducted NMT metrics and identified sensory interventions with consumers in residential placements, which helped non-NMT providers better understand consumers' behaviors and triggers. Additionally, the NMT clinicians offered recommendations for therapeutic strategies or interventions that the non-NMT providers could implement that were effective with the clients—such as walking, using a glider chair, or engaging in breathing exercises. Providers also noted that some psychiatrists began implementing or requesting NMT interventions, marking a shift to try behavioral interventions rather than medication alone.

Throughout the pilot, non-NMT providers increasingly requested NMT assessments for consumers on their caseloads, including adult consumers as well as parents of youth consumers. Non-NMT providers shared that they typically requested an assessment when they knew the individual had a history of trauma and other interventions were not working. One provider stated they requested an assessment when “you realize we need to be doing something different with the consumer, but we aren't sure what.” Non-NMT providers then worked with the NMT-clinician during the assessment process, providing background information to the NMT provider, helping explain the process to the consumer, as well as being present during the assessment to help the consumer feel more at ease.



Additionally, as the NMT adult pilot progressed, BHRS received a greater volume of requests for the core principles training throughout the Adult System of Care. Providers who participated in the core principles training found it helpful to begin to understand NMT and how to take a more trauma-informed approach to care. Although some providers shared that they did not intend to get certified in NMT due to the intensive training demands, they also felt that all providers should participate in the six core principles training to

better understand the impact of trauma on individuals' behavior—including both consumers and caretakers. BHRS is also working with some non-NMT trained providers to adapt the core principles training to non-clinical providers and environments that still work closely with consumers, such as board and care facilities.

NMT clinicians mentioned that other providers within their clinics or programs were not always open or receptive to NMT, but having a supportive supervisor or more than one NMT-trained clinician made it easier for providers to implement NMT. In some cases, NMT providers worked on interdisciplinary teams or with non-BHRS providers who did not have as much training in trauma-informed approaches and were more dismissive of NMT. Providers also observed that non-NMT clinicians who worked in the mental health system for a long time may have seen NMT as an intervention that will “come and go”.

Other non-NMT trained saw the utility in the NMT approach, but felt the NMT assessment was too time intensive, and were unsure whether the assessment yielded practical information. Some non-NMT trained providers who participated or requested an assessment were surprised by the lack of depth in the assessment results and had hoped for more specific interventions and recommendations given the extensiveness of the assessment process. However, non-NMT providers who worked with other NMT trainers or mentors (rather than NMT trainees) appeared to have clearer expectations and a better understanding of how to interpret and use the NMT assessment output to inform interventions.

Non-NMT providers also questioned how well the NMT assessment questions translate across different cultures and socioeconomic backgrounds. Others felt that NMT interventions were not as effective if factors in the consumers' home environment could not be changed. In particular, non-NMT providers noted that oftentimes parents have experienced their own trauma that needs to be addressed before they can better support their child. In some cases, providers did not realize that NMT assessments and interventions could be conducted with parents or caretakers, or shared that billing structures made it

Board and Care operators are the caregivers, and so how they're interacting with the client is so important. I'm trying to keep interventions in line with the six core strengths, it's nothing fancy. But, none of operators are mental health providers, they have high school education, and they tend to see behavior as very volitional. Providing them an alternative rationale to what's going on and different ways to intervene are helpful.

– Non-NMT Provider

The NMT questionnaires were so lengthy. We really went through it all with the family because we wanted them to have all the information they could. But when the report came back, I was like wow that's it. My expectations were for something more groundbreaking.

– Non-NMT Provider



San Mateo Behavioral Health and Recovery Services

MHSA Innovation Evaluation – Adult NMT Pilot Final Evaluation Report

difficult to provide interventions to the parents or caretaker. Moving forward, it may be important to set clearer expectations with non-NMT providers about the NMT assessment process—including information the NMT assessment can provide and how it can be used. Additionally, some non-NMT providers suggested that to increase buy-in for the NMT approach, NMT providers may be able recommend interventions without first conducting the full NMT assessment.

Having a supervisor who is trained in or supportive of NMT made it easier for NMT providers to implement NMT more widely within a clinic or program. During case conferencing, supervisors could recommend that a consumer on a non-NMT provider's caseload receive an NMT assessment based upon the consumer's presentation and history of trauma. In contrast, NMT clinicians in non-supervisory roles and/or in larger teams felt they had less authority to suggest NMT to their fellow colleagues. NMT providers are hopeful that with the increasing exposure to NMT in the Adult System of Care, more providers will be receptive to and request NMT for their clients.



Conclusion

In 2016, BHRS implemented the NMT adult pilot with the aim of providing alternative treatment options to broaden and deepen the focus on trauma-informed care and provide better outcomes in recovery for adult BHRS consumers. Over the course of the four-year NMT adult pilot, BHRS achieved these goals.

During the NMT adult pilot project, a total of 29 providers in the BHRS Adult System of Care participated in NMT training—including 12 providers who completed the Phase I NMT certification, 6 trainees who were still participating in NMT certification as of the end of the pilot period, and 5 providers who completed Phase II “NMT Train-the-Trainer” training to become certified mentors and trainers. Providers were intentionally selected to fill gaps in NMT services across adult clinics and programs. **As more providers were trained in NMT across BHRS adult programs, the volume of adult consumers receiving NMT services steadily grew from 20 consumers in Year 1 to 90 consumers by Year 4.**

Throughout the pilot project, BHRS continually built upon lessons learned to effectively adapt the NMT approach to adults and an adult system of care. For some providers, learning NMT principles and interventions was challenging and represented a shift from the more traditional adult treatment model of medication management and talk therapy. BHRS implemented a number of strategies to better support providers throughout the intensive NMT training. In particular, greater one-on-one mentorship throughout the training process was instrumental in supporting providers to learn NMT principles, streamline the assessment process, and adapt the approach to an adult population. Additionally, BHRS continued to better equip clinics and programs with NMT resources to expand the NMT interventions available to adult consumers, enabling providers to tailor NMT interventions to adult consumers’ specific interests and needs.

The NMT adult pilot also demonstrated that adult consumers can benefit from the NMT approach. Consumers who participated in NMT progressed in their recovery, and for some, the NMT approach may have made it easier for consumers to engage in therapy. For many consumers, the NMT approach was the first time that providers had implemented strategies other than talk therapy or medication. Consumers appreciated the individualized approach of NMT, and both consumers and providers cited improvements in consumers’ coping mechanisms and overall quality of life as a result of NMT interventions. Although follow-up assessment data were somewhat limited, data suggest that consumers who participated in NMT improved across all functional domains. TAY appeared to respond particularly well to NMT and showed greater and more consistent improvements in functional domain scores compared to adults. This may reflect the greater neuroplasticity of TAY compared to adults. However, among all age groups, providers noted that consumers who engaged in NMT interventions more regularly tended to show the greatest improvements.

NMT implementation also strengthened BHRS providers’ ability to serve consumers with a history of trauma. As more providers were trained in NMT, worked with NMT-trained clinicians, and/or were exposed to principles of NMT and trauma-informed care, the NMT pilot supported the adoption of trauma-informed practices and treatment options in the BHRS Adult System of Care overall.



NMT Program and Funding Continuation

San Mateo County BHRS presented interim NMT outcomes to stakeholders, the MHSA Steering Committee, and the Mental Health Substance Abuse Recovery Commission (MHSARC) in 2019. During this meeting, BHRS provided an update on progress toward program learning goals, implementation milestones and accomplishments, client outcomes and improved mental health indicators, and a proposed sustainability plan. The sustainability plan included leveraging the train-the-trainer model implemented during the project period as well as request of \$200,000 ongoing MHSA funds, beginning in FY 2020-21 to support a 0.3 FTE Mental Health Specialist to oversee the project, training maintenance and increased interventions for clients. An estimated 30 members of the public attended the presentation and had the opportunity to ask questions and provide public comment.

In a subsequent meeting, the MHSA Steering Committee made a motion to approve a one-year no cost extension of NMT for FY 2019-20. Additionally, the idea to fund NMT using MHSA one-time unspent funds as an interim solution was presented at this meeting, with the intention to incorporate the ongoing project sustainability into the FY 2020-23 MHSA Three-Year Plan Community Program Planning process. The Plan to Spend was developed in collaboration with stakeholders during two MHSA Steering Committee meetings and input sessions with the MHSARC Older Adult, Adult, and Youth Committees, as well as the Contractor's Association, the Office of Consumer and Family Affairs/Lived Experience Workgroup and the Peer Recovery Collaborative.

In October 2019, the MHSA Steering Committee reviewed the draft Plan to Spend and provided comments. In November, the MHSARC held a public hearing, closed the 30-day public comment period, reviewed the public comments, and subsequently voted to submit the plan to the Board of Supervisors for approval. The final Plan to Spend was submitted and approved by our Board of Supervisors in April 2020.

During the FY 2020-23 MHSA Three-Year Plan Community Program Planning process, the COVID-19 pandemic transpired. Given the significant revenue decrease projections expected due to the pandemic, it is unlikely that San Mateo County will be able to fund any new programs or expansions, including NMT, past FY 2021-22. At the MHSA Steering Committee in February 2021, BHRS will work with stakeholders on a plan to utilize reserves for possible sustainability of this and other programs. BHRS also plans on addressing ongoing sustainability of NMT and other programs past FY2022-23 again during the next MHSA Three-Year Plan Community Program Planning process scheduled to begin in the fall of 2022.

As mentioned above, preliminary project outcomes were presented to stakeholders, the MHSA Steering Committee and the MHSARC in 2019. The final report will be presented to these same groups in May 2021 as part of the FY 2020-21 MHSA Annual Update, posted on the San Mateo County MHSA website, BHRS blog and disseminated to the over 2,000 local MHSA subscribers. There are no current plans to present to other counties but BHRS is open to this possibility.



Appendix I. Baseline NMT Assessments Across Target Populations

Adults compared to TAY

Table 5. Average Baseline Functional Domain Scores among Adults and TAY (N=82)

Functional Domain	Adult (N=55)	TAY (N=27)
	Average Score (Range)	Average Score (Range)
Total Brain Map	76% (29 to 96%)	78% (53 to 99%)
Sensory Integration	82% (38 to 100%)	80% (51 to 100%)
Self-Regulation	70% (34 to 94%)	74% (45 to 100%)
Relational	70% (27 to 96%)	74% (49 to 100%)
Cognitive	82% (15 to 100%)	80% (62 to 99%)

No significant differences were found across groups using t-test.

Table 6. Baseline Recommended Intervention Level among Adults and TAY (N=82)

Functional Domain	Recommended Intervention Level	Adult (N=55)	TAY (N=27)
		% of Consumers	% of Consumers
Sensory Integration	Essential	15%	7%
	Therapeutic	38%	59%
	Enrichment	47%	33%
Self-Regulation	Essential	38%	26%
	Therapeutic	38%	56%
	Enrichment	24%	19%
Relational	Essential	42%	22%
	Therapeutic	35%	56%
	Enrichment	24%	22%
Cognitive	Essential	9%	11%
	Therapeutic	31%	33%
	Enrichment	60%	56%

No significant differences were found across groups using chi-square test.



Non-Reentry compared to Reentry Adults

Table 7. Average Baseline Functional Domain Scores among Non-Reentry and Reentry Adults (N=55)

Functional Domain	Adult: Non-Reentry (N=27) Average Score (Range)	Adult: Reentry (N=28) Average Score (Range)
Total Brain Map	74% (40 to 96%)	78% (29 to 96%)
Sensory Integration	79% (53 to 100%)	85% (38 to 100%)
Self-Regulation	66% (35 to 94%)	73% (35 to 94%)
Relational	69% (36 to 96%)	71% (27 to 93%)
Cognitive	82% (22 to 97%)	82% (15 to 100%)

No significant differences were found across groups using t-test.

Table 8. Baseline Recommended Intervention Level among Non-Reentry and Reentry Adults (N=55)

Functional Domain	Recommended Intervention Level	Adult: Non-Reentry (N=27) % of Consumers	Adult: Reentry (N=28) % of Consumers
Sensory Integration	Essential	19%	11%
	Therapeutic	44%	32%
	Enrichment	37%	57%
Self-Regulation	Essential	52%	25%
	Therapeutic	30%	46%
	Enrichment	18%	29%
Relational	Essential	48%	36%
	Therapeutic	33%	36%
	Enrichment	19%	28%
Cognitive	Essential	4%	14%
	Therapeutic	37%	25%
	Enrichment	59%	61%

No significant differences were found across groups using chi-square test.



Appendix II. Changes in NMT Scores Across Target Populations

Adults compared to TAY

Table 9. Type of Change in Functional Domain Scores among Adults and TAY (N=28)

Functional Domain	Change in Scores	Adult (N=24)	TAY (N=22)
		% of Consumers	% of Consumers
Total Brain Map	Decrease	37%	27%
	Maintain	-	-
	Increase	63%	73%
Sensory Integration	Decrease	21%	32%
	Maintain	29%	5%
	Increase	50%	64%
Self-Regulation	Decrease	37%	27%
	Maintain	13%	-
	Increase	50%	73%
Relational	Decrease	42%	41%
	Maintain	8%	4%
	Increase	50%	55%
Cognitive	Decrease	33%	23%
	Maintain	13%	9%
	Increase	54%	68%

No significant differences were found across groups using chi-square test.

Table 10. Average Change in Functional Domain Scores among Adults and TAY (N=28)

Functional Domain	Adult (N=24)	TAY (N=22)
	Average Change (Range)	Average Change (Range)
Total Brain Map	2% (-13 to +23%)	5% (-9 to +25%)
Sensory Integration	3% (-7 to +25%)	3% (-10 to +22%)
Self-Regulation	3% (-11 to +28%)	6% (-8 to +30%)
Relational	3% (-14 to +30%)	5% (-9 to +30%)
Cognitive	0% (-26 to +13%)	4% (-9 to +25%)

No significant differences were found across groups using t-test.



Non-Reentry compared to Reentry Adults

Table 11. Type of Change in Functional Domain Scores among Adults and TAY (N=24)

Functional Domain	Change in Scores	Adult: Non-Reentry (N=11) % of Consumers	Adult: Reentry (N=13) % of Consumers
Total Brain Map	Decrease	45%	31%
	Maintain	-	-
	Increase	55%	69%
Sensory Integration	Decrease	36%	8%
	Maintain	-	54%
	Increase	64%	38%
Self-Regulation	Decrease	45%	31%
	Maintain	8%	18%
	Increase	36%	62%
Relational	Decrease	55%	31%
	Maintain	9%	7%
	Increase	36%	62%
Cognitive	Decrease	31%	36%
	Maintain	-	23%
	Increase	63%	46%

No significant differences were found across groups using chi-square test.

Table 12. Average Change in Functional Domain Scores among Non-Reentry and Reentry Adults (N=24)

Functional Domain	Adult: Not Reentry (N=11) Average Change (Range)	Adult: Reentry (N=13) Average Change (Range)
Total Brain Map	2% (-13 to +23%)	2% (-6 to +14%)
Sensory Integration	3% (-7 to +25%)	2% (-3 to +14%)
Self-Regulation	3% (-11 to +28%)	3% (-11 to +19%)
Relational	3% (-13 to +30%)	3% (-14 to +14%)
Cognitive	0% (-26 to +13%)	0% (-15 to +13%)

No significant differences were found across groups using t-test.



CONNECTING PEOPLE
WITH CARE

Date: April 6, 2021

To: Help@Hand Collaborative Cities and Counties

From: CalMHSA

Re: CalMHSA Comments on Help@Hand Year 2 Annual Evaluation Report

Dear Help@Hand Cities and Counties,

CalMHSA is proud to support this multi-year innovation project in which 14 California Cities and Counties work together to explore mental health solutions through the use of technology. At publication of this report, the Help@Hand project has seen:

- Four product launches
- Stakeholder engagement through webinars, listening sessions, local input opportunities and focus groups
- Streamlined processes and rapid-response deployments to support communities during the COVID-19 pandemic

A key component of the project is evaluation, which results reports on a quarterly and annual basis. This annual report encompasses Year 2 (January 1, 2020 – December 31, 2020) of the Help@Hand evaluation and synthesizes evaluation findings across Cities/Counties.

The analysis and findings presented are those of the University of California, Irvine's (UCI) Help@Hand evaluation team. CalMHSA works collaboratively with UCI throughout the project and reviews the report for confidentiality, but neither CalMHSA, nor Cities/Counties are authors of the report.

How to Read This Report

Evaluation Reports are written with the Help@Hand Cities/Counties in mind as the target audience, however the project understands there are many other stakeholders who also have interest in these reports. Annual evaluation reports provide Help@Hand Cities/Counties with a larger perspective of the work in progress. Different from the quarterly evaluation reports, which are not intended to be exhaustive, the annual reports provide a more thorough view of the activities which took place throughout the year. Despite the comprehensive approach the annual report takes, readers should note the analysis and findings outlined in the report are still in summary and do not constitute all City/County, collaborative or project management activities completed during this evaluation period.

4/6/2020



CONNECTING PEOPLE
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CalMHSA invites Help@Hand Cities/Counties to consider the following as they review the report:

- **Reflect** – Review and acknowledge the incredible work that has been done to date. Please take the time to recognize those on your teams, and in your communities, who have worked diligently to bring the project this far.
- **Learn** – One of the primary intentions of the Help@Hand innovation project is to learn. Learning includes both acknowledgement of successes and consideration of opportunities to improve. CalMHSA respects the openness and vulnerability of all project participants in embracing a learning mindset through which we explore and discover innovative solutions to improve our communities and save lives.
- **Respond** – Help@Hand project participants in particular should consider where and how to integrate the recommendations and learnings captured in this report. All audiences who have questions or wish to provide comments related to this report may email feedback to CalMHSA at helpathand@calmhsa.org and to UCI at dsorkin@uci.edu.

This report is a lengthy document in excess of 160 pages. To assist you in navigating, here is a preview of how the report is organized:

- Executive Summary (pages 5-6)
- Summary of Activities (pages 10-14)
- Recommendations (page 97)
- Spotlights (pages 14, 17, 21, 47, 61, 78,)
- Report Chapters are structured in the following format:
 - Key points for chapter
 - Overview and outline
 - Methods & Findings
 - Learnings

Preview of Activities in Year 3, Quarter 1

- Three additional product pilots and launches
- Monterey county RFP closed, scoring completed and intent to award notification made
- Recruitment for the Peer Program Coordinator role
- Completion of SharePoint redesign to facilitate communication and information sharing
- Facilitation of next collaborative Lessons Learned presentation
- Revised evaluation scope of work



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Thank you for your interest in the learnings from Help@Hand. Questions or comments can be provided by contacting CalMHSA at helpathand@calmhsa.org and to UCI at dsorkin@uci.edu.

help @ hand™ Evaluation

Mental Health Services Act (MHSA) Innovation Technology Suite Evaluation

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University of California, Irvine

Year 2 Annual Evaluation Report January – December 2020 Submitted February 2021





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INTRODUCTION

Year 2 of the Help@Hand project was marked by the same critical ruptures, social upheavals, and unprecedented challenges that have shaped 2020 for all of us, and have made the work of providing targeted and accessible digital mental health therapeutics newly profound for our communities.

The COVID-19 pandemic has revealed itself to be a generation-defining complex of interrelated crises—not only the public health emergency which is still overwhelming Help@Hand counties/cities, but also new crises of rampant unemployment, housing issues, and much more. Meanwhile, 2020 witnessed thousands of protests that have demanded an evolution of the conversation around systemic racism and its effects in communities of color. And through all of this, the year in politics culminated in the national election in November, with Joseph R. Biden Jr. and Kamala D. Harris, respectively, selected as the President and Vice President of the United States.

The past year had several challenges, but also gave way for communities to speak loudly and clearly about their needs, strengths, fears, and hopes. 2020 revealed all of these needs to be inextricably linked, and emphasized the collective toll on mental health. And yet, Year 2 of the Help@Hand program has afforded a vital opportunity to respond to community need with renewed dedication and community-driven effort.

Year 2 of the project was a year of careful community needs assessments, rigorous assessment of digital therapeutic technologies and market surveillance, thoughtful piloting and implementation phases, and vital shared learnings across the collaborative with an emphasis on even greater cross-unit collaboration moving forward. Critical insights into the needs and trends of different linguistic communities, age groups, and regions with respect to the use of digital and online mental health tools were gained. A high-level overview of Year 2 program and evaluation activities as well as learnings is provided below. As the program looks ahead to Year 3, it will continue to build upon the successes and learnings of this unparalleled, yet incredibly formative year.

HELP@HAND EVALUATION ACTIVITIES AND LEARNINGS

SYSTEM EVALUATION- MARKET SURVEILLANCE, ENVIRONMENTAL SCAN, AND COLLABORATIVE PROCESS EVALUATION

The Year 2 system evaluation focuses on evaluating system-related factors that may affect Help@Hand. It presents evaluation activities and learnings from the market surveillance, as well as the status of the environmental scan and the collaborative process evaluation. Findings include:

- User experience assessment suggests that many mental health apps offer interesting, engaging, and easy-to-use support. However, limited accessibility features indicate that not everyone can get on-demand support from these apps and may face barriers beyond ease of use.
- User experience, downloads, and engagement were higher for chatbot apps than for meditation or peer support apps.
- Digital phenotyping, an approved component of Help@Hand technologies, is not a widely available feature in publicly available mental health apps.
- Apps identified through Help@Hand's most recent Request for Statement of Qualification (RFSQ) tended to underperform in the marketplace in terms of number of downloads and number of monthly active users.

PEER EVALUATION

The evaluation of the Peer component carried out in Year 2 documents Peer activities, identifies successes and challenges to implementing the Peer component, and shares lessons learned across the Collaborative. Findings include:

- Peers are playing an active role in supporting the Help@Hand program across the Collaborative. There is enthusiasm overall for the contribution of the Peer component to the Help@Hand project.
- Digital educational materials can be delivered remotely to address digital literacy, in response to the in-person constraints brought about by COVID-19.
- Peers have been engaged in digital product testing throughout Year 2, and counties/cities plan to sustain this engagement into Year 3.
- Over time, more counties/cities are reporting successes with incorporating Peer input into Help@Hand decisions, but challenges to program implementation are being reported by an increasing number of counties/cities.

COUNTY/CITY TECHNOLOGY, USER EXPERIENCE, AND IMPLEMENTATION EVALUATION

In Year 2, the Help@Hand evaluation team conducted needs assessments to assure that technologies remain appealing and accessible to all users throughout the reach of the Collaborative. In particular, the needs of Los Angeles community college students and individuals within the Riverside County Deaf and Hard of Hearing Community were assessed, and plans for additional assessments with Orange County were initiated.

Marin, Riverside, San Francisco, and San Mateo Counties, as well as City of Berkeley and Tri-City explored different technologies with target populations to provide valuable feedback about how well or poorly specific technologies were received, which in turn will inform the pilot and implementation phase of selected technologies.

Meanwhile, Los Angeles, Marin, San Francisco, San Mateo, Santa Barbara, and Tehama Counties planned pilots to test potential technologies. A few of these pilots were paused or discontinued for various reasons. At the same time, Los Angeles and Orange Counties implemented technologies, with the intention of offering these technologies to a larger group of community members or using them for the remainder of the project.

In addition, the Help@Hand Collaborative developed a framework to rapidly launch technologies to respond to the needs of their communities during COVID-19. Riverside County developed and launched a peer-chat app called Take my Hand in 2020. San Francisco County is planning to partner with Riverside County on piloting this app as well in 2021. Another technology launched was Headspace, which Los Angeles and San Mateo Counties began offering to county residents in 2020. San Francisco plans to launch Headspace in their county in 2021.

Also, Monterey and Los Angeles Counties released a Request for Information and created a Request for Proposal as part of their development of a tool that screens and refers residents of Monterey County.

Finally, Kern and Modoc Counties completed their projects and transitioned off of Help@Hand. Exit interviews were conducted with both counties.

OUTCOMES EVALUATION AND DATA DASHBOARDS

The outcomes evaluation assesses Help@Hand's overall impact in the state of California. Key findings include:

- For both teens and adults, individuals with higher distress levels were more likely to have used online tools to connect with other individuals living with similar addiction or mental health conditions.

- California Health and Human Services (CHHS) and its Institutional Review Board (IRB) approved the Help@Hand evaluation team request for data from vital statistics, which allowed the evaluation team to start analyzing data regarding suicides, and drug and alcohol overdoses. The analysis of the five-year baseline period from 2015 to 2019 revealed that the general rates of suicide and overdose are generally slightly higher in comparison counties than in Help@Hand counties.

RECOMMENDATIONS

Recommendations based on evaluation learnings are provided on page 97 for the Help@Hand Collaborative and the individual Help@Hand counties/cities.

INTRODUCTION



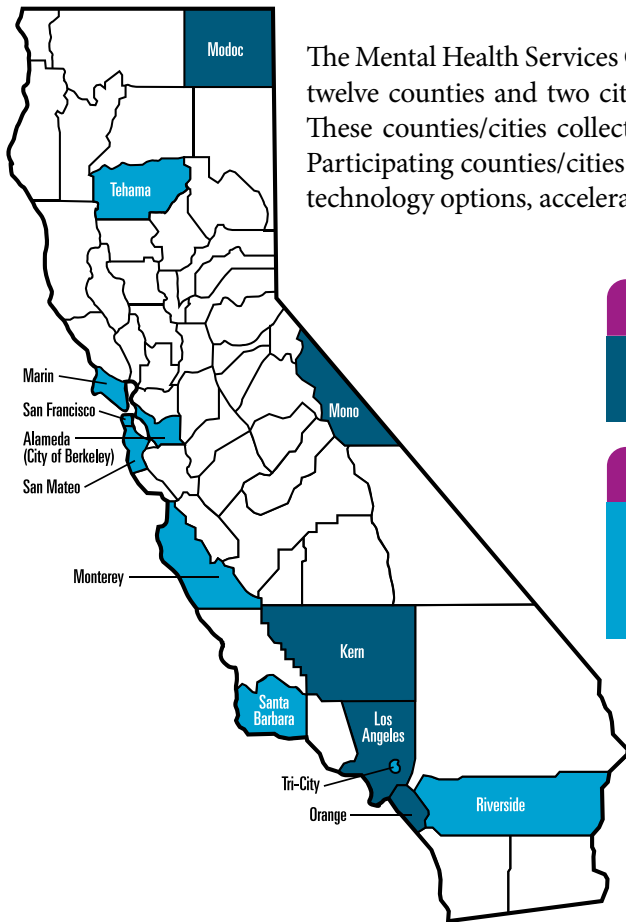
The Innovation Technology Suite (branded as Help@Hand in 2019) is a five-year¹ statewide demonstration funded by Prop 63 (now known as the Mental Health Services Act) and has a total budget of approximately \$101 million. It is designed to bring a set (or “suite”) of mental health digital therapeutic technologies into the public mental health system. The program intends to provide people across California with free access to high quality, digital mental health therapeutics. In addition, Help@Hand leads innovation efforts by integrating Peers² throughout the program.

The efforts of Help@Hand are guided by the following five shared objectives:

- 1
Detect and acknowledge mental health symptoms sooner;
- 2
Reduce stigma associated with mental illness by promoting mental wellness;
- 3
Increase access to the appropriate level of support and care;
- 4
Increase purpose, belonging, and social connectedness of individuals served;
- 5
Analyze and collect data to improve mental health needs assessment and service delivery.

¹ The project was originally designated as a 3-year effort.

² Help@Hand defines a Peer as a person who publicly self-identifies with having a personal lived experience of a mental health/co-occurring issue accompanied by the experience of recovery. A Peer has training to use that experience to support the people they serve.



The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved twelve counties and two cities across the state of California to participate in the program.³ These counties/cities collectively represent nearly one-half of the population in California. Participating counties/cities collaborate to develop a shared learning experience that expands technology options, accelerates learning, and improves cost sharing.

Cohort #1 Counties:

Kern County, Los Angeles County, Modoc County, Mono County, Orange County

Cohort #2 Counties/Cities:

City of Berkeley, Marin County, Monterey County, Riverside County, San Francisco County, San Mateo County, Santa Barbara County, Tehama County, Tri-City

ABOUT THE EVALUATION

The University of California, Irvine (UCI) in partnership with the University of California, San Diego (UCSD) is conducting a comprehensive formative evaluation of Help@Hand. The formative evaluation observes and assesses the program as it happens in order to provide real-time feedback and learnings.

This evaluation report presents learnings from Year 2 (January-December 2020). The report is organized as follows:

- **Summary of Activities – Describes key activities and milestones accomplished during the period**
- **Evaluation – Reports activities and learnings on:**
 - o System Evaluation
 - o Peer Evaluation
 - o County/City Technology, User Experience, and Implementation Evaluation
 - o Outcomes Evaluation and Data Dashboards
- **Help@Hand Evaluation Advisory Board Recommendations – Presents recommendations based on learnings**

³ Counties and cities can participate by submitting a proposal to the MHSOAC. Upon approval, counties and cities contract with CalMHSA, which serves as the administrative and fiscal intermediary for the program. Inyo County began participating in 2018, but later withdrew in 2018 due to insufficient internal resource capacity.

SUMMARY OF ACTIVITIES



Word cloud generated by Tech Leads to describe 2020

QUARTER 1 (JAN-MAR 2020)

Oversight and Help@Hand Leadership

- Published semi-annual report and presented update to the MHOAC (Help@Hand Collaborative)
- Approved pilot evaluation plan (Help@Hand Leadership)
- Convened Roadmap workgroup and Linguistic and Cultural Adaptation workgroup (Help@Hand Leadership)
- Announced resignation of Peer and Community Engagement Manager (CalMHSA)
- Created business continuity plans in response to COVID-19 crisis (Help@Hand Collaborative)
- Examined feasibility of statewide rapid response to COVID-19 pandemic (Help@Hand Collaborative)

County/City Activities

- Began exploring technologies and/or pilot planning (Los Angeles, Riverside, San Mateo, Santa Barbara, Tri-City)
- Presented 2nd edition of app guide to several stakeholders and worked on 3rd edition (Kern)
- Prepared to launch Take my Hand, a county-developed peer chat website (Riverside)
- Continued planning screening and referral tool (Monterey)
- Continued planning for Mindstrong implementation (Orange)
- Convened Digital Mental Health Literacy Train-the-Trainer workshop (Help@Hand Collaborative)

CRISIS

At the beginning of Year 2, the Help@Hand Collaborative made major strides to plan successful launches of technologies within their communities. Los Angeles, Riverside, San Mateo, and Santa Barbara Counties, as well as Tri-City, began planning pilots, which involved: exploring and vetting apps with staff, community members, and other stakeholders; meeting with vendors to learn more about their technologies; and engaging members of target populations with technology and the project through app guides, “AppyHours,” and other outreach activities. Riverside County prepared to launch a pilot of their own peer chat website, Take my Hand. Meanwhile, Monterey and Orange Counties continued to plan their technology implementations. The project management team consulted experts and developed templates, tools, processes, and guidance to support these various planning endeavors. A description of some support can be found in the spotlight on page 14.

In addition, workgroups were convened to operationalize key strategic project priorities as well as address linguistic and cultural community needs. A Digital Mental Health Literacy (DMHL) train-the-trainer workshop was hosted by CalMHSA and held in Kern County with 30 Peers. The workshop provided training on a number of topics, including CalMHSA’s digital mental health literacy curriculum and coaching sessions. CalMHSA also launched

- Held virtual Help@Hand Collaboration meeting (Help@Hand Collaborative)

Project Management

- Contracted with expert to provide clinical guidance for risk and liability (CalMHSA)
- Created and shared new vendor contract template and pilot proposal template (CalMHSA)
- Developed organizational change management tool, product matrix tool and Digital Behavioral Health Questionnaire (DBHQ) risk assessment tool (CalMHSA)
- Established pilot process and procurement process for county/city purchases (CalMHSA)
- Provided guidance for short code messaging and to operationalize Help@Hand branding (CalMHSA)
- Created interactive dashboard on project-related metrics
- Developed digital mental health literacy video series (CalMHSA)
- Launched HelpAtHandCa.org website (CalMHSA)
- Hosted webinar on Help@Hand for stakeholders and the general public (Help@Hand Collaborative)

QUARTER 2 (APR-JUN 2020)

Oversight and Help@Hand Leadership

- Approved 3 pilot proposals received from Los Angeles County (Help@Hand Leadership)
- Developed a rapid response option for counties/cities to deploy a rapid response solution in response to COVID-19 (Help@Hand Collaborative)
- Began recruiting for a new Peer and Community Engagement Manager (CalMHSA)
- Revisited project budget model, including evaluation scope of work (Help@Hand Collaborative)
- Approved and published grievance policy on Help@Hand website (Help@Hand Leadership)

County/City Activities

- Conducted college student needs assessment (Los Angeles, Help@Hand evaluation team)
- Explored technologies and/or planned pilots (Marin, Riverside, San Francisco, San Mateo, Santa Barbara, Tehama, Tri-City)
- Released Request for Information (RFI) to inform planning of screening and referral tool development (Monterey, Los Angeles)
- Began negotiating contract with MindLAMP to replace MindStrong for electronic diary card in Dialectical Behavior Therapy (DBT) program (Los Angeles)
- Launched Take my Hand COVID-19 Rapid Response (Riverside)
- Launched Headspace COVID-19 Rapid Response (Los Angeles)
- Began planning Headspace COVID-19 Rapid Response (San Mateo)
- Launched Mindstrong (Orange)

the Help@Hand website (HelpAtHandCa.org) and hosted a webinar to inform stakeholders and the general public about the Help@Hand program.

In March 2020, the program faced a major crisis with the arrival of the global COVID-19 pandemic and California's subsequent stay-at-home order. In response, CalMHSA actively worked with counties/cities to create business continuity plans and began to examine the feasibility of rapidly deploying technologies to immediately help communities during the COVID-19 pandemic. Several counties/cities quickly presented pilot proposals for Help@Hand Leadership approval in order to launch technologies to help communities. Others adapted planning activities for virtual formats. For example, Marin County and Tri-City began planning remote app exploration sessions with their target groups.

CALIBRATION

During quarter 2, the COVID-19 pandemic continued to impact the physical health, mental health, and economic security of individuals worldwide, and residents of the Help@Hand counties/cities were no exception. Meanwhile, the prevalence of systemic racism in the U.S. drew global attention, as high-profile cases of police violence erupted into an unprecedented series of sustained protests and civil unrest. While raising awareness and sparking dialogue on race and social justice issues, these highly traumatic public events also compounded the need for mental health and other much needed services in communities of color.

Several Help@Hand counties/cities worked tirelessly to explore technologies and plan technology pilots and implementations to meet community needs. In addition, the Help@Hand Leadership developed the Rapid COVID-19 Response framework in order to calibrate to the immediate needs of communities. The framework streamlined the process to launch technologies and allowed those counties/cities who were ready to deploy technologies to both target populations and the general public to quickly do so. Two counties— Los Angeles and Riverside – launched efforts via the framework. San Mateo County began to plan a launch of Headspace using the framework. While these counties pursued rapid response interventions, Orange County launched its Mindstrong implementation with psychiatric patients seen at UCI Health Psychiatry Services.

Meanwhile, many counties/cities paused activities while their local leadership assessed their organizational impacts amid the uncertainty brought about by the pandemic. These assessments helped inform how counties/

Project Management

- Developed Hybrid Pilot Implementation process (CalMHSA)
- Published product profiles to consolidate key information about RFSQ products and vendors (CalMHSA)
- Assessed current product certifications, licensures, and other accreditation of healthcare technology companies (CalMHSA)
- Developed Recommended Staff Expertise guidance and project onboarding materials for new Collaborative members (CalMHSA)
- Published Stakeholder Report on Help@Hand website (helpathand-ca.org)

QUARTER 3 (JUL-SEPT 2020)

Oversight and Help@Hand Leadership

- Onboarded new CalMHSA Executive Director (CalMHSA, Help@Hand Collaborative)
- Instituted new Help@Hand budget (Help@Hand Collaborative)
- Continued discussions on Help@Hand evaluation's scope of work (Help@Hand Leadership)
- Approved Tehama County's pilot proposal (Help@Hand Leadership)
- Approved funding for translation of six documents into Spanish (Help@Hand Leadership)

County/City Activities

- Began planning needs assessment with behavioral health clients (Orange, Help@Hand evaluation team)
- Explored technologies and/or planned pilots (Berkeley, Marin, Riverside, San Francisco, San Mateo, Tehama, Tri-City)
- Expanded implementation to allow more clinicians to refer patients to Mindstrong (Orange)
- Began developing Request for Proposal (RFP) development for screening and referral tool (Monterey, Los Angeles)
- Implemented Headspace using Rapid COVID-19 Response (Los Angeles, San Mateo)
- Assessed Take my Hand Rapid COVID-19 Response (Riverside)
- Announced pause in Help@Hand work until January 2021 (Tri-City)

Project Management

- Added county and city resources to the County Collaboration Center on SharePoint (CalMHSA)
- Began coordinating how to collect and share lessons learned with counties/cities (CalMHSA, Help@Hand evaluation team)
- Developed Digital Mental Health Literacy (DMHL) Planning Guide (CalMHSA)
- Adapted DMHL courses and supplemented Facilitator Guides for virtual delivery (CalMHSA)
- Developed video tutorial series on Zoom Features (CalMHSA)
- Worked on vendor contracts for Los Angeles, Orange, San Mateo, Tehama, Tri-City (CalMHSA)
- Designed Marketing Outreach Recommendations document (CalMHSA)
- Updated Helpathandca.org website and Help@Hand project dashboard (CalMHSA)

cities could adapt and re-calibrate Help@Hand activities. For example, Santa Barbara County paused their technology pilot planning to focus on impact of COVID-19 within the agency. During this pause, Santa Barbara re-directed its efforts on developing a Peer Ambassador Program.

COLLABORATION

Collaboration was discussed at the leadership level in quarter 3. In July 2020, CalMHSA's Board and the Help@Hand Collaborative welcomed a new Executive Director, Amie Miller, PsyD. As part of her on-boarding, she met with each county/city in order to understand their projects and strengthen collaboration.

Project activities also reflected greater collaboration during the quarter. Each county/city gathered lessons learned from their technology planning and implementations, which they began to readily share with other counties/cities in the Help@Hand Collaborative. Cross-collaboration learnings were shared on several weekly Tech Lead calls. Painted Brain, who subcontracted with a number of Help@Hand counties/cities, also shared learnings from these collaborations (see spotlight on page 17). CalMHSA and the Help@Hand evaluation team began to strategize for how to better collect and share lessons learned with counties/cities. A central county collaboration center was also created on SharePoint to save local resources for other to use as well.

In addition to collaborative learnings, technology collaborations were explored. For example, Monterey County partnered with Los Angeles County on the development of a screening and referral tool. Both counties discussed expanding their collaboration on the tool to other counties/cities. Similarly, several counties/cities discussed potential technology collaborations with Take my Hand, Mindstrong, and Wysa.

Lastly, collaborative solutions were created to address common challenges. For example, the Collaborative approved a subcontract with a translation vendor to ensure linguistic and cultural appropriateness—a common challenge among all counties/cities (see spotlight on page 21). CalMHSA also created several guides and tutorials to address another common challenge, helping counties/cities provide outreach virtually, while looking into addressing contracting challenges with technology vendors.

CONTINUATION AND CHANGE

Significant changes occurred at the end of Year 2. Kern and Modoc Counties announced they completed their projects and met their project objectives. As such, they

QUARTER 4 (OCT-DEC 2020)

Oversight and Help@Hand Leadership

- Separated from the George Hills Company (CalMHSA)
- Approved Marin County's pilot proposal (Help@Hand Leadership)
- Announced project completion (Kern, Modoc)

County/City Activities

- Conducted Deaf and Hard of Hearing Community needs assessment (Riverside, Help@Hand evaluation team)
- Explored technologies and/or planned pilots (Berkeley, Marin, Riverside, San Francisco, San Mateo, Tehama, Tri-City)
- Began planning Headspace Rapid COVID-19 Response (San Francisco)

Project Management

- Initiated thorough research on resources to help inform a county/city's approach to equitable device distribution (CalMHSA)
- Developed and shared a communication plan template to accompany new project artifacts so that the purpose, goal(s), and objectives of each new item are clear and can be shared with the Collaborative (CalMHSA)
- Updated website based on initial feedback (CalMHSA)
- Translated and shared the Digital Mental Health Literacy curriculum from English to Spanish (CalMHSA)
- Shared insights on Terms of Service development (Riverside)

The noted list of activities is meant to describe programmatic highlights and does not necessarily reflect all effort across the various levels of the program.

would transition off Help@Hand. In addition, CalMHSA separated from George Hills, a firm who had provided CalMHSA administrative functions for several years. The separation involved some initial disruptions, such as issues with the projects website and SharePoint as well as CalMHSA's email and Zoom accounts.

At the same time though, counties/cities continued to make significant strides with their project planning, pilots, and implementations. For example, Marin County developed pilot plans, which were reviewed and approved by the Help@Hand Leadership. Additionally, some counties/cities also explored and planned new technology launches. A needs assessment was conducted with Riverside County's Deaf and Hard of Hearing Community. New technologies were also explored with Riverside County behavioral health clients.

Despite unexpected challenges in Year 2, the Help@Hand program has had many successes and learnings that poised them for continued progress in Year 3.

SPOTLIGHT

Foundational Knowledge

Authors: Kim Tarabetz, Help@Hand Organizational Change Management Manager; Erik Newland, Help@Hand Implementation and Product Consultant; Brittany Ganguly, Help@Hand Program Manager

The Help@Hand project seeks to build a complementary support system that offers a bridge to care, helps identify early signs of mental health changes, offers timely support, removes barriers, and seeks to include new avenues of care for communities not connected to conventional county services. In the implementation of emerging technologies in the behavioral health space, Help@Hand, through a collaborative of California cities and counties, hopes to enable this complementary support system. A primary component of the project is the identification and evaluation of feasibility to implement these technologies within the regional government structures.

In order to be successful, Help@Hand has identified the need to provide and support implementation of behavioral health applications through technology industry methodologies and standards, project management, and organizational change management (OCM).

TECHNOLOGY

Technical Basics

In supporting innovative technology applications representing the latest and greatest products, it is critical that collaborative partners and decision makers have the foundational knowledge of software system engineering, methodologies and best practices in order to make informed decisions.

Some of these practices include:

- Understanding of technology industry common vernacular and language
- An overview of the Software Development Lifecycle (SDLC) and the steps involved
- Agile and Waterfall software development methods
- The importance of testing, even with an off-the-shelf product, to verify the technology meets government regulations and standards, as well as consumer needs
- Roles and responsibilities in software development as the custodians and implementers of products

Expectations

Setting expectations and needs around the support infrastructure for technology applications and implementations is critical. The identification of partner vendors and purchasing of technology applications is not enough. Successful implementation and supporting consumer adoption requires a lot of work. This includes supporting administration and compliance with city, county, and state standards. Understanding and supporting the difficulty and complexity of technology in terms of the level of support required to make decisions, negotiate partnerships, make changes (e.g. translations, customizations with city and county specific information), and navigating local and state policies and standards.

Deploying a product that is successfully launched and used by the community requires cities and counties to find the right solution and take the right approach to meet the needs of their community. This includes understanding local risk tolerances, the number of changes to a product that is needed and weighing the pros and cons of finding that right solution.

Some of the Tactics Help@Hand Used:

- Overview of Agile Methods
- SDLC Panel Discussion
- Digital Behavioral Health Questionnaire
- Product Vendor Profiles
- Product Vendor Security Questionnaire
- Digital Mental Health Literacy
- Facilitating vendor and City/County planning discussions



CHANGE MANAGEMENT

What is Change Management

Organizational Change Management (OCM) is support for the people-aspect of change projects. Adoption of new technologies and supporting communities that may not be as familiar with innovative technology requires a great deal of effort to establish common goals, align expectations and keep stakeholder apprised of the project. While a significant level of effort, this level of engagement is essential to be a good partner to project stakeholders and the communities served, as well as to mitigate the risk of future hurdles that may arise when a stakeholder group is uninformed. At the collaborative and local levels, Help@Hand has identified and supported the need to draw from industry subject matter experts and integrate change management throughout the project.

Communication

Communication is vital to stakeholders and the communities that are being served by technology. The frequency of communication is often much greater than anticipated, both within the city and county internal networks and to community members. However, communication is not a 1-way channel. Feedback from the collaborative members on project expectations and where there may be a lack of clarity is crucial to refining communication approaches including channels and messages. In addition, feedback and engagement from the stakeholder community to inform technology product selection is equally vital in helping counties select a product that resonates with their communities.

Alignment

In all projects, but especially in a collaborative setting, alignment is a tremendous influence on how successfully the project moves forward. Simply put, alignment means project leaders and decision-makers have a unified perspective of what it means for the project to be successful and they work together to achieve that goal. On a complex and collaborative project, this becomes even more challenging partly due to the larger number of decision-makers and key stakeholders, including community stakeholders, Peers, oversight agencies, budget, risk, legal, and technology.

- Take time to build common goals & expectations and check back on them frequently
- Recognize internal partnerships (IT, Peers, Legal, Program)

- Recognize external partnerships (Collaborative members, Stakeholders, CBOs)
- Anticipate areas of concern or potential resistance by gathering regular feedback and proactively addressing areas of concern as they arise

Stakeholders

Identification and support of stakeholders to provide guidance and transparency in technology selection and evaluation is a necessity. This requires significant organizational change needs and communication strategies. As a public innovation project supporting the behavioral health community, Help@Hand has worked to increase stakeholder involvement through focus groups, regular status reporting and creating forums for open discussion. Stakeholder groups include Peers, community, government oversight and evaluation

Some of the Tactics Help@Hand Used:

- OCM Plans
- OCM Training
- OCM Coaching
- Lesson Learned
- Highlighted Examples from Other Counties
- Collaborative Roadmap
- Executive Alignment Workshop
- County Strategic Plan Template
- Stakeholder Webinar & Report
- Local Stakeholder Meetings
- Polling during tech lead calls



SPOTLIGHT

Painted Brain: Working with Multiple Counties to Address Digital Literacy

For Santa Barbara and San Mateo counties, digital literacy became a critical issue in Year 2 of the Help@Hand program. While efforts were being taken towards the implementation of the Help@Hand program, for both counties, it became increasingly clear that many in their communities did not know how to use a smartphone or tablet – let alone understand how to use an app that is on that device. With such a gap in understanding, both counties understood that raising digital literacy was key to the success of the program. Painted Brain, an organization with a history of teaching digital literacy in behavioral settings and with vulnerable populations, was separately contracted by both counties to address this gap. Painted Brain, according to Rayshell Chambers, Chief Operating Officer and one of the original founders,

“ Meets people where they are at. They understand the needs of communities of color and other disenfranchised communities and being able to develop the curriculum and other outreach and engagement strategies that are culturally responsive and linguistically appropriate to address the digital divide in isolated communities and counties across the state of California. ”

Santa Barbara

Painted Brain was contracted by Santa Barbara to integrate digital literacy into traditional mental health settings. To do this, Painted Brain provided four services – designing a brochure, training Santa Barbara’s workforce, developing a digital literacy curriculum for the TAY community, and providing ongoing technical support, Appy Hours. The impact of these services has been substantial. Although in different formats, digital literacy support has been provided in Santa Barbara County to older adults, TAY, adults and youth leaving a hospital after a psychiatric hold, and Santa Barbara County’s peer workforce.

● Brochure

To support individuals with mental health issues, Painted Brain in collaboration with Santa Barbara created a brochure, Guide to Wellbeing Apps. Based on Painted Brain’s assessment and evaluation of several mental health apps, this brochure lists 12 apps that support overall wellbeing. Other resources are also provided including contact information those in crisis or suicidal,



Lifeline, a 24-hour toll-free Access line, and a QR code to access Santa Barbara County's Mental Health, Alcohol & Substance Use Information, Referrals & Crisis Support website and information about the 8 Dimensions of Wellness. This brochure along with a smartphone are given to adults and youth getting out of hospitals on psychiatric holds.

8 Dimensions of Wellness
The Eight Dimensions of Wellness take into account not only an individual's physical health, but all the factors that contribute to a person's overall wellness. To learn more about the Eight Dimensions of Wellness, visit: www.santabarbaracounty.gov

EMOTIONAL
Coping effectively with life and creating satisfying relationships.

SOCIAL
Developing a sense of connection, belonging, and a well-developed support system.

PHYSICAL
Recognizing the need for physical activity, diet, sleep and nutrition.

SPIRITUAL
Expanding your sense of purpose and meaning in life.

INTELLECTUAL
Recognizing creative abilities and finding ways to expand knowledge and skills.

OCCUPATIONAL
Personal satisfaction and enrichment derived from one's work.

FINANCIAL
Support in budgeting and accounting for all expenses.

ENVIRONMENTAL
Good health by occupying pleasant, stimulating environments that support well-being.

Headspace
Supports emotional, spiritual, environmental wellbeing through guided meditation for sleep, stress, anxiety, depression, and overall wellness.

Lumosity
Enjoy playing games to help improve your focus, problem-solving, and memory in an interactive way backed by science to support your intellectual wellbeing.

Khan Academy
Build a deeper understanding in math, grammar, science, history, SAT/ACT, school loans, tax filing, resume-building, and more to support your intellectual and occupational wellbeing.

Hoopla
Borrow digital movies, music, eBooks and more, 24/7 for all devices with your public library card to support your intellectual, emotional, and environmental wellbeing.

Picture This
Instantly identify plants, their descriptions, and plant care tips. Enjoy beautiful plant pictures around the world to support your environmental and social wellbeing.

Fooducate
Enjoy thousands of recipes to improve your health, and learn more about healthy eating to support your physical and emotional wellbeing.

CALWIN
This app helps California residents with medical insurance, food, financial aid, and job skills assistance to support your financial, occupational, and overall wellness.

MindShift
Develop more effective ways of thinking and use active steps to take charge of your anxiety to support your emotional wellbeing.

7-Minute Workout
Workout anywhere and anytime in a way that is fast and simple to support your physical wellness.

Mango Health
Create a schedule of healthy habits, including taking medication on time, checking blood pressure/glucose level, and more to support your physical wellbeing.

Meeting Guide
Stay informed and connected to your local and world-wide Alcoholics Anonymous community to continue gaining the support you need for your overall wellness.

NA Meeting Search
Stay informed and connected to your local and world-wide Narcotics Anonymous community to continue gaining the support you need for your overall wellness.

These Apps have been assessed and used by local peers of Santa Barbara County.

The Apps listed are digital tools to support your overall wellbeing.

Workforce Training

Painted Brain also trained the Santa Barbara County Department of Behavioral Wellness' peer workforce. The purpose of the training was twofold. The first goal of the training was to enhance the digital literacy skills of Santa Barbara County's peer workforce. The second goal of the training was for Peers to have the skills to support client's use of digital devices. In other words, the purpose of the training was for Peers to become proficient in the use of digital devices as well as learn how to support others in their use of mobile devices. To fulfill both goals, Painted Brain used a train-the-trainer model that fits the needs of the community members they serve. A digital health curriculum created by Painted Brain that covered such topics as setting up a gmail account, downloading an app, and using a phone camera provided the structure of the training. To assure that Peers would be able to support their specific community members, lessons were framed within the context and the community that Peers would be working in. Peers who completed the training became the first cohort of peer digital ambassadors – a new role created for the Help@Hand program. Equipped with digital understanding and the skills to teach others the same, the next step for peer digital ambassadors will be to use the curriculum to facilitate groups on digital wellness.

Appy Hours

Appy Hours is a regular opportunity for older adults in the Santa Barbara area to learn and optimize their mobile device knowledge. Specific topics, such as how to scan a QR reader and creating a YouTube account as well as opportunities for attendees to ask specific questions are given. Adapted from the in-person Appy Hours offered prior to covid, Appy Hours take place online via Zoom. Knowing the importance of making what can be a stressful topic fun, informative and engaging, Painted Brain includes games, polls, music, videos, and opportunities to win gift cards throughout the event.

Their efforts appear to be successful too. Chambers explained that Painted Brain has received positive feedback from those who attend the Appy Hours and from family members whose parent attends them too. As an example, Chambers shared that one family member described the impact of the Appy Hours on their mother as “transformational” and that it raised her “confidence”.

● TAY curriculum

Most recently, Painted Brain has been contracted by Santa Barbara County to create a digital health literacy curriculum for the TAY community. Still in the design phase, the focus of the curriculum will be digital wellness and recovery. It will cover the topics of recovery & resilience; online safety practices; and basic computer skills. Gaby Garcia, Program Analyst for Painted Brain explained that “each topic will focus on how technology can support TAY’s overall wellness”. To guide the development of the curriculum, Painted Brain, in collaboration with local colleges, is hosting listening sessions with TAY throughout the region. According to Chambers the listening sessions have been informative. Within the TAY community they’ve heard from TAY who “saw no purpose of basic digital literacy skills – like email set-up and email maintenance. Then, there were TAY at the community college that said we need this so bad”. For the TAY who wanted to learn about digital literacy, they are interested in learning about email maintenance as well as using email for personal advocacy and professional use. The advantages Painted Brain gains from the listening sessions expand beyond using responses to develop the curriculum. It also is a unique opportunity for Painted Brain to share what they learned with Santa Barbara County colleagues.

San Mateo

Painted Brain’s work with San Mateo began after the County had launched the distribution of mobile devices to community members. Having quickly mobilized the requisition and begun the delivery of smartphones or tablets to community members, San Mateo learned that the challenges to the effort were not logistics, instead it was the support that individuals were seeking from the peer workers who were delivering them. That is, peer workers were reporting that when they delivered the mobile devices, they were being asked questions about how to use the devices – how to turn it on, how to make phone calls, etc. While willing to help, Peers were not skilled at offering digital support. Recognizing that there was a need for digital literacy training within their community, San Mateo, who had heard about the positive work that Painted Brain was doing in other Counties, decided on a plan that would meet the needs of their workforce and the community they served. Like Santa Barbara, they chose to contract Painted Brain to train their workforce on digital literacy. With this training, Peers, in turn, would be able to use their newly acquired digital literacy skills to support the San Mateo community.

● Workforce Training

Painted Brain chose to use a train-the-trainer model for the workforce training. As they did with the Santa Barbara peer workforce training, Painted Brain taught topics from their digital literacy curriculum including online security and privacy, introduction to digital peer navigation, email set-up and maintenance on a computer and a mobile device as well as telehealth. Importantly, the training was geared toward San Mateo County’s needs. Painted Brain, first, identified community needs then during the training incorporated topics that the peer workforce had already encountered while distributing mobile devices. As Painted Brain staff member, Rashawn Morris, explained “I think the main thing is that we’re trying to come from the perspective of what their Peers may need and what Peers themselves are going to need to train others”. He also explained that “The whole time we are going through different training modalities to support people even wanting to be a part of this digital world”.

Two trainings were completed by the end of 2020. The first was for the County peer workforce while the other was open to the workforces of the organizations that San Mateo has contracted with for the distribution of the mobile devices. Morris summarized training participants in the following quote “both times they’ve been very receptive to the information we are giving, and they have also been able to speak on their experience”. Both trainings received positive feedback.

● Next Steps

For 2021, San Mateo will continue using Painted Brain to offer digital literacy education to their community. Digital literacy education will be offered in three contexts. First, another set of workforce trainings will be offered to the organizations that are assisting with the distribution of the mobile devices. Second, an intermediate

level training on online platforms and facilitation methods will be provided for community organizations. Last, Painted Brain will host online Tech Cafés to all San Mateo County community members. This additional work has the potential to greatly impact the County. As explained by Chambers “We’re hitting three sectors of their population. We’re hitting internal peer workforce, their community-based organizations(their contractors) and we’re hitting their communities”.

● Workforce Trainings

A total of 18 organizations have received mobile devices for their clients, with over 1,000 devices having been distributed. The need for digital literacy education has been noticeable by many in the workforce. To support workforces from all organizations, Painted Brain will replicate the Fall 2020 trainings. Two additional trainings will be offered. Chambers explained that the goal of the trainings is to “build their current workforce’s capacity to understand digital literacy topics and be able to interact and work with clients around digital literacy topics”.

● Tech Cafés

With the peer workforce trained in digital literacy, San Mateo County Health learned that community members were routinely reaching out to them for technical support. Workforce trainings had focused on peer workers having the skills to support individuals in the first steps of using a mobile device. They weren’t, however, supposed to become technical support. To address this need, Painted Brain will host Tech Cafés. Similar to the Appy Hours provided in Santa Barbara, Tech Cafés will cover various digital literacy topics, address questions, and engage attendees with games, polls, music and opportunities to win gift cards. Tech Cafes are offered community-wide.

● Zoom Training

To support community-based organization providers who had shared during a townhall on race and equity that they too struggled with technology, apps and offering support services online, Painted Brain will develop and provide an online facilitation training. Still in development, Chambers explained that the training would “provide the opportunity for participants to learn the various aspects of the teleconferencing platforms as well as group facilitation techniques that supports individuals social and emotional well-being, behavioral health, physical health, and workforce development. Training will discuss the intersection between the need for: technical skills to conduct virtual groups and the employment of inclusive facilitation techniques that are grounded in anti-racist and equitable practices”. The training is planned to be at an intermediate level. Examples of topic include using the chat box, creating community agreements, facilitation from a racial equitable lens, and encouraging participation.

SPOTLIGHT

A Collaborative Driven Approach to Language Vendor Selection

Authors:

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Introduction

One of Help@Hand's principles for collaboration is to "Maintain accountability and transparency with all stakeholders." Included in this initiative is ensuring language access. Spanish is the most common threshold language across all the Collaborative Counties and Cities. So, in the Spring of 2020 during a Tech Lead Collaboration Meeting the members decided to solicit a vendor to translate major stakeholder update materials from English to Spanish.

CalMHSA supported collaborative members by providing recommendations for vendors to work with, developing the scope of work, and supporting the contract process to execute the translation work.

The Collaborative materials in this scope of work included the:

- Stakeholder Update Report (Q2 2020)
- Help@Hand Update to the MHSOAC (Q4 2019)
- Digital Mental Health Literacy (DMHL) Curriculum
- Digital Mental Health Literacy video series
- Help@Hand webpage

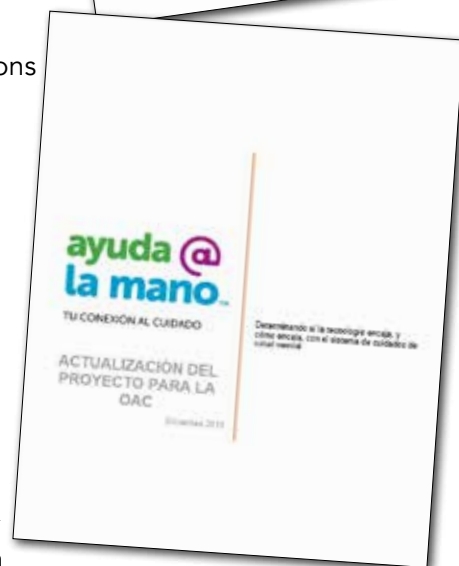
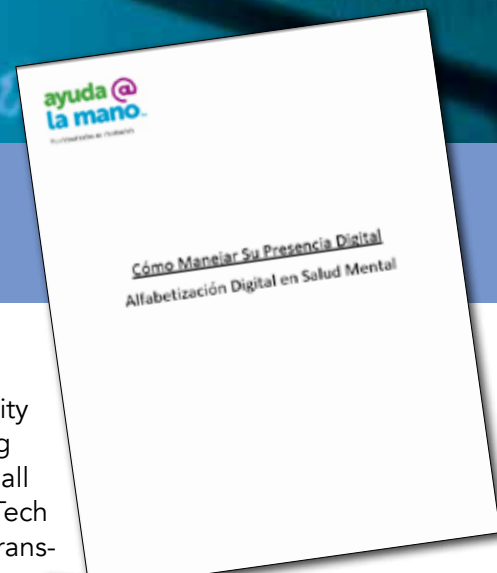
The overall process for this initiative included:

1. CalMHSA research cost and vendor qualifications for the scope of work
2. Get feedback from the Tech Leads/Collaborative on vendor selection
3. Collaborative vote for vendor approval

Informed decision making

Collaborative members shared their requirements to assess language translation vendors with the CalMHSA team during Tech Lead calls. These requirements informed CalMHSA's approach to solicit vendors and communicate the project needs with potential vendors.

Initially CalMHSA researched and provided three recommendations for vendors the collaborative could work with. Upon presenting this information during a Tech Lead call, collaborative members requested more information on the vendors, such as work samples, and shared additional requirements they were looking for vendors to fulfill. This prompted CalMHSA to receive additional vendor recommendations from the Cities and Counties and reach out to the vendors that better met the Collaborative's needs. Throughout the process Collaborative members were encouraged to voice any questions they had for the vendors to the CalMHSA team who consolidated these questions to communicate out to the prospective vendors.



The Collaborative outlined the following requirements of vendors:

- Vendors provide their background experience and/or certification.
- Vendors have experience with behavioral health subject matter and vocabulary to trust that they would capture nuances in the language.
- Vendors provide samples of their work as part of the vendor selection process.
- That the translation process has a “back translation” step included.
 - This was specifically outlined as: Person A will translate the document, Person B will back translate the document, then A+B will confer.

After collecting this information from each vendor under consideration, CalMHSA compiled packets for Collaborative members to review.

These packets included:

- The vendors quote(s) for the outlined scope of work
- File(s) documenting the vendor’s certification and/or background
- Up to 3 samples of the vendor’s work.

The collaborative discussed the vendor selection and translation process at the following Tech Lead meetings:

- April 4, 2020 – Initial translation discussion with expectation setting
- May 19, 2020 – Scope of work outlined
- June 19, 2020 – Presentation of research and vendor recommendations
- July 14, 2020 – Update on vendor quotes and expertise and follow up discussion
- July 21, 2020 – Back translation process outlined
- August 18, 2020 – Presentation of three additional vendor recommendations
- August 25, 2020 – Reminder to Collaborative to send their rank order choices of the translation vendors

After the vendor option packets were shared with the collaborative, members voted in rank order for their top two vendor choices. These votes were collected by CalMHSA to tally. The results were shared with the Collaborative and confirmed during a Tech Lead Collaboration meeting announcement. Following the vendor selection choice by the collaborative, CalMHSA entered a contract with the vendor for the elected translation services.

Lessons Learned

Each county/city has their own local process for document translation, through the vendor selection process CalMHSA learned some cities/counties have more resources to translate their materials than others, resulting in different expectations for working with vendors. A few Collaborative members shared they typically outsource the work to translate materials to Spanish, but that they also build the “back translation” step into the process, while others use internal staffing resources to translate documents. Consensus showed that having Collaborative wide stakeholder materials translated with CalMHSA’s support was the best way to uphold the project level principle of accountability and transparency.

A best practice recommendation from this process is to understand the city/county’s process for the work before shortlisting potential vendors. This will help to ensure the vendor selections meet all collaborative members’ minimum criteria. For example, the first three vendors CalMHSA shortlisted did not provide samples of their work. The collaborative provided feedback that receiving samples is a standard practice in their county and city processes prompting CalMHSA to find additional vendors that were willing to provide work samples. These additional vendors ultimately made it on the short list that the Collaborative chose from.



Hello!



¡Hola!

1 SYSTEM EVALUATION

Key Points

- User experience of apps reviewed in the market surveillance suggest that many mental health apps offer interesting, engaging, and easy-to-use support. However, limited accessibility features (e.g. languages, assistive technologies, and internet requirements) indicate that not everyone can get on-demand support from these apps and may face barriers beyond ease of use.
- User experience, downloads, and engagement were higher for chatbot apps than for meditation or peer support apps. This may mean that people are more likely to download and use apps with better user experiences.
- Digital phenotyping, an approved component of Help@Hand technologies, is not a widely available feature in publicly available mental health apps. Many digital phenotyping apps are still in the research and development phase.
- Apps identified through Help@Hand's most recent Request for Statement of Qualification (RFSQ) tended to underperform in the marketplace in terms of number of downloads and number of monthly active users.

OVERVIEW

This section focuses on evaluating system-related factors that may affect Help@Hand. It presents evaluation activities and learnings from the market surveillance, as well as the status of the environmental scan and the collaborative process evaluation.



The **market surveillance** is a review of apps within and outside of Help@Hand. In Year 2, three types of apps were reviewed (meditation, peer support, and chatbot apps) and assessed for their accessibility, user experience, and marketplace performance. In addition, the market surveillance includes a review of chatbot app features, digital phenotyping platforms, products from Help@Hand's recent Request for Statement of Qualification (RFSQ), and various learning briefs shared with the Help@Hand Collaborative in Year 2.



An **environmental scan** monitors public perceptions of mental health documented through key media events. It understands how international and local events (e.g. a celebrity opening up about their mental health struggles or a traumatic world event) may impact Help@Hand.



The **collaborative process evaluation** takes into consideration the processes, interactions, and collaboration across the Help@Hand counties/cities and stakeholder groups.

MARKET SURVEILLANCE

For the Help@Hand program, counties/cities must implement mental health technologies that meet the approved components shown in **Figure 1.1**. In Year 2, counties/cities considered three types of apps that met these criteria: meditation apps, chatbot apps, and peer support apps.

Figure 1.1. Approved Components of Help@Hand Technologies⁴

Peer Chat and Digital Therapeutics:
Use technology-based mental health solutions to intervene and offer support

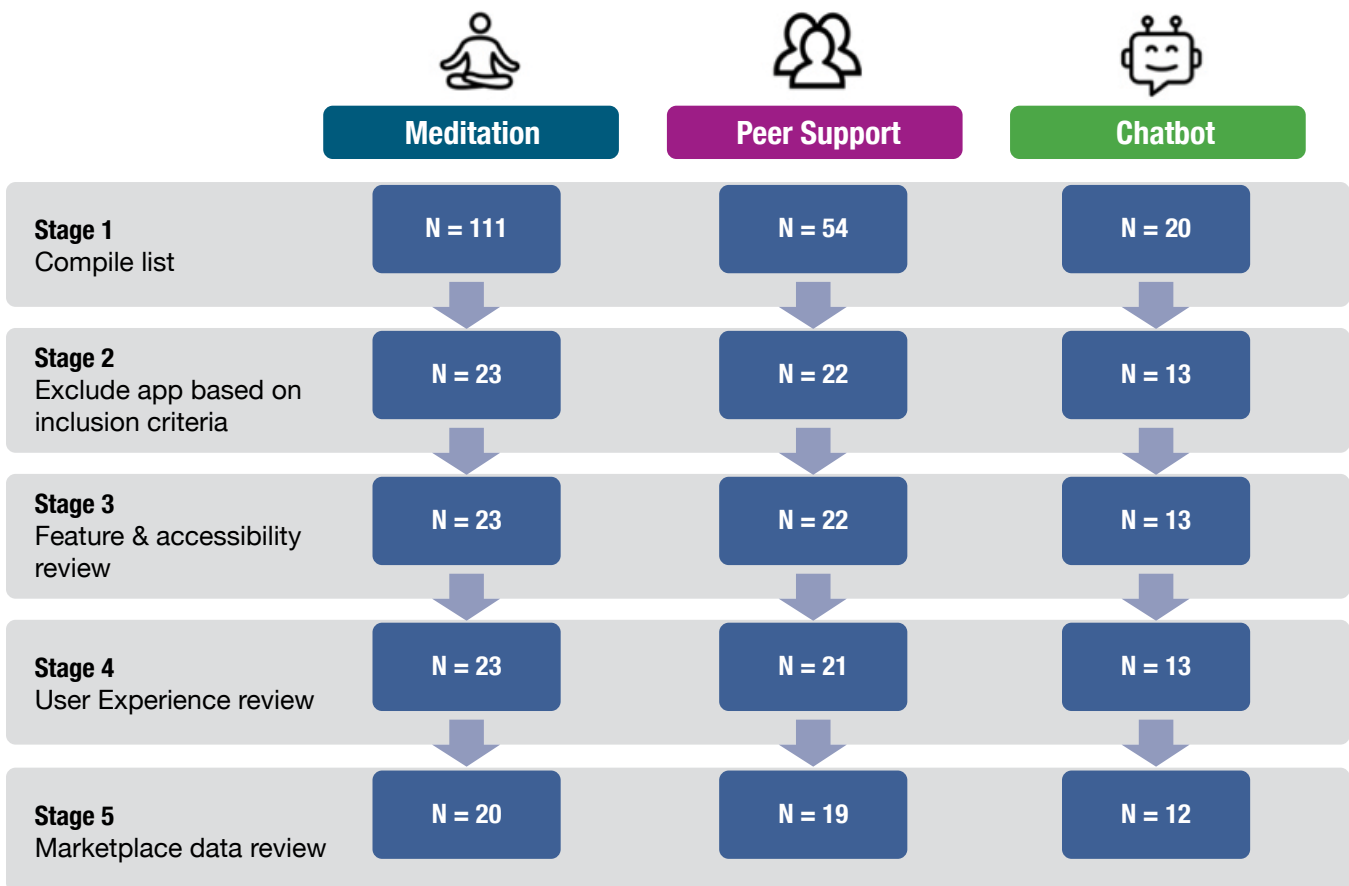
Virtual Evidence-Based Therapy Using an Avatar:
Use an avatar or other technologies for self-care

Digital Phenotyping:
Use passive data for early detection and intervention

⁴ Definitions of required components are from the RFSQ Vetting Process and Scoring Tool Criteria.

These apps were reviewed in the market surveillance in order to help counties/cities understand what the apps can offer, how they are being used, and to provide evaluation benchmarks. **Figure 1.2** illustrates the review process for these three types of apps.

Figure 1.2. Market Surveillance Review Process



Market Surveillance Review Process

- **Stage 1-** The evaluation team compiled a broad list of apps for each review based on app store searches and the team's expertise in digital mental health.
- **Stage 2-** The team excluded apps not meeting the inclusion criteria.⁵ Fewer criteria were applied to the chatbot list since there were only a few chatbots available in the app marketplace.
- **Stage 3-** The team downloaded and explored the apps to determine the presence or absence of various features, including accessibility features (e.g., language, internet access, and assistive technology).
- **Stage 4-** The evaluation team had experts and consumers review the user experience of apps using the Mobile App Rating Scale (MARS), a well-known, validated, and standardized tool that assesses the engagement, functionality, aesthetics, and information quality of health apps (Stoyanov et al, 2015).
- **Stage 5-** The team gathered marketplace data (e.g., the number of monthly active users and downloads for each apps over the past year) from Apptopia, a third-party analytics platform.⁶

⁵ The inclusion criteria for meditation and peer chat apps were: 1) available on both iOS and Android; 2) updated within the last 12 months; and 3) has either meditation or peer support as its primary feature. The inclusion criteria for chatbot apps was that it had a chatbot component as it's primary feature. Because there were fewer chatbot apps available in the marketplace to begin with, fewer criteria were applied to narrow down the chatbot app list.

⁶ Apptopia, Marketplace data was not available for every app because apps needed to rank within the top 1500 apps for iOS and within the top 200 apps for Google Play in order to have marketplace data available on Apptopia. This explains why the number of apps reviewed in stage 5 differed from stage 3 and 4. In addition, the number of apps differed between the stages because apps are frequently added and removed from the marketplace.

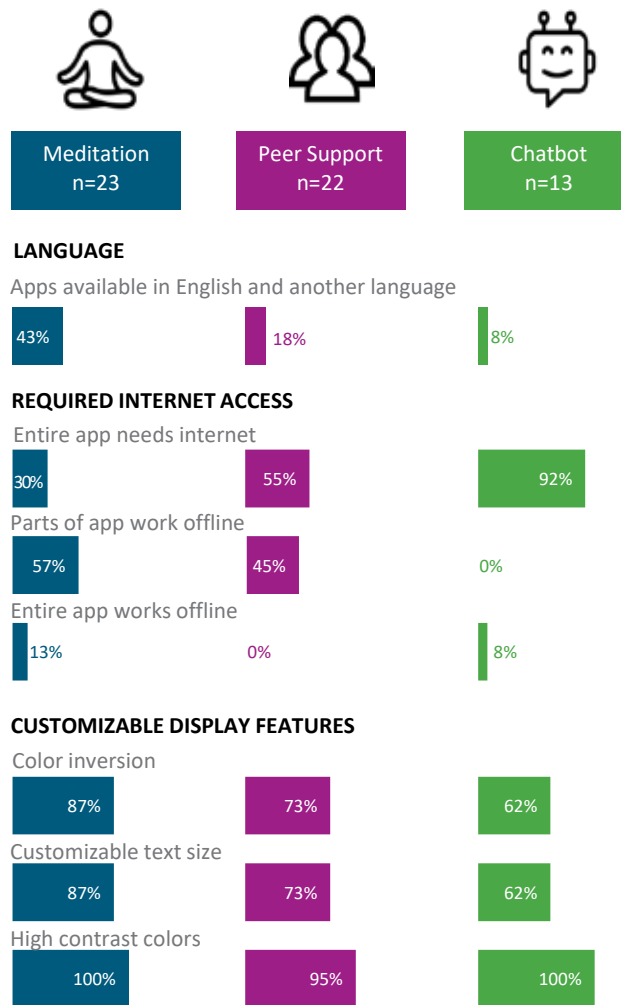
Accessibility, User Experience, and Marketplace Data Reviews:

ACCESSIBILITY

Accessibility means making apps easy to use for a broad range of people. If apps are only easy or possible to use for some people and not others, this can widen the gap in access to care. The accessibility of meditation, peer support, and chatbot apps was reviewed with respect to language, internet access, and customizable display features.

Figure 1.3 compares language availability, the need for internet connection for full or partial functionality, and customizable display features across all apps. Key learnings are presented below.

Figure 1.3. Accessibility Reviews of Meditation, Peer Support, and Chatbot Apps



App Accessibility Review - Key Points

Language: The majority of apps were available in English only. Note that even when different languages are available, this does not always mean that the app is culturally appropriate. It simply means that the text has been translated.

Required Internet Access: The majority of meditation, peer support, and chatbot apps reviewed need internet connectivity and could not be used without internet access. This can be a problem since some people may have inconsistent or limited internet access. Some meditation and peer support apps had parts that were available offline. For example, almost half (45%) of peer support apps had some content, such as assessments and journals available offline, but not the peer support forums or chatrooms themselves.

Customizable Display Features: For most apps, screen readers could only read some, but not all, of the app content. This means that users who need the text to be read aloud to them cannot use every part of the app. The ability to change text size, contrast, and colors can allow someone to read text on screen more easily.

USER EXPERIENCE REVIEWS

User experience means the overall experience one has when using an app. Questions to consider include:

- Is the app easy to use?
- Does the app work properly?
- Is the app interesting and fun to use?
- How good does the app look?
- Is it interactive?
- Is the content well-written and accurate?

User experience of mental health apps can be assessed through the Mobile App Ratings Scale (MARS; Stoyanov et al., 2015), which can be found in **Appendix B**. For each app reviewed in Year 2, two experts and one consumer used the MARS to assess the user experience of each app. Experts had extensive experience in user experience and mental health app reviews. Consumers were individuals who had lived experience with mental health challenges.

Figure 1.4 details both the expert and consumer scores for the chatbot apps reviewed. Note that while the MARS tool gives a total score out of 5.00, the developer of the tool states that a score of 4.00 can indicate high-quality apps. The majority of chatbot apps (77% expert rated, 62% consumer rated) scored higher than 4.00. **Appendix C** shows the expert and consumer user experience scores for meditation and peer support apps.

Figure 1.5 shows combined user experience scores across meditation, peer support, and chatbot apps to allow for comparisons. User experience was rated higher in chatbot apps than meditation and peer support apps. This suggests that chatbot apps have the best user experience. That said, there were fewer apps (N=13) in the chatbot group than the meditation and peer support group, so readers should be cautious when interpreting these results.

Figure 1.4. Expert and Consumer User Experience Reviews of Chatbot Apps

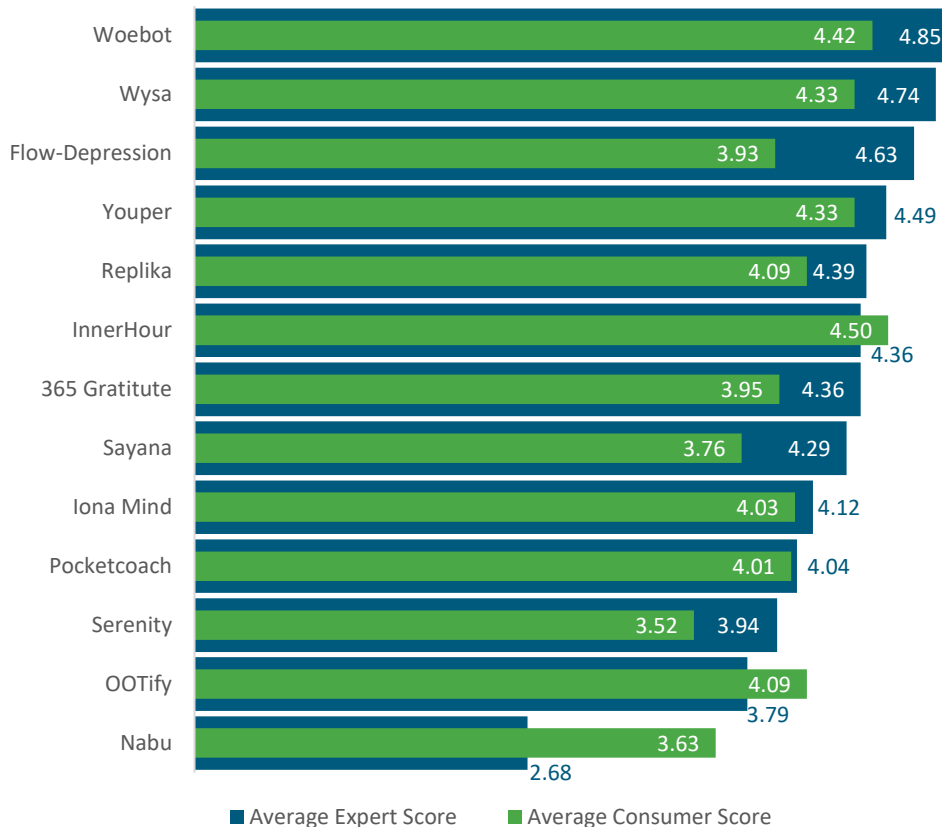
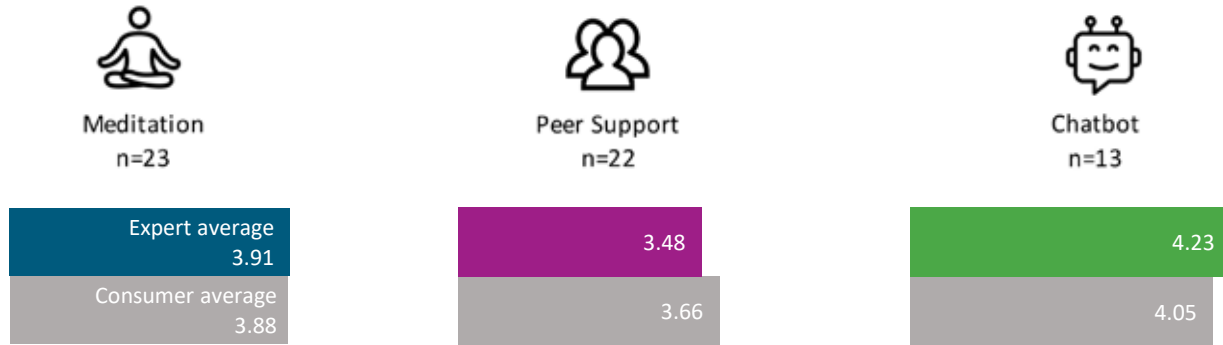


Figure 1.5. Average User Experience Reviews for Meditation, Peer Support, and Chatbot Apps



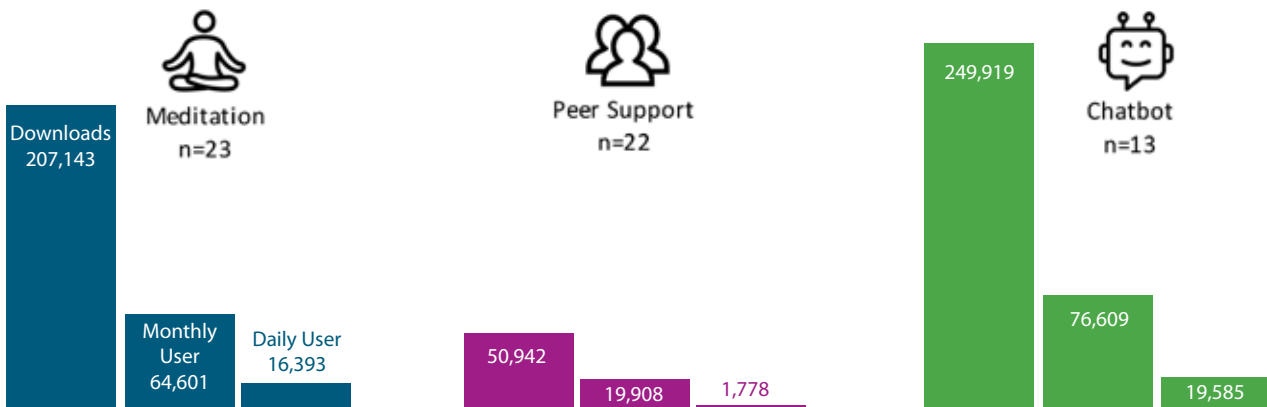
MARKETPLACE DATA REVIEW

Finally, marketplace data was reviewed to explore how people engage with and use these products. **Figure 1.6** compares the following metrics across meditation, peer support, and chatbot apps⁷:

- **Downloads:** The number of new users downloading the app for the first time.⁸
- **Monthly Active Users (MAU):** The number of users who opened the app at least once in a 30-day period
- **Daily Active Users (DAU):** The number of users who opened the app at least once in a day

Figure 1.6 shows that chatbot apps have higher median number of downloads and engagement (both MAU and DAU), compared to meditation and peer support apps. However, 1) there are fewer chatbot apps than meditation and peer support apps available in the marketplace, and 2) the highest performing apps in terms of downloads and engagement belong to the meditation category (Calm and Headspace). Meditation and peer support apps therefore have both very high and very low performing apps whereas chatbot apps tend to perform more consistently well.

Figure 1.6. Median Downloads, Monthly Users, and Daily Users of Meditation, Peer Support, and Chatbot Apps



⁷ Ns noted in the figures represent the number of apps in each group with marketplace data available for both iOS and Android, which is why there are some differences between the Ns here and those reported elsewhere.

⁸ If a user gets a new phone or re-downloads the app, it still counts as one download.

Feature Review: Chatbot Apps

Meditation and peer support apps were reviewed in previous evaluation reports and can be found in **Appendix C**. This section provides a feature review of chatbot apps.

The goal of chatbots most often is not to make users think they are talking with a real person. Although they are sometimes called “virtual therapists,” they are not a replacement for a therapist or other provider. Instead, chatbots may be helpful when used: 1) in addition to an existing professional care; 2) while someone waits for an appointment with a provider; and 3) to support overall wellness, rather than to treat mental health symptoms.

The evaluation team conducted a feature review of 13 chatbot apps as shown in **Table 1.1**. There are several key findings from the feature review of chatbots related to:

- **Chatbot Goals:** The primary purpose of chatbots may be to chat with the user about how they are feeling or to guide the user through the use of the app.
- **Response Options:** Interaction between a user and a chatbot varies from open-text to pre-set responses.
- **Chatbot Personalities:** Chatbot interface ranges from avatars with distinct “personalities” to simple text-based exchanges without an attached persona.
- **Crisis Response:** Chatbots varied drastically in their response to users indicating that they are experiencing a mental health crisis.

What is a chatbot?

A chatbot is a software program designed to mimic a conversation with a human.

Table 1.1. Full Feature Reviews of Chatbot Apps

App name	Screen Reader Capabilities	Customizable Display Features	Internet required for use?	# Languages	Content for underserved groups	Features of chatbot			
	+++ All buttons spoken ++ Most buttons or features spoken + Some buttons or features spoken	A+ Text size T High contrast text Color inversion Animation reduction	Yes No			Is the primary goal to a) chat with the user about how they are feeling, or b) to guide them through using the app?	Can users respond via a) pre-set responses only or b) both open text and pre-set responses?	What is the personality of the chatbot avatar (if any)?	How does the chatbot respond to mental health crisis? ⁹
365 Gratitude	++	Color inversion Animation reduction	Yes	1	None	Guide	Pre-set only	Animated alpaca named Joy	N/A
Flow	+	A+ Text size High contrast text Color inversion Animation reduction	Yes	2	None	Guide	Both	No clear avatar	N/A
InnerHour	++	A+ Text size High contrast text Color inversion	Yes	1	None	Guide	Pre-set only	No clear avatar	N/A
Iona Mind	+	Color inversion Animation reduction	Yes	1	None	Chat	Both	No clear avatar	Words of comfort. States the app is not designed to handle crisis. Advises user to contact emergency services.
Nabu	++	A+ Text size Color inversion Animation reduction	Yes	1	None	Guide	Pre-set only	Animated owl	N/A
OOTify	++	High contrast text Color inversion Animation reduction	Yes	1	None	Guide	Pre-set only	No clear avatar	N/A

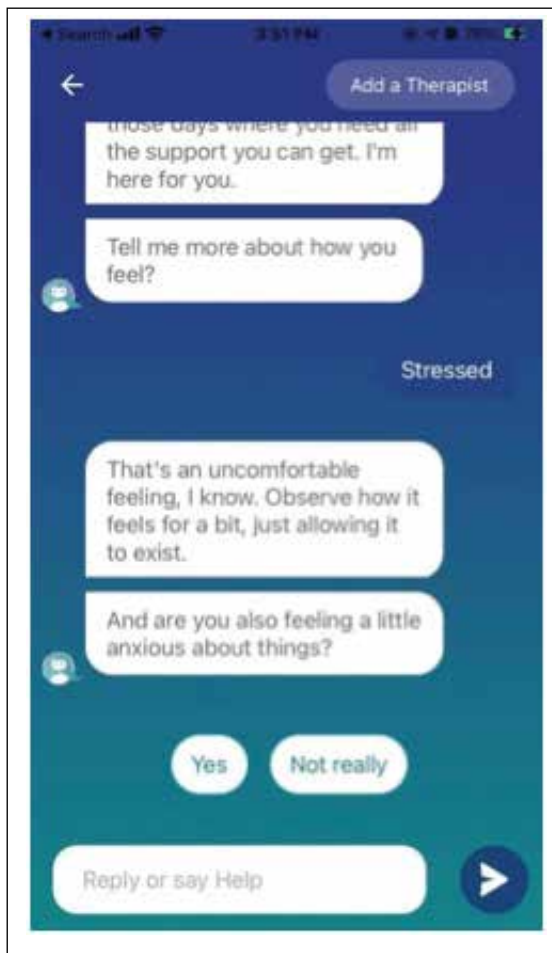
⁹ N/A means that users were not able to say that they were in crisis. Therefore, the response is not applicable.

Pocketcoach	+	A+  		1	None	Both	Both	No clear avatar	N/A
Replika	++	A+  		1	None	Chat	Both	User can create/customize avatar	Crisis hotlines, offers tools to help manage panic attacks.
Sayana	+	 		1	None	Guide	Both	Human character	No crisis response
Serenity	++	A+   		1	None	Chat	Both	Human character	Advises user to speak to "a human" in their life. Provides crisis hotline.
Woebot	+++	A+  		1	None	Chat	Both	Animated robot	Words of comfort. States the app is not designed to handle crisis. Asks user's location and provides hotlines and text lines.
Wysa	+++	  		1	LGBTQ+ Community	Chat	Both	Animated penguin	Words of comfort, provides crisis line resources. SOS button also on home page with crisis resources.
Youper	+++	A+  		1	None	Chat	Both	No clear avatar	Words of comfort. States the app is not designed to handle crisis. Asks user's location and provides hotlines and text lines.

CHATBOT GOALS

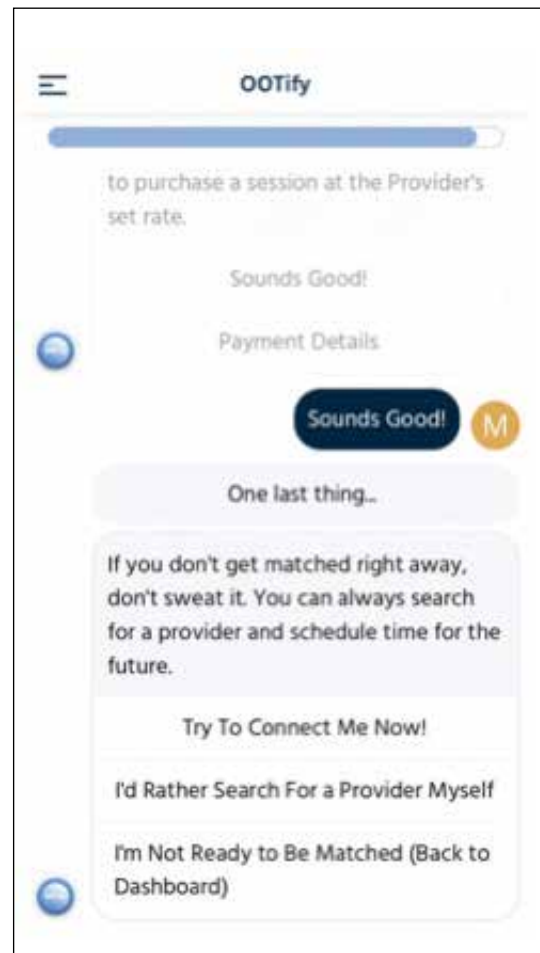
Figure 1.7 shows that the goals of chatbots vary from one mental health app to another. About half ($n=7$) of the 13 chatbot apps reviewed aimed to chat with the user about how they are feeling. The other half ($n=6$) aimed to guide the user through the app and help them find resources within the app. Furthermore, some chatbots were only available in the app at certain times. For example, the chatbot in 365 Gratitude only appeared during first use to introduce the user to the app—it was not available during later sessions.

Figure 1.7. Sample Goals of Chatbot Apps



Interactive Example: Wysa

Goal is to talk through how the user is feeling



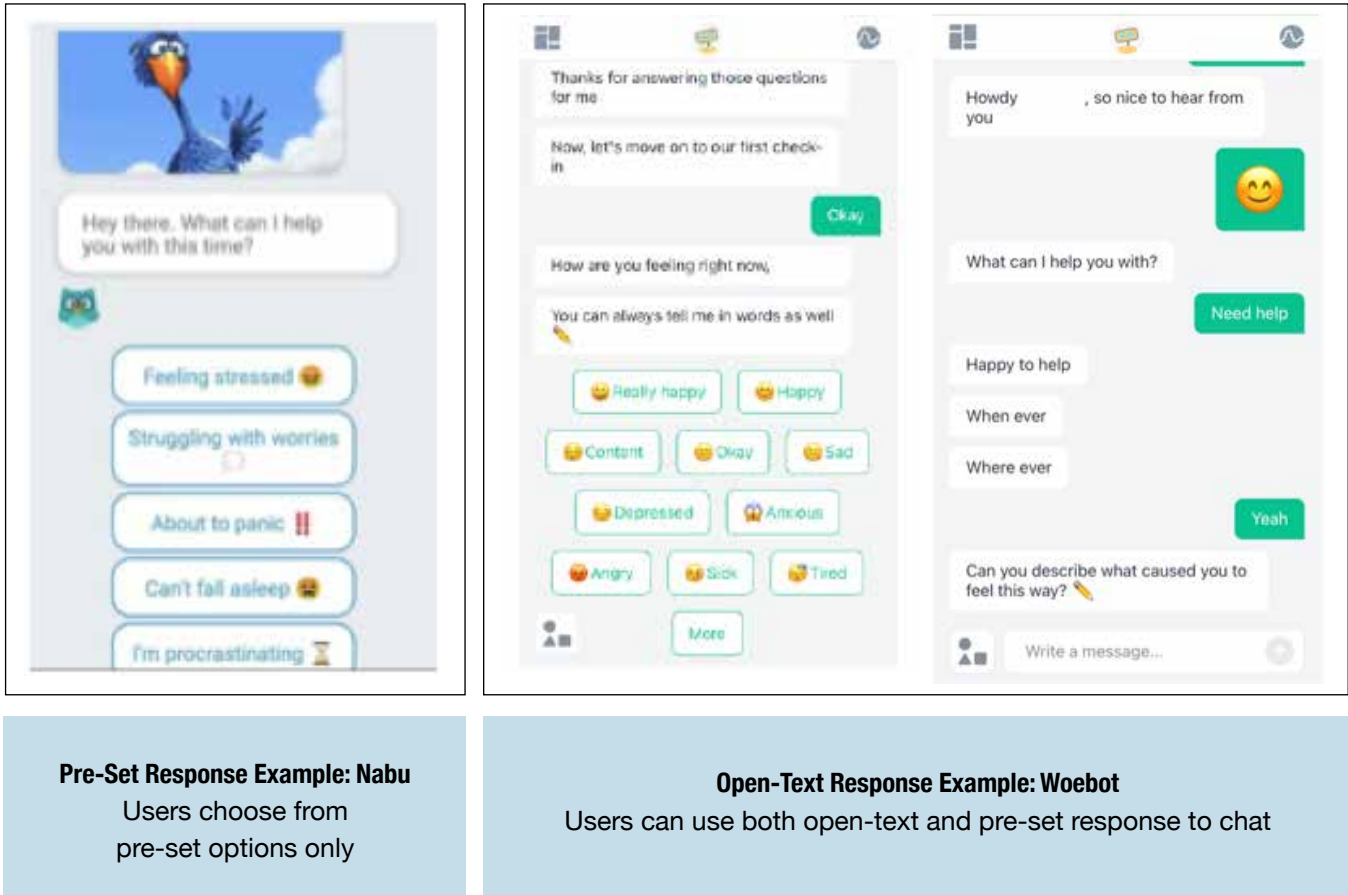
App Use Example: Ootify

Goal is to guide app use and match user with a provider

RESPONSE OPTIONS

Users may chat with the chatbot through pre-set responses or open-text responses. In a pre-set response model, users can only select options for response determined by the app. In an open-text response model, the user can type anything they like into the chat, as if they were sending a text message. Examples of both models are shown in **Figure 1.8**.

Figure 1.8. Sample Response Options of Chatbots Apps



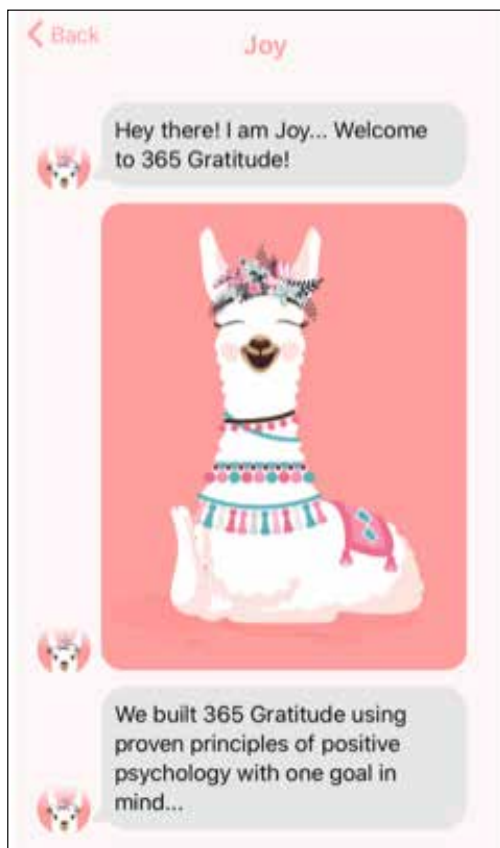
Of the apps reviewed, one-third (n=4) had only pre-set responses and two-thirds (n=9) had both open-text and pre-set options. A user cannot choose when they want to use a pre-set versus open-text response; the app determines that.

All apps whose primary goal was to chat with the user about their mental health allowed both open-text and pre-set options. While open text responses allow users to provide more personalized information and describe things in their own words, they may also pose challenges with monitoring. A chatbot may not necessarily know how to respond to an unlimited number of responses.

CHATBOT PERSONALITIES

Some chatbots have a distinct “personality” or avatar, while others are more simplistic and lack a clear avatar. Almost half (46%; n=6) of the apps reviewed had a distinct avatar personality, and 54% (n=7) did not. **Figure 1.9** provides examples of these chatbot styles.

Figure 1.9. Sample Personalities in Chatbot Apps



Avatar Example: 365 Gratitude
Chatbot is a cute alpaca named Joy



Non-Avatar Example: Youper
Chatbot does not have a clear or distinct personality

CRISIS RESPONSE

When talking to a chatbot, a user may disclose that they are in a mental health crisis and need immediate support. Research has shown that people view a conversation with a virtual therapist as more anonymous than a conversation with a human. They may then be more likely to disclose or describe something that they may not discuss with a human due to stigma (Lucas et al., 2017). Since users may disclose a mental health crisis to a chatbot, the evaluation team reviewed how each chatbot app responds to a crisis in order to help determine if the app responds sensitively and appropriately.

Not every app allowed a user an option to say that they were in crisis because some apps only allow for pre-set responses. Users were unable to say that they were in crisis through pre-set responses in 46% of the apps reviewed (n = 6). When users could say they were in crisis, one app did not acknowledge this or respond, and appeared to glitch. Of the apps that did respond, the most common response to crisis was providing hotline numbers where the user could get support. Details of crisis responses are in the last column of **Table 1.1**.

Review of Digital Phenotyping Platforms

Digital phenotyping platforms were also reviewed in Year 2. Digital phenotyping, one of the approved components of Help@Hand technologies, passively collects data to predict or monitor mental health and wellness. Passive data is collected “in the background,” rather than being actively input into a device by a user (although users should always give permission for this data to be collected). Digital phenotyping models propose that how users interact with their devices can tell as much about their mental states as what they enter into their devices.

In Year 1, the market surveillance identified digital phenotyping platforms through app store searches and app descriptions. Mindstrong was the only platform found, since many digital phenotyping platforms were under development and not yet available on the app stores for download.¹⁰ In Year 2, the evaluation team broadened the search to also include digital phenotyping platforms identified through expertise and knowledge of the digital mental health space, the published literature, and review papers and lists of digital phenotyping platforms in mental health. This resulted in a list of 11 digital phenotyping platforms. While this review was not meant to be exhaustive, it intended to identify some emerging digital phenotyping products and illustrate some of the variation in digital phenotyping platforms and available features.

Each platform was reviewed for the presence or absence of various features related to: 1) passive data collection (e.g., sensor-based data collection); 2) active data collection (e.g., surveys, cognitive tests, and voice recordings); and 3) types of interventions associated with the platform. **Table 1.2** displays the full information for each platform.

Table 1.2. Features of Digital Phenotyping Platforms

	Operating System	Passive Data Collection Features					Active Data Collection			Interventions	Intended for Research Purposes Only
		Location Features	Interaction Features	Communication Features	Movement Features	Physiology Features	Other Features	Surveys	Cognitive Tasks		
Aware	Android, iOS	•	•	•	•		•			Tracking	•
BiAffect	iOS		•		•		•	•		No intervention	•
BeiWe	Android, iOS	•		•	•		•			No intervention	•
EARS	Android, iOS	•	•		•		•		•	No intervention	•
inSTIL	Android, iOS	•		•	•		•	•	•	No intervention	•
MindLAMP	Android, iOS	•		•	•		•	•		Mindfulness, Education tracking, interactive modules	
Mindstrong	Android, iOS	•	•	•			•			Linkage to care provider	
Monsenso	Android, iOS			•	•		•			Tracking	
MoodTriggers	Android	•		•	•	•	•			Tracking	•
MoviSensXS	Android				•	•	•			Triggered Interventions	•
Sensus	Android, iOS	•		•	•	•	•			No intervention	•

¹⁰ This might be because they do not have a business-to-consumer model or are intended mostly for research purposes.

PASSIVE DATA COLLECTION

Six types of passive data collected via digital phenotyping platforms were identified:

<i>Location Features</i>	<i>Location Features</i> included Global Positioning System (GPS), or specific locations from other databases, such as Google Places location types. Location data was collected by 9 of 11 platforms (82%).
<i>Interaction Features</i>	<i>Interaction Features</i> refer to the way a person uses or interacts with their phone and include keystrokes, time and length of messages, typing movement, phone swipes, etc. Interaction data was collected by 4 of 11 platforms (36%).
<i>Communication Features</i>	<i>Communication Features</i> included call and text logs that provide information such as number, timing, and length of phone calls and text messages, and social media. Communication data was collected by 8 of 11 platforms (73%).
<i>Movement Features</i>	<i>Movement Features</i> included accelerometer data, step counts, exercise data, and metabolic equivalent of task. Movement data was collected by 10 of 11 platforms (91%).
<i>Physiology Features</i>	<i>Physiology Features</i> included galvanic skin response, heart rate, and heart rate variability. Physiological data was collected by 3 of 11 platforms (27%).
<i>Other Features</i>	<i>Other Features</i> included battery life, weather data, ambient light, facial expressions in “selfie” photos, and BlueTooth sensors triggers. Data from other features was collected by 8 of 11 platforms (73%).

ACTIVE DATA COLLECTION

Three types of active data collected via digital phenotyping platforms were identified:

<i>Surveys</i>	<i>Surveys</i> included both standard assessments and customizable assessments. Surveys could either be available for users to complete as desired, at fixed intervals, or triggered by passive data. Survey data was collected by 11 of 11 platforms (100%).
<i>Cognitive Tasks</i>	<i>Cognitive Tasks</i> are those that require a person to actively process information in order to assess cognitive processes, such as memory, attention, or learning. Data from cognitive tasks was collected by 3 of 11 platforms (27%).
<i>Voice Recordings</i>	<i>Voice Recordings</i> allowed users to record information through speech. Voice recording data was collected by 2 of 11 platforms (18%).

INTERVENTIONS

The digital phenotyping platforms reviewed included various interventions. About half of the platforms (n=6, 54%) included some form of intervention.

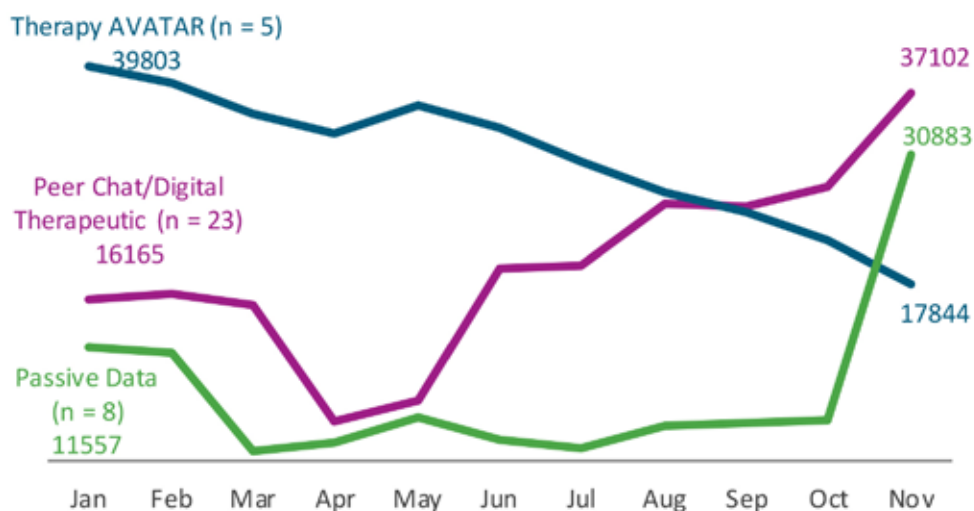
- **Tracking:** Tracking symptoms, mood, behaviors, and medication was most common.
- **Linkage to care provider:** Only *Mindstrong* included direct linkage to care providers, but *MindLAMP* could potentially facilitate this with a provider dashboard.
- **Triggered interventions:** *MoviSensXS* offered triggered interventions, or what are known as “ecological momentary interventions.” These interventions could be triggered by different actions, including answers in a questionnaire or information from the sensor-based data collection. Interventions could take the form of text, audio, or video, but the content of these interventions would have to be created by the team deploying *MoviSensXS*.
- **Other:** *MindLAMP* included intervention modules such as mindfulness and psychoeducation. It also provided a dashboard that allows for information received by the *MindLAMP* platform to integrate with care providers.

Marketplace Data Review of Help@Hand RFSQ-Approved Apps

In addition to reviewing apps in the broader marketplace, the market surveillance reviewed apps in the Help@Hand Request For Statement of Qualifications (RFSQ).¹¹ The Help@Hand RFSQ-approved apps only included apps that met the project’s required components: peer chat/digital therapeutics (N=75), therapy avatars (N=75), and digital phenotyping (N=41), where Ns represent the number of apps approved for inclusion in each category.

Figures 1.10 and 1.11 show the changes in downloads and monthly active users (MAU) across 2020 by component for each Help@Hand approved app where data is available (e.g., Ns in the graphs show the number of apps with marketplace data is available). Additional marketplace data is in **Appendix D**¹². Although there is a general increasing trend for peer chat/digital therapeutic apps and decreasing trend for therapy avatar apps, significant variation exist in the month-to-month levels. Changes observed in downloads or use of the Help@Hand RFSQ-approved apps might be due to general changes in downloads and use in the broader app marketplace. Counties/cities should keep this in consideration when viewing app data obtained from vendors.

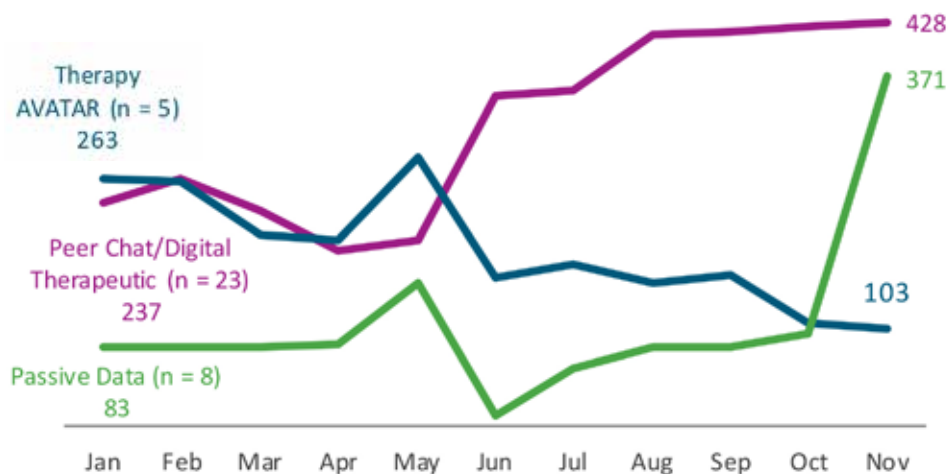
Figure 1.10. Median Downloads of Help@Hand RFSQ Apps in 2020



¹¹ Help@Hand released an RFSQ to vendors in September 2019 in response to a need for expanding the technology offerings within the project.

¹² Marketplace data was not available for every app in the RFSQ, because apps needed to rank within the top 1500 apps for iOS and within the top 200 apps for Google Play in order to have marketplace data available on Apptopia.

Figure 1.11. Median Monthly Active Users of Help@Hand RFSQ Apps in 2020



It is also worth noting the scale of downloads and monthly active users for the Help@Hand RFSQ apps versus the broader marketplace. The median download for Help@Hand RFSQ apps tended to be between 100-500 per month, whereas the meditation, peer support, and chatbot apps in the broader marketplace were approximately 17,000, 4,000, and 21,000 downloads per month, respectively. Similarly, the monthly active users for Help@Hand RFSQ apps were in the 10,000 to 40,000 range, and meditation, peer support, and chatbot apps in the broader marketplace were in the 20,000 to 76,000 range. As such, Help@Hand RFSQ-approved apps tended to be less downloaded and less used than the average app of similar categories in the marketplace. The maturity of products submitted to the Help@Hand RFSQ is a concern for their viability in the Help@Hand project.

Market Surveillance Learning Briefs

Learning briefs examining other aspects of the app marketplace were developed in Year 2 and can be found in **Appendix E**. These brief include.

- **Free Apps with COVID-19 Content Brief** reviews 10 free apps with COVID-19 content that could support the community during the pandemic.
- **Selected Mental Health App Performance during COVID-19 Brief** examines marketplace performance data of selected apps identified since the onset of COVID-19.
- **Mental Health Apps Provided or Recommended by Insurance Plans in California Brief** identifies mental health apps available for the community by major insurance companies in California.
- **myStrength and Apps Similar to myStrength Brief** summarizes features and research on RFSQ-approved apps that are similar to myStrength.

Learnings from the Market Surveillance

Learnings from reviews of apps considered by counties/cities and apps outside of Help@Hand found:

- **Language:** Many of these apps are not suitable for counties/cities targeting non-English speaking populations since they do not provide resources in languages other than English.
- **Internet Access:** Most apps need to be connected to the internet to work. People with limited access to the internet, such as geographically isolated populations or those with limited data plans, will not be able to get on-demand mental health support from these apps.
- **Assistive Technology:** Most apps allow the user to customize content display to some degree (e.g., a user could increase the text size to better view the content). However, if users need a screen reader to read content aloud to them, this was not widely available.
- **User Experience:** Chatbots had higher user experience scores than meditation and peer support apps from both experts and consumers.
- **Marketplace Data Review:** Marketplace data showed that peer support apps were far less popular than meditation or chatbot apps. They were downloaded less and had fewer monthly and daily active users. This suggests that people may be more likely to engage with meditation or chatbot apps.
- **Purpose of Chatbots:** Although an app may say that it provides a mental health chatbot, some apps simply guided the user through the app rather than providing mental health support or chatting with the user about how they are feeling. Chatbot apps also may not always respond appropriately when a user says that they are in crisis.
- **Digital Phenotyping Platforms:** Digital phenotyping platforms can collect a range of passive data but are more limited in the range of active data collection modes. Most digital phenotyping platforms are intended for research and assessment purposes with limited opportunities for clinical intervention.
 - **Passive Data:** The most common passive data features are location, communication, and movement.
 - **Active Data:** The most common active data collection method is surveys.
 - **Availability:** Most of the digital phenotyping platforms reviewed were available on both Android and iOS.
- **Help@Hand RFSQ-Approved Apps:** Marketplace data of the RFSQ app show considerable monthly changes in downloads and use. Comparisons between RFSQ apps with number of downloads and monthly active users from products in similar categories in the marketplace generally show fewer downloads and less use of RFSQ products.

ENVIRONMENTAL SCAN

An environmental scan monitors public perceptions of mental health documented through key media events. News stories based on keywords related to Help@Hand were collected, but analysis of these stories has not started due to limited staffing to support the environmental scan. This activity was on hold in Year 2.

COLLABORATIVE PROCESS EVALUATION

Help@Hand is also influenced by the processes, interactions, and collaboration across the Help@Hand counties/cities and stakeholder groups. The collaborative process evaluation examines how these factors affect Help@Hand at the system and organizational level.

The evaluation team developed an interview guide and survey for the collaborative process evaluation in Year 1 and updated the interview guide in Year 2 to reflect project changes. However, the Collaborative requested a pause on conducting interviews and surveys since October 2019. There are plans to re-launch the collaborative process evaluation in Year 3.

2 PEER EVALUATION

Key Points

- Peers play an active role in supporting the Help@Hand program across the Collaborative. There is overall enthusiasm for the contribution of the Peer component to Help@Hand.
- In response to the COVID-19 pandemic and the halting of in-person outreach activities, counties/cities created educational materials that could be delivered virtually to address digital literacy.
- Peers engaged in digital product testing throughout Year 2, and counties/cities plan to sustain this engagement into Year 3.
- Counties/cities reported a number of successes and challenges related to the Peer component of Help@Hand. Over time, more counties/cities reported successes with incorporating Peer input into Help@Hand decisions. However, challenges to program implementation were reported by an increasing number of counties/cities.

OVERVIEW

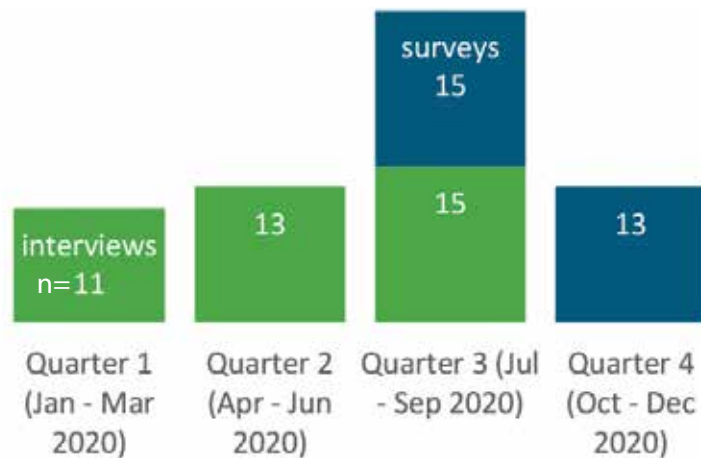
The evaluation of the Peer component of Help@Hand documents Peer activities, identifies successes and challenges to implementing the Peer component, and shares lessons learned across the Collaborative.

PEER EVALUATION

Surveys were developed from interviews conducted in quarters 1 and 2.¹³ Surveys in quarter 3 (n=15) were completed by 14 Peers and 1 Tech Lead (from a county/city without a Peer Lead), while surveys in quarter 4 (n=13) were completed by 10 Peer Leads, 1 Tech Lead, and 2 Peer/Tech Leads.¹⁴

Figure 2.1 shows Peer evaluation activities conducted in each quarter of Year 2. **Appendix F** includes learning briefs summarizing findings from the quarter 2 interviews and quarter 3 surveys.

Figure 2.1. Peer Evaluation Interviews and Surveys Conducted in Year 2



Peer Activities in Year 2

Surveys asked about the activities that Help@Hand Peers engaged in within counties/cities during quarter 3 and quarter 4. **Figure 2.2** shows the survey results.

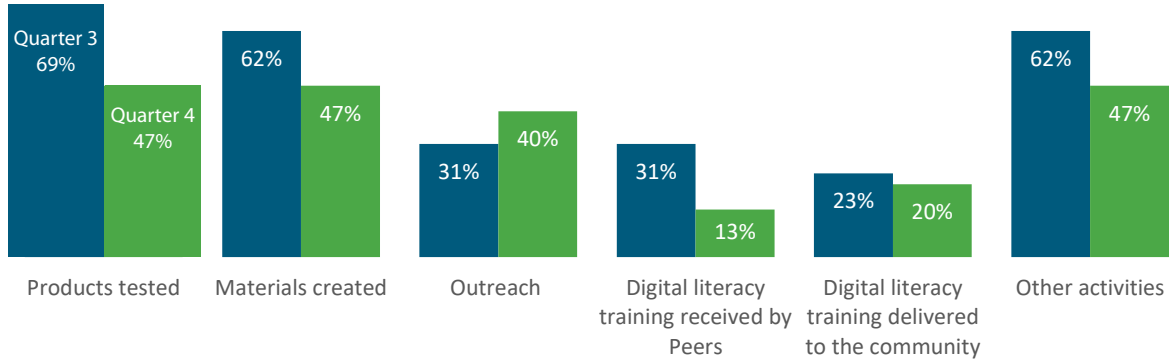
- Product Testing and Material Creation.** The most common Peer activities in both quarters were testing products (e.g., potential digital mental health apps) and creating materials (e.g., developing educational presentations related to digital literacy) for target populations. Owing to social distancing mandates issued toward the end of quarter 1, collaboration among the Peers during quarters 3 and 4 occurred virtually and the materials developed were primarily intended for distribution through digital platforms. Using these platforms helped Peers learn new skills that would prepare them to carry out outreach virtually.

¹³ Quarter 1 interviews (n=11) included ten Help@Hand Peer Leads and the Help@Hand Peer and Community Engagement Manager. Quarter 2 interviews (n=13) included 11 Peer Leads and two Tech Lead (from counties without a Peer Lead).

¹⁴ Follow-up interviews were conducted in quarter 3 to elicit details on survey responses and were not conducted in quarter 4 due to the winter holiday.

- **“Other” Activities.** Peers were engaged in a variety of “other” activities during quarter 4. These included: 1) implementing the Mindstrong and Headspace apps; 2) becoming proficient in using virtual communication platforms; and 3) working with the Help@Hand evaluation team to refine surveys and focus group guides.

Figure 2.2. Peer Activities Reported in Peer Evaluation Surveys

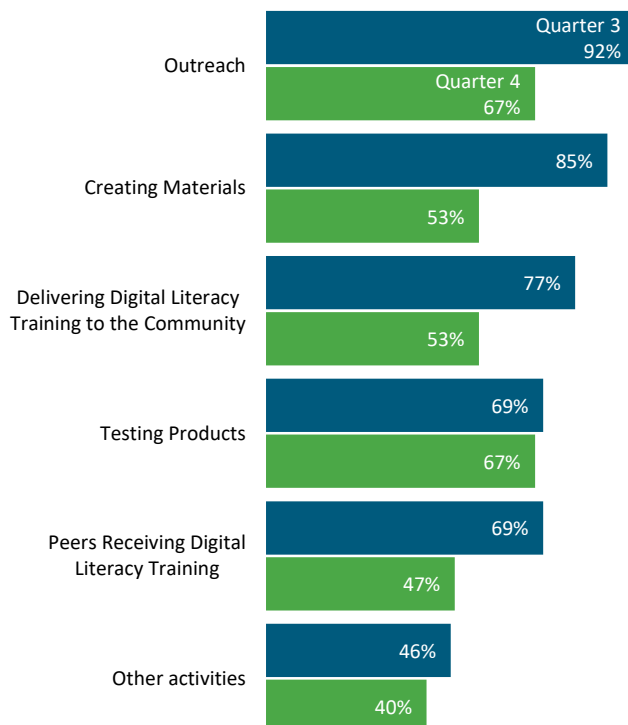


Planned Peer Activities

Surveys and interviews also asked about planned Peer activities for the following quarter. **Figure 2.3** shows the survey results. Together with the interviews, surveys reveal:

- **Changes in planned activities.** Outreach, creating materials, and delivering digital literacy training to the community were the most frequently identified planned Peer activities in the quarter 3 survey. Plans for all three of these activities were reduced in the quarter 4 survey, though over half of the respondents still indicated that these activities were planned. Plans to test products remained steady over both quarters at about two-thirds of respondents.
- **Optimism.** Interviews conducted in quarter 3 conveyed a general optimism about shifting from preparing for digital mental health literacy outreach and into implementing outreach in 2021.

Figure 2.3. Planned Peer Activities Reported in Peer Evaluation Surveys



Successes

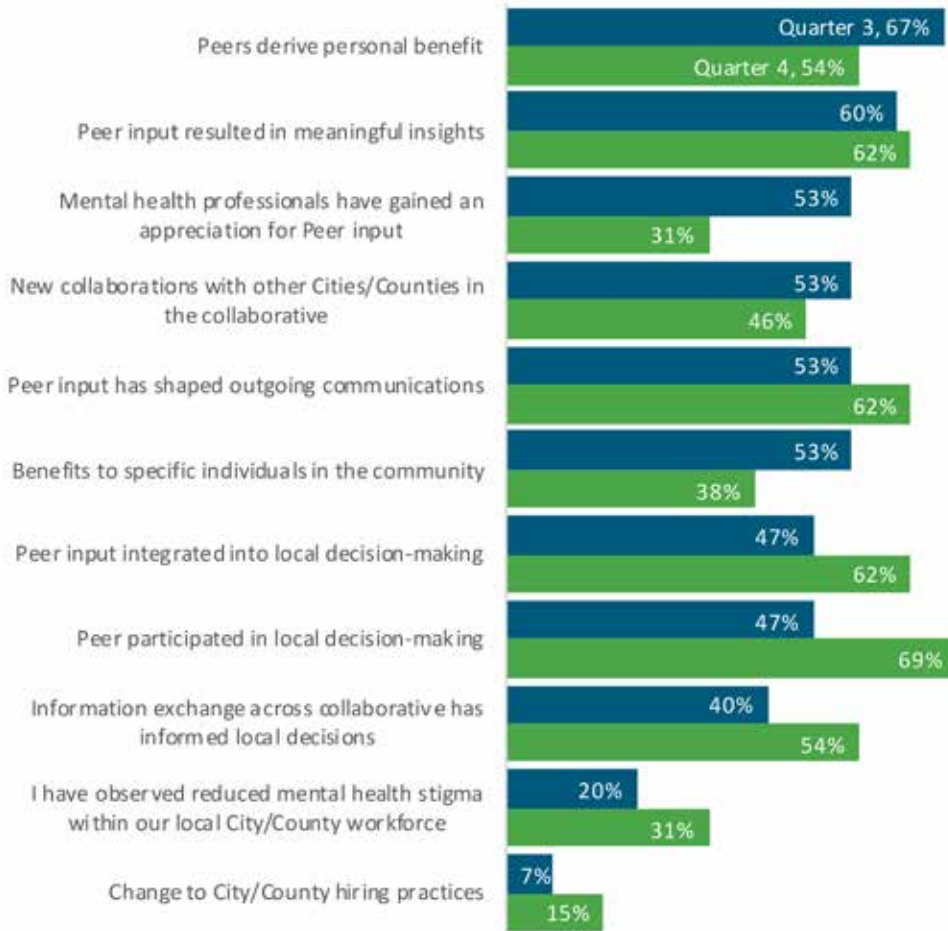
Early interviews (those conducted in quarters 1 and 2) found the following Peer successes:

- **Active Peer Engagement.** Peers were actively engaged in supporting Help@Hand by vetting potential technologies, developing digital literacy education materials, conducting outreach to the community, and delivering digital literacy workshops. In addition, Peers represented their counties/cities on Peer Leadership calls and participated in the digital mental health literacy (DMHL) train-the-trainer event held by CalMHSA.
- **Peers as Contributors and Collaborators.** Peers were recognized by Help@Hand as experts and partners in program development and delivery, which had a perceived impact on mental health stigma reduction within county organizations. Peer Leads attributed the reduced stigma both to the appreciation accorded to Peers by Help@Hand physicians and therapists, as well as the openness and transparency surrounding mental health issues that characterized the work between Peers and their colleagues. For Peers, openly addressing their mental health issues was a novel experience, which they felt brought about a cultural shift in the workplace, as colleagues responded with understanding and acceptance about mental health needs.
- **New Peer-related Personnel Policies.** Efforts to overcome hiring challenges led to changes in personnel policies in some counties/cities, such as creating a new job classification for peer employees.

Figure 2.4 shows successes identified in surveys from quarters 3 and 4. Interviews and surveys showed:

- **Quarter 3 Successes.** More than half of survey respondents noted the following successes since the beginning of the Help@Hand program:
 - o Peer input was integrated into local decision-making.
 - o Peer input yielded meaningful insights, such as focusing attention on the logistical issues of technology implementation (e.g., how much data would a cell phone plan need to use a given technology).
 - o Peer input shaped outgoing communication, resulting in more effective messaging that was tailored for the intended audience.
 - o New collaborations emerged across counties/cities, which was noted as unusual within the state since cross-county sharing is rare.
 - o Help@Hand yielded benefits to specific individuals in the community. This includes the delivery of mental health services through telehealth, which was facilitated by digital literacy training given to the community by Peers. Another example is San Mateo and Youth Leadership Institute's anthology project, which is described in the **spotlight** on page 47.
 - o Mental health professionals gained an appreciation for Peer input, which resulted in a reduction in the stigma around mental health within the county workforce. Peer Leads reported that this reduction in workplace stigma was a personal benefit for the Help@Hand Peers.
 - o Peers derived personal benefit, including both gainful employment and a forum for discussing their mental health.
- **Changes in Successes from Quarter 3 to Quarter 4.** There was an increase in the proportion of counties/cities reporting that Peers were participating in local decision-making and that Peer input was integrated into local decision-making in the quarter 4 survey. There was also an increase in the proportion of respondents who indicated that information exchange across the Collaborative had informed local decisions.

Figure 2.4. Successes Reported in Peer Evaluation Surveys





DMHL Train-the-Trainer Workshop Attendees

Challenges

Early interviews found challenges with:

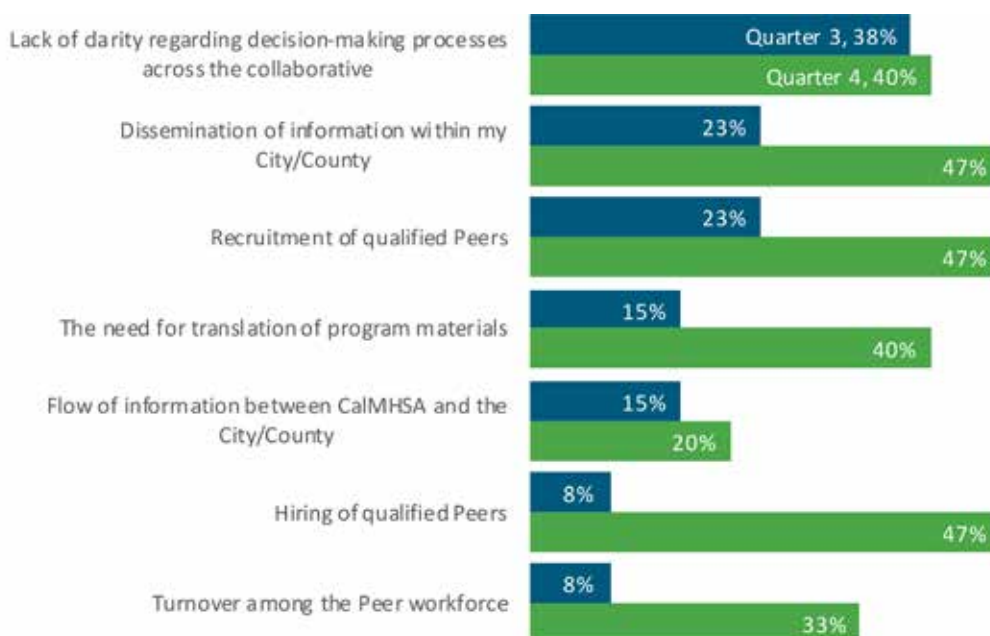
- **Recruiting, hiring, and retaining Peers.** It was challenging to recruit Peers who possessed the right constellation of skills and abilities for supporting Help@Hand (e.g., digital literacy, proficiency in a language other than English). Hiring has been complicated by county/city human resource policies that make some Peers ineligible. Attrition among the Peers was related to individuals being promoted, being in time-limited appointments, or being unable to meet the demands of the position over time.
- **Community outreach.** There was limited digital literacy among both the Peers and the members of the target populations. There were also challenges with meeting community needs. These challenges included: not having enough bilingual staff to reach non-English speaking communities; difficulty finding the right place and time to engage transition-age youth (TAY); and transportation and technology barriers for older adults and isolated communities.
- **Communication within and across counties/cities.** The departure of the Peer and Community Engagement Manager in March 2020 exacerbated delays in the flow of information across the Collaborative and highlighted limited information sharing mechanisms.
- **Decision-making and roles/responsibilities.** Interviews in the early part of Year 2 revealed that Peers were not completely integrated into decision-making processes within and across counties/cities during the start-up phases of Help@Hand. Also, there was a lack of clarity across the collaborative in terms of roles and responsibilities, causing Peers to be uncertain as to the decision-making processes.

- **COVID-19.** In quarter 1, counties/cities planned to mobilize outreach and digital literacy campaigns by hosting in-person “Appy Hours” and distributing paper DMHL materials. Plans also included disseminating information about digital mental health resources within the Peer workforce and to communities. Since COVID-19 restrictions hindered these plans, counties/cities generally responded by focusing their Peer efforts on technology testing and material development, much of it intended for virtual dissemination. The wide range of innovative responses illustrated the resilience of the Peer Leads in finding ways to continue to add value to the Help@Hand Collaborative and influence local decision-making through Peer input.

Figure 2.5 shows challenges identified in the latter half of Year 2. Surveys from quarters 3 and 4, as well as interviews from quarter 3, found:

- **Unclear Decision-Making Processes.** Lack of clarity regarding decision-making processes across the Collaborative was reported by about 40% of respondents in both surveys.
- **Challenges with hiring and internal information sharing (Quarter 3).** Difficulty with hiring and internal information sharing emerged as the most common challenges experienced by counties/cities since the beginning of Help@Hand in the quarter 3 survey. It is interesting to note that these challenges were reported by fewer counties/cities in the quarter 4 surveys.
 - o **Difficulties in recruiting and hiring Peers.** There was difficulty in recruitment and hiring efforts due to employment structures (e.g., human resources and hiring policies) and personnel turnover.
 - o **Insufficient flow of information within the county/city.** Two structural factors emerged as major contributing factors: 1) the use of subcontractors to carry out the Peer component, which added levels of authority and delayed transmission of information; and 2) the dual program management structure involving both Peer Leads and Tech Leads, which was viewed as creating silos of information that were not conducive to knowledge-sharing.

Figure 2.5. Challenges Reported in Peer Evaluation Surveys



Learnings from the Peer Evaluation

Interviews and surveys about the Peer component of Help@Hand reveal learnings on:

- **Product Testing and Material Creation.** Common Peer activities in Year 2 included testing potential technologies and creating outreach materials, particularly for virtual dissemination. Peer Leads expressed general optimism about implementing digital mental health literacy outreach in 2021.
- **Peer Successes.** There were several Peer successes in Year 2. These include:
 - **Local Decision-Making and Peer Input.** Peers were participating in local decision-making and their input was integrated in decision-making processes. Peer input offered meaningful insights for technology implementation and outgoing communication. It was also appreciated by mental health professionals and reduced mental health stigma within the county workforce.
 - **Collaborations across counties/cities.** This was a particularly noteworthy success since cross-county sharing is rare within the state. Information-sharing across the Collaborative helped inform some local decisions.
 - **Benefits for community members and Peers themselves.** Peers were involved in activities that helped the community. For example, Peers provided digital literacy trainings that helped community members access telehealth. In addition, Peers benefited from gainful employment and a forum for discussing their own mental health.
- **Peer Challenges and Opportunities.** Overall, interviews and surveys at the end of Year 2 revealed both enthusiasm and appreciation for the added value that Peers brought to the Help@Hand Collaborative. This was tempered, however, by frustration with the slow pace of technology implementations and the continued gap in the leadership structure resulting from the unfilled Peer and Community Engagement Manager position. Still, counties/cities appeared to engage an entrepreneurial spirit, especially in response to the challenges of the COVID-19 pandemic, and began to establish cross-collaborations to accelerate learnings.

SPOTLIGHT Anthology

Self Affinity
to be one with oneself
...oneself is
...one has.
...that you deserve
...love unconditionally
...selfless,
...yourself.



Once the pandemic began, Youth Leadership Institute San Mateo (YLI) like other community organizations found themselves in need of novel ways to connect with the youth they served. Their shift to zoom meetings proved to be inaccessible for some and inadequate for others. Indeed, YLI's, Help@Hand Peer Leader, Adam Wilson, who was interviewed for this Spotlight, stated *We saw early on that having conversations and being on zoom, that not everyone was equipped to do it or wants to do it.* YLI, then, sought additional ways for young people to have a dialogue or outlet to deal with the pandemic. Inspired by one employee's recent experience with collecting stories from local community members, in partnership with San Mateo County Behavioral Health and Recovery Services, YLI created the anthology project.

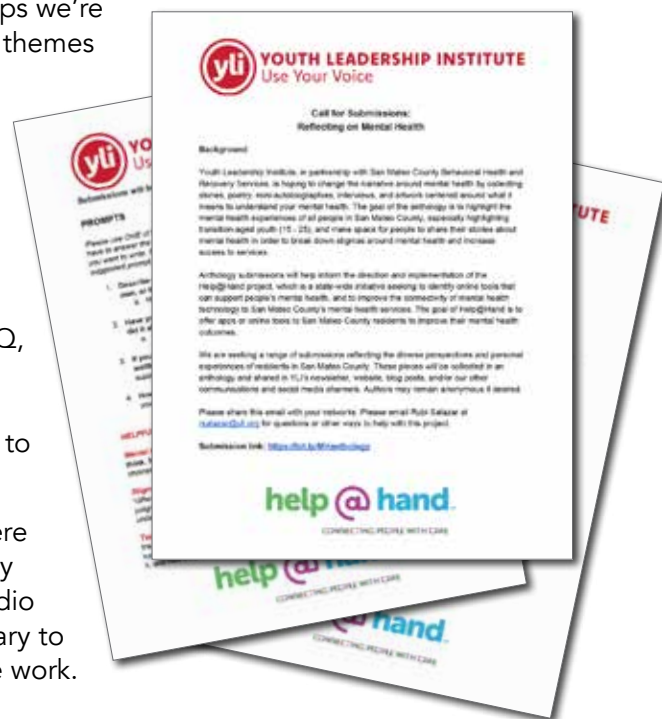
Artist: Marcela Cordova

An anthology is a collection of selected literary pieces or passages or works of art or music (Merriam-Webster, n.d.). Anthologies can be centered around a certain theme, genre, culture, nation, or time period. With that in mind, the Youth Leadership Institute (YLI) San Mateo anthology project sought to gather a collection of writings, art, videos, etc. by individuals in San Mateo County. All pieces would center around the theme of mental health.

Specifically, in hopes of changing the narrative around mental health, the anthology project aimed to provide San Mateo County community members with an opportunity to express their experiences with mental health, emotional wellbeing, and COVID-19. The plan was to have individuals submit pieces that, together, would be turned into a collection of works. The anthology would highlight the mental health experiences of all people of San Mateo County especially transition-aged youth (15-25 years old). To break down stigmas around mental health as well as provide a space where the community could openly share their thoughts, and feelings about mental health, YLI planned to publish the anthology on their website. The project would, also, be used to inform the direction and implementation of the Help@Hand program. For instance, Wilson suggested it may inform YLI about what features the apps we're looking at for Help@Hand might need to include based on the themes we're seeing in the pieces.

Initially, YLI planned to invite only the youth that they worked with. It quickly shifted, however, to a community-wide project when YLI partnered with San Mateo County Behavioral Health and Recovery Services. This partnership expanded their reach to all adults – TAY through older adults. Likewise, to reflect the diversity of the community, YLI reached out to agencies and organizations that worked with such communities as Latinx, LGBTQ, and youth with mental health issues. They also made sure to include organizations in different economic areas and located throughout the county. Three organizations were subcontracted to assist with outreach and engagement for the anthology project.

Outreach began with a call for submissions. In it, individuals were invited to submit pieces using any medium and format that they chose. Suggestions included poetry, mini-autobiographies, audio and video, interviews, and artwork. Although it was not necessary to use them, four prompts were provided to inspire and guide the work.



Prompts included describing experiences with mental health, stigma around mental health, treatment for mental health and the impact of COVID-19 on mental health and emotional wellbeing. All prompts also included the role that technology had on one's mental health. Definitions were provided for the terms mental health, stigma, and technology too. Submissions could be in any language and everyone who submitted one or more pieces received a stipend. If YLI published a piece, that individual would receive an additional sum too.

As submissions were received, YLI was in awe of the depth of each piece. Using collage, prose, poetry, videos, and art created from various mediums, individuals described such feelings as isolation, loneliness, confinement, recovery, and self-affinity. Thus far, pieces from over 50 individuals between the ages of 15-30 years-old and written in English or Spanish have been submitted. Wilson was unsure of the total number of pieces received because many individuals submitted several pieces.



Artist: Kai Doran

One challenge they faced was reaching older adults. Outreach efforts included texting, creating flyers, printing them, and personally distributing flyers to the community they worked with. Staff also tried slipping flyers under doors in older adult communities as well as emailing and calling them. Although these efforts were effective for younger adults, they were ineffective with older adults.

Nonetheless, the project grew to be larger and more time-consuming than expected. With a steady flow of pieces being submitted, YLI decided to start posting individual pieces on their Instagram. This, however, was more labor intensive than expected. Or, as Wilson stated, the capacity to meaningfully engage with all pieces is challenging. For instance, YLI needed to determine whether creators wanted to be anonymous. Also, because Instagram is a visual platform, pieces such as stories and poems that were text only needed to be designed in a visually appealing manner. Additionally, YLI staff chose hashtags and wrote captions for each piece; all of which needed to be approved by the creator before posting. Aware that they had followers who were Spanish-speaking, YLI also had captions written in both English and Spanish. As Wilson shared There's a lot of steps you want to take to assure that the youth's voice is being authentic and that it's also being anonymous if that's what they want.



Artist: Marcela Cordova

Unexpectedly, another benefit surfaced. Youth and parents shared that it positively impacted themselves and their families. Some parents shared that this was the first they were able to learn about their child's feelings about mental health and/or COVID-19. Wilson explained It has opened up some young people and their families to conversations that they might not have had. Secondly, for some young artists, having their work posted on Instagram was the first time they'd had a piece published. Indeed, Wilson stated that we had one young person submit five paintings and we've published a few of those. They've had a good amount of engagement and click throughs. That's been exciting to be able to give them a platform to show off their skills. Moreover, Wilson explained that the project gave youth an opportunity to express themselves in a way that they might not be able to do in their home, with their friends, or at school.

As stated above, submissions were to be used as way to learn about the mental health needs of the San Mateo Community. As of now, with submissions slowing down, the next steps for YLI include identifying the common themes in the anthology which will be used to inform what features the app should include and if there are specific mental health needs within their community. Wilson explained that we've seen some themes like isolation, depression and needing more mental health services. They haven't, however, been able to sit down and say what the biggest themes coming out of it are. YLI is also planning to include organizations that subcontracted with them in the Help@Hand pilot as well as create a space on their website to post the anthology.

Reference

(Merriam-Webster. (n.d.) Anthology. In Merriam-Webster.com dictionary. Retrieved January 22, 2021, from <https://www.learnersdictionary.com/definition/anthology>)

3 COUNTY/CITY TECHNOLOGY, USER EXPERIENCE, AND IMPLEMENTATION EVALUATION

Key Points

- Los Angeles and Riverside Counties conducted needs assessments with community college students and members of Riverside County's Deaf and Hard of Hearing Community, respectively. Orange County is planning a needs assessment of its clients. Needs assessments gather detailed information on perceptions of mental health among the target population, use of technology to support mental health, and resources desired to support mental health.
- Marin, Riverside, San Francisco, and San Mateo Counties, as well as City of Berkeley and Tri-City explored different technologies with target populations to select which technology to pilot or implement.
- Los Angeles, Marin, San Mateo, Santa Barbara, and Tehama Counties as well as Tri-City planned pilots that would test potential technologies with their target population on a small scale. Some pilots were paused or discontinued for various reasons.
- Los Angeles and Orange Counties implemented technologies, with the intention of scaling these across their target population or using them for the remainder of the project. Evaluation interviews and surveys with leadership, providers, and users were conducted in Year 2.
- Riverside County developed and launched a peer-chat app called Take my Hand in 2020, and San Francisco is planning to partner with Riverside on piloting this app as well in 2021.
- Los Angeles and San Mateo Counties began offering county residents Headspace in Year 2 in order address mental health needs in communities, particularly those impacted by COVID-19. San Francisco began planning their Headspace launch for 2021.
- Monterey and Los Angeles Counties released a Request for Information and created a Request for Proposal as part of their development of a tool that screens and refers consumers.
- Kern and Modoc Counties completed their projects and transitioned off of Help@Hand. Exit interviews were conducted with both counties.

OVERVIEW

This section presents county/city activities as of the end of Year 2, which are summarized in **Table 3.1**.

The progress made toward needs assessments, technology explorations and selections, pilot, and implementation phases is further detailed in this section. The COVID-19 Rapid Response, development of a Request for Information (RFI) and Request for Proposal (RFP), and project completion by some counties are also described.

Table 3.1. Overview of County/City Efforts at the End of Year 2

County/City	Activity	Target Audience(s)	Technology	Current Status
City of Berkeley	<ul style="list-style-type: none"> Technology Exploration and Selection 	<ul style="list-style-type: none"> General population Transitional age youth (TAY) Isolated older adults 	<ul style="list-style-type: none"> Headspace myStrength 	<ul style="list-style-type: none"> Active– planning underway
Kern	<ul style="list-style-type: none"> Project Completion 	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> Completed
Los Angeles	<ul style="list-style-type: none"> Needs Assessment 	<ul style="list-style-type: none"> Community college students 	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> Completed
Los Angeles	<ul style="list-style-type: none"> Pilot Planning 	<ul style="list-style-type: none"> Older Adults Isolated populations at higher risk of serious complications from COVID–19 Adult cognitive behavioral health clients Individuals seeking Peer Resource Center support 	<ul style="list-style-type: none"> Uniper CredibleMind Headspace (pilot) 	<ul style="list-style-type: none"> Inactive– planned but not executed and no longer in progress
Los Angeles	<ul style="list-style-type: none"> Implementation 	<ul style="list-style-type: none"> Dialectical behavior therapy (DBT) clients 	<ul style="list-style-type: none"> Mindstrong/ MindLAMP 	<ul style="list-style-type: none"> Active– transitioning from Mindstrong to MindLAMP
Los Angeles	<ul style="list-style-type: none"> Rapid COVID–19 Re–sponse 	<ul style="list-style-type: none"> Los Angeles County residents 	<ul style="list-style-type: none"> Headspace 	<ul style="list-style-type: none"> Active– implementation underway
Marin	<ul style="list-style-type: none"> Technology Exploration and Selection (completed) Pilot Planning 	<ul style="list-style-type: none"> Older (isolated) adults 	<ul style="list-style-type: none"> myStrength Uniper 	<ul style="list-style-type: none"> Active– pilot planning under–way
Modoc	<ul style="list-style-type: none"> Project Completion 	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> Active– participation in Help@Hand concludes April 2021
Mono	<ul style="list-style-type: none"> Technology Exploration and Selection 	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> Considering Headspace or myStrength 	<ul style="list-style-type: none"> Inactive– Will become active Spring 2021
Monterey	<ul style="list-style-type: none"> Request for Information (RFI) (completed) Request for Proposal 	<ul style="list-style-type: none"> Monterey County residents 	<ul style="list-style-type: none"> Screening and referral tool 	<ul style="list-style-type: none"> Active– planning underway
Orange	<ul style="list-style-type: none"> Needs Assessment 	<ul style="list-style-type: none"> Behavioral Health Services clients Parents of Behavioral Health Services clients 	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> Active– planning underway
Orange	<ul style="list-style-type: none"> Implementation 	<ul style="list-style-type: none"> Eligible clients at UCI Health Psychiatry Services 	<ul style="list-style-type: none"> Mindstrong 	<ul style="list-style-type: none"> Active– implementation underway

County/City	Activity	Target Audience(s)	Technology	Current Status
Riverside	<ul style="list-style-type: none"> Needs Assessment 	<ul style="list-style-type: none"> Deaf and Hard of Hearing Community 	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> Active– completed and planning expansion underway
Riverside	<ul style="list-style-type: none"> Technology Exploration and Selection 	<ul style="list-style-type: none"> Full Service Partnership (FSP) consumers 	<ul style="list-style-type: none"> A4I or Focus 	<ul style="list-style-type: none"> Completed
Riverside	<ul style="list-style-type: none"> Rapid COVID–19 Re–response 	<ul style="list-style-type: none"> Riverside County residents 	<ul style="list-style-type: none"> Take my Hand 	<ul style="list-style-type: none"> Active– implementation underway
San Francisco	<ul style="list-style-type: none"> Technology Exploration and Selection 	<ul style="list-style-type: none"> TAY Transgender youth and adults 	<ul style="list-style-type: none"> Take My Hand 	<ul style="list-style-type: none"> Completed
San Francisco	<ul style="list-style-type: none"> Rapid COVID–19 Re–response 	<ul style="list-style-type: none"> San Francisco County residents 	<ul style="list-style-type: none"> Headspace 	<ul style="list-style-type: none"> Active– planning underway
San Mateo	<ul style="list-style-type: none"> Technology Exploration and Selection (completed) Pilot Planning 	<ul style="list-style-type: none"> Older adults TAY 	<ul style="list-style-type: none"> Wysa 	<ul style="list-style-type: none"> Active– pilot planning underway
San Mateo	<ul style="list-style-type: none"> Rapid COVID–19 Re–response 	<ul style="list-style-type: none"> San Mateo County residents 	<ul style="list-style-type: none"> Headspace 	<ul style="list-style-type: none"> Active– implementation underway
Santa Barbara	<ul style="list-style-type: none"> Pilot Planning 	<ul style="list-style-type: none"> Clients recently discharged from inpatient psychiatric care Geographically isolated individuals TAY 	<ul style="list-style-type: none"> Headspace 	<ul style="list-style-type: none"> Paused
Tehama	<ul style="list-style-type: none"> Pilot Planning 	<ul style="list-style-type: none"> Persons who are Homeless or at risk of Homelessness Isolated Individuals Tehama County Health Services Agency – Behavioral Health Consumers 	<ul style="list-style-type: none"> myStrength 	<ul style="list-style-type: none"> Active– planning underway
Tri-City	<ul style="list-style-type: none"> Technology Exploration and Selection 	<ul style="list-style-type: none"> TAY Older adults Monolingual Spanish speakers 	<ul style="list-style-type: none"> Headspace myStrength Mindstrong 	<ul style="list-style-type: none"> Active– planning underway
Tri-City	<ul style="list-style-type: none"> Pilot Planning 	<ul style="list-style-type: none"> TAY engaged at Tri–City’s Wellness Center 	<ul style="list-style-type: none"> Wysa 	<ul style="list-style-type: none"> Inactive– planned but not executed

NEEDS ASSESSMENT (LOS ANGELES, ORANGE, RIVERSIDE)

In Year 2, needs assessments were conducted, planned, and expanded to engage members of target Help@Hand audiences regarding their mental health needs and their thoughts on how technology can help meet those needs. Specifically, Los Angeles, Orange, and Riverside Counties worked with the evaluation team to develop, conduct, and/or analyze data from their local needs assessments. These needs assessments identified: 1) current mental health needs and beliefs of the target population; 2) current apps, technologies, and resources used in the community; 3) factors likely to influence uptake of technologies; 4) initial measures of outcomes, such as stigma and social connectedness, and mental health literacy; and/or 5) insights for county/city recruitment strategies.

Los Angeles Completed needs assessment

Los Angeles County partnered with El Camino College (a community college in Los Angeles County) and the Help@Hand evaluation team to conduct a needs assessment with students at El Camino College. A needs assessment survey was distributed electronically to a random sample¹⁵ of 5,000 students from April 16 – June 30, 2020. A total of 500 participants completed the survey.¹⁶

Results from the needs assessment were shared with the Collaborative in past Help@Hand evaluation reports. A learning brief and comprehensive report were created and shared with Los Angeles County and El Camino College.

Orange Planning needs assessment

Orange County began to use telehealth to deliver county behavioral health services during COVID-19. Anecdotally, some transitional aged youth (TAY) clients expressed a preference for in-person appointments. Orange County and the Help@Hand evaluation team tailored the needs assessment to learn: 1) whether all behavioral health clients had this preference; 2) what challenges clients may face in using telehealth services; and 3) what factors may contribute to dissatisfaction with telehealth services.

Two versions of the survey were created: one for clients over the age of 13, and another for parents or guardians of clients under the age of 13. The surveys were updated based on findings from a clinician telehealth study conducted by the county. The surveys are expected to be implemented in 2021.

Riverside Expanding needs assessment

Riverside County partnered with the Center on Deafness Inland Empire (CODIE) and the Help@Hand evaluation team to conduct a needs assessment of the Deaf and Hard of Hearing Community. In September 2020, a focus group and survey were conducted with community advocates who identified as members of the Deaf and Hard of Hearing Community and were members of CODIE. Eleven people were invited to participate in the focus group and survey. Ten people participated in the focus group and nine people completed the survey.¹⁷ Findings were shared in a learning brief with Riverside County and presented for the Collaborative in the quarter 3 report.

Results cannot be generalized to the larger Riverside Deaf and Hard of Hearing Community because of the small sample of the focus group and survey. As such, plans to expand the needs assessment survey to the larger Riverside Deaf and Hard of Hearing Community are underway. The survey is also anticipated to be implemented in 2021.

¹⁵ Sampling was done proportionate to gender and race for California community colleges.

¹⁶ Participants received a \$10 Amazon gift card for completing the survey.

¹⁷ Focus group participants received a \$30 Amazon gift card, and survey participants received a \$10 Amazon gift card.

LEARNINGS FOR THE HELP@HAND COLLABORATIVE: NEEDS ASSESSMENT (LOS ANGELES, RIVERSIDE)

While needs assessments are valuable for understanding the unique characteristics of a particular population, looking across needs assessments may also lead to broader insights. **Figure 3.1** shows common learnings from needs assessments with community college students in Los Angeles County and the Deaf and Hard of Hearing Community in Riverside County.

In particular, both target audiences expressed an interest in accessing professional services and informal support. Counties/cities should consider if their specific target audiences is also interested in such access and think about how technologies may support these needs. Privacy also emerged as a potential barrier for both community college students and the Deaf and Hard of Hearing Community who participated in the needs assessment. Ranging widely, privacy concerns included worries about vendors sharing personal data with third parties, potential data breaches, and being identified in peer chat apps. Counties/cities should consider privacy as a potential barrier in adopting and using mental health technologies for target populations.

Figure 3.1. Learnings from Needs Assessments with College Students and the Deaf and Hard of Hearing Community



TECHNOLOGY EXPLORATION AND SELECTION (BERKELEY, MARIN, RIVERSIDE, SAN FRANCISCO, SAN MATEO, TRI-CITY)

Technology exploration allows target audience members or those familiar with the target audience to explore technologies and give initial feedback on whether the technology fits the target audience. Those technologies that fit may be selected to pilot and/or implement with the target audience. In 2020, Marin, Riverside, San Francisco, and San Mateo Counties, as well as City of Berkeley and Tri-City, engaged in technology exploration and selection¹⁸.

City of Berkeley Exploring technologies

City of Berkeley reviewed four apps (Headspace, myStrength, HeyPeers, and Uniper) that may fit their TAY, isolated older adult, and general populations. In the wake of recent nationwide political upheaval surrounding the topic of racial justice, the city intends to make additional efforts to reach communities of color, including African American, Latinx, and Asian Pacific Islanders. City of Berkeley staff and Peers reviewed each app and determined myStrength and/or Headspace as likely technologies to implement, due especially to their widespread use with large numbers of people in various populations.¹⁹ Staff will further review myStrength and Headspace in 2021.

¹⁸ Mono County will conduct technology explorations in Spring 2021.

¹⁹ Although a pilot was initially considered, City of Berkeley decided to proceed with a COVID-19 Rapid Response implementation.

Marin

Completed technology exploration and selection

Marin County examined myStrength and Uniper with its older adult population. With support from CalMHSAs and the Help@Hand evaluation team, the county developed processes and tools to support virtual technology exploration that complied with COVID-19 social distancing requirements. Twelve older adults and community members explored myStrength and Uniper over seven days and then participated in focus groups and surveys.²⁰ Findings were shared in a learning brief with Marin County and in the quarter 3 Help@Hand evaluation report for the Collaborative.

Riverside

Completed technology exploration and selection

In addition to conducting a needs assessment with the Deaf and Hard of Hearing Community (described above) and launching their own platform – Take my Hand (described below), Riverside County reviewed other apps to pilot with their various target populations.²¹ Based on their review, Riverside County determined A4i and/or Focus may meet the needs of those in their Full Service Partnership (FSP) program, an intensive program offering mental health and support services for those experiencing and/or at-risk for institutionalization, homelessness, incarceration, or psychiatric in-patient services.

A total of 24 county clinic participants, including some FSP consumers, participated in focus groups and a survey. Eleven were aged 16-25 years and twelve were aged 26+ years.²² Findings were shared in a learning brief with Riverside County. Key findings include:

Key Findings from Technology Exploration with FSP Consumers



APP PREFERENCE

TAY participants seemed to show a preference for A4i, whereas adult participants were more split and acknowledged that both technologies had useful features.



CONNECTION WITH OTHERS

Participants valued being able to connect with others, both with a care team and other users.



IMPROVED COMMUNICATION

Participants liked being able to communicate with their care team and share information with A4i, but there were some concerns around what would happen if messages do not receive a reply.



VIDEO AND TEXT

Different modalities to view information, such as video and text, were viewed positively.



PRIVACY CONCERNS

Participants reported possible privacy concerns from others seeing technology notifications on their phone, and expressed the need for users to trust the app in order to share information with others within it.

San Francisco

Completed technology exploration and selection

At the beginning of 2020, San Francisco considered piloting Headspace with county staff. Toward the end of 2020, San Francisco decided to implement Headspace to anyone who lives or works in San Francisco County. San Francisco later used CalMHSAs Request for Statement of Qualification (RFSQ) product matrix²³ to review potential peer-chat apps for county residents, particularly transgender and TAY communities. The county considered 11 apps: HeyPeers, Ouchie, Pre Registry, SageSurfer, Sharpen Minds, Sober Grid, Support Groups Central, Supportiv, Uniper, Wysa, and Take my Hand (described below). Based on careful review and discussions, the county is considering to work with Riverside County to pilot Take my Hand in 2021.

²⁰ Participants received a gift card for their participation.

²¹ Riverside County's priority target populations include: TAY; Deaf and Hard of Hearing; visually impaired; males aged 45+ years; high-risk populations (e.g., those who are re-entry, enrolled in the FSP Program, or with an eating disorder); Mid-County & Desert populations; adults aged 65+ years; and ethnic, cultural and LGBTQ+ communities.

²² Participants received a gift basket for their participation.

²³ The RFSQ product matrix was created by CalMHSAs to help counties/cities review the 93 RFSQ apps. The matrix has three components: (1) Ability to filter apps based on specific features; (2) Product profiles to compare across apps; and (3) Glossary of terms.

San Mateo

Completed technology exploration and selection

Figure 3.2 depicts the potential apps that San Mateo County primarily considered for its target audiences. For its technology exploration and selection, San Mateo County recruited older adults and TAY to engage with and review each app. They were then invited to complete a survey and discuss their experiences in focus groups.

Figure 3.2. Target Audiences and Technologies Considered for San Mateo County’s Technology Exploration and Selection



TAY. Five TAY spent up to 6 hours exploring Headspace, myStrength, and Wysa. They then participated in both surveys and focus groups. Findings were shared in a learning brief with San Mateo County. Key findings include:

Key Findings from Technology Exploration with TAY



APP PREFERENCE

Participants seemed to show a preference for Headspace and Wysa over myStrength in terms of navigation, cultural sensitivity, meeting needs, and visual look.



NAVIGATION

It was important to easily navigate through the app to be able to engage with content. myStrength was perceived to be harder to navigate compared to the other two technologies due to the large amount of material, which was not organized in a user-friendly and aesthetically-pleasing manner.



CULTURAL SENSITIVITY

myStrength was perceived to be less culturally sensitive relative to Headspace and Wysa. Headspace had a relatively high rating and included content involving racial groups. Wysa also had a relatively high rating, though a participant acknowledged room for improvement.



RESOURCES REQUIRED

Most participants felt they had appropriate devices to access these technologies. However, it not only mattered whether participants had the resources required to use the app, but also to engage in various activities suggested by the app (e.g., cost of using therapist, need for equipment for workouts).



VISUAL LOOK AND VARIETY OF CONTENT

Participants were more engaged if they thought the app was visually pleasing, and a large variety of content prompted users to engage with the app.

Older Adults. Eight older adults spent 1-6 hours exploring myStrength and Wysa.²⁴ Seven of these older adults participated in surveys and six participated in a focus group. Findings were shared in a learning brief with San Mateo County and in the quarter 3 Help@Hand evaluation report for the Collaborative.

²⁴ Uniper was not explored because test accounts were not available.

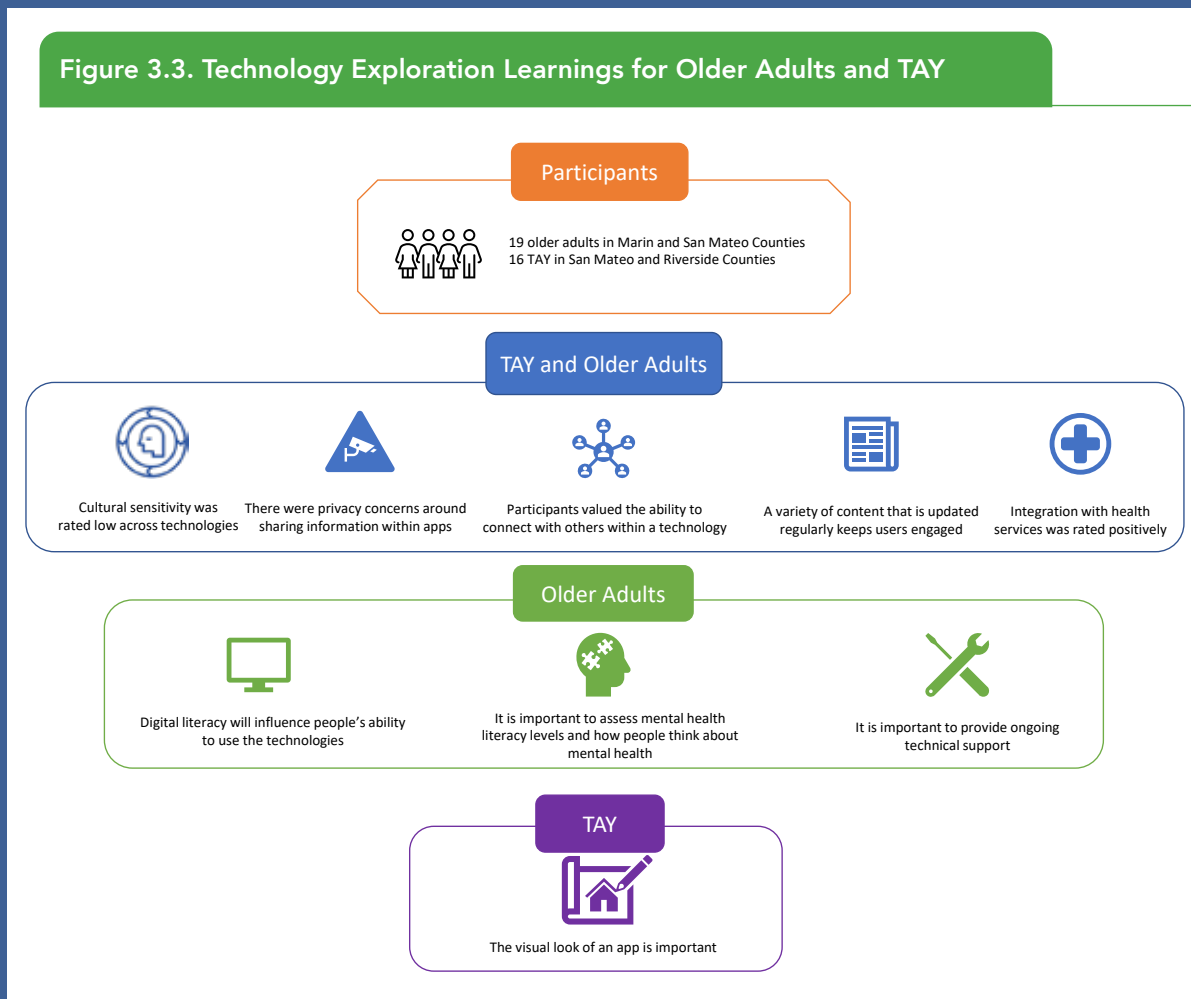
Tri-City Exploring technologies

In late 2020, Tri-City began to shift from planning a pilot with Wysa to exploring Headspace and myStrength. Tri-City is also interested in a possible collaboration with Orange County to implement Mindstrong. In early 2021, Tri-City will conduct focus groups with Tri-City’s clinical staff, Peers, and community members in order to determine which technologies best fit the needs and scope of their older adult, TAY, and monolingual Spanish-speaking populations.

LEARNINGS FOR THE HELP@HAND COLLABORATIVE: TECHNOLOGY EXPLORATION AND SELECTION (MARIN, RIVERSIDE, SAN MATEO)

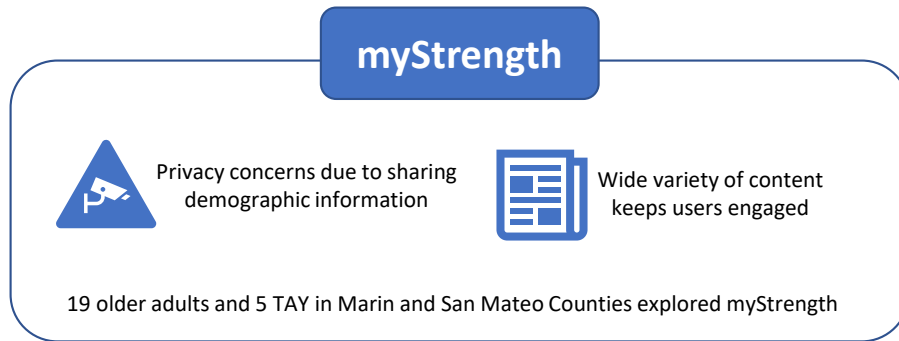
Marin, Riverside, and San Mateo Counties worked with target audience members to explore technologies and provide feedback that would help select appropriate technologies to pilot and/or implement. Learnings from common target audiences (e.g., older adults and TAY) and technologies (e.g., myStrength) are presented below to help other counties/cities considering these audiences or technologies.

Figure 3.3 presents learnings from technology explorations with older adults and TAY in Marin, Riverside, and San Mateo Counties. Counties/cities across the Collaborative, particularly those targeting TAY or older adults, should consider these learnings when selecting technologies for their pilots or implementations.



myStrength was the only technology explored in multiple counties. **Figure 3.4** shows learnings from technology exploration with myStrength in Marin and San Mateo Counties. Participants enjoyed the variety of content that myStrength offers, such as information about mental health and the ability to track mood and sleep. However, they reported privacy concerns due to sharing demographic information within the app. These findings may be valuable to counties/cities planning to implement myStrength.

Figure 3.4. Technology Exploration Learnings for myStrength



PILOT (LOS ANGELES, MARIN, SAN MATEO, SANTA BARBARA, TEHAMA, TRI-CITY)

Los Angeles, Marin, San Mateo, Santa Barbara, and Tehama Counties as well as Tri-City planned pilots that would test potential technologies with their target population on a small scale. Pilots help to answer:

- 1) Should a county/city continue on a larger scale with the technology for their target population?
- 2) If a county/city continues with the technology, what can help inform a successful scale-up?
- 3) What learnings from the pilot can help other Help@Hand counties/cities?

Los Angeles Pilot planned, but not executed

In March 2020, Los Angeles County presented three pilot proposals to Help@Hand Leadership for approval: Uniper for older adults; CredibleMind for isolated populations at higher risk of serious complications from COVID-19; and Headspace for adult cognitive behavioral health (CBT) clients and individuals seeking Peer Resource Center support. In April 2020, the three pilot proposals were approved, but Los Angeles County paused pilot launches in order to focus on their Headspace Rapid COVID-19 Response. In July 2020, the County decided not to move forward with these three pilots.

Marin Planning pilot

Based on findings from their technology exploration of Uniper and myStrength with older adults and community members, Marin County’s Advisory Committee decided to pilot both myStrength and Uniper with isolated older adults. The county worked with CalMHSA and the Help@Hand evaluation team to plan its pilots. In December 2020, Marin County presented its myStrength pilot to the Help@Hand Leadership and received approval to move forward.²⁵

For their myStrength pilot, Marin County plans to recruit 30 English- and Spanish-speaking isolated older adults to engage with the technology. Tech4Life, a contractor hired by Marin County, will provide digital literacy training to all participants before engaging with myStrength. Marin County also secured a partnership with the Telehealth Equity Project, which will provide nurse interns to help recruit isolated older adults, offer them technical assistance, and conduct evaluation surveys. In addition to surveys with users, the evaluation will involve interviews with

²⁵ Marin County’s pilot planning for Uniper is on hold until spring 2021 due to challenges planning two simultaneous pilots. In addition, Uniper was still finalizing the Spanish version of the app, which was a high priority for Marin County, whereas myStrength was ready to go.

users as well as surveys and interviews with the nurse interns (as shown in **Table 3.2**). The evaluation may also include interviews with the Marin County’s Tech Lead and Peer. Marin plans to launch their pilot in early 2021.

Table 3.2. Evaluation Activities for Marin and Tehama Counties’ Pilots

Evaluation Activity	Marin County	Tehama County
User Surveys	✓ once before digital literacy training once after digital literacy training once at the end of the pilot	✓ once at the beginning and once at the end of the pilot
User interviews	✓ once 4–weeks after the pilot start	✓ once 4–weeks after the pilot start and once at the end of the pilot
User Focus Groups		✓ once 3 months after the pilot start and once 5 months after the pilot start
Staff Surveys	✓ once at the end of the pilot	✓ once no sooner than 2 months after the start of the pilot
Staff Interviews	✓ once at the end of the pilot	✓ once at the end of the pilot

San Mateo Planning pilot

After reviewing technology exploration findings with older adults and TAY, San Mateo County selected to pilot Wysa with their older adult and TAY. Both target populations viewed Wysa as more culturally competent compared to the other technologies explored. San Mateo County also appreciated Wysa’s flexibility to make changes to the app and add county-specific resources. A contract between Wysa and CalMHSA is expected in early 2021. San Mateo will also work with CalMHSA and the Help@Hand evaluation team to develop a pilot proposal.

Santa Barbara Pilot planned, but not executed

In early 2020, Santa Barbara County collected input from community members and began planning to pilot Headspace with their target populations (e.g., TAY in colleges and universities; certain isolated adult clients; and adults discharged from psychiatric hospitals or who received crisis services). In May 2020, Santa Barbara County paused its pilot planning in order to focus on the impact of COVID-19 within the agency. Given feedback from community members that they needed digital literacy training and access to devices before launching an app, the county then shifted its efforts to developing and implementing their Digital Wellness Ambassador program. The program utilizes Peers to support those transitioning from inpatient to outpatient psychiatric care by sharing information on mental health resources and assisting with navigation to outpatient referrals. Santa Barbara County also partnered with other agencies to improve digital literacy among their target population. They subcontracted with Painted Brain to engage TAY in “listening sessions” that allows the county to hear from TAY about their mental health and technology needs. They also worked with a local community-based organization to host Appy Hours and plan digital literacy trainings for isolated older adults.

Tehama Planning pilot

Tehama County initially considered piloting Happify, but Happify notified Help@Hand that they were not taking on new clients due to COVID-19. At that point, based on input and evaluation of other apps by their staff and Peers, Tehama decided to move forward with piloting myStrength. Target populations for the pilot include persons

who are Homeless or at risk of Homelessness, isolated individuals, and Tehama County Health Services Agency – Behavioral Health (TCHSA-BH) consumers. Their pilot will include Peer staff and wellness advocates recruiting and engaging 30 participants (10 from each target population) via a one-on-one approach.

In September 2020, Tehama County presented their pilot proposal to the Help@Hand Leadership and received approval to move forward. The county anticipates to finalize their contract with myStrength and launch their pilot in early 2021. **Table 3.2** summarizes how the pilot will be evaluated. The **spotlight** on page 61 highlights how Tehama County Peers helped shape and inform the pilot evaluation.

Tri-City Pilot planned, but not executed

At the beginning of 2020, Tri-City decided to pilot Wysa with TAY engaged at Tri-City’s Wellness Center based on insights from their wellness advocates. They actively worked with CalMHSA and the Help@Hand evaluation team to negotiate a contract with Wysa and plan their pilot. However, Tri-City paused their pilot planning in August 2020 due to personnel turnover and staff capacity concerns. In late 2020, Tri-City decided to no longer pursue a pilot with Wysa. Although Wysa met the needs of Tri-City’s TAY population, it did not meet the needs of its other target populations (e.g., it would not work with their monolingual Spanish-speaking population). Thus, Tri-City shifted to exploring other technologies (as described above).

LEARNINGS FOR THE HELP@HAND COLLABORATIVE: PILOT (LOS ANGELES, MARIN, SAN MATEO, SANTA BARBARA, TEHAMA, TRI-CITY)

Los Angeles, Marin, San Mateo, Santa Barbara, and Tehama Counties as well as Tri-City planned different pilots to test potential technologies in Year 2. Key learnings from planning these pilots include:

- Structuring pilots: Pilots may be structured differently depending on the technology and target audience. For example, some target audiences may benefit from digital literacy and individualized support as part of a pilot. On the other hand, some technologies may be used on devices that target audiences are more familiar with, and may require less individualized support.
- New recruitment and engagement challenges: COVID-19 created new challenges for recruiting and engaging target audience members in pilots. Digital literacy levels influenced target audience members’ ability to engage in remote data collection and redeem incentives distributed electronically. Careful planning and consideration was needed to address these challenges.
- Community-based partnerships: Partnering with organizations that serve the target audience can provide vital support with recruitment and staffing. For example, Marin County’s partnership with the Telehealth Equity Project created a referral stream for their myStrength pilot and provided nurse interns to offer support.
- Easy to understand materials can support decision-making: Materials that use very little jargon helped people understand core concepts and make informed, insightful decisions. For example, materials with little jargon helped people easily understand statistics and inform decisions for the evaluation.
- Understand vendor data: It was important to know what data vendors were able to provide and whether vendors were open to taking new clients early in the pilot planning process.
- Involve Peers in evaluation: Peers offered valuable input when selecting appropriate evaluation items. Evaluation efforts must always find a balance between what is scientifically valid and what is feasible – a partnered Peer-driven approach was an effective strategy for striking this balance.

SPOTLIGHT

Engaging Peers in the Evaluation: A Model for Measurement

In the winter of 2019, the Help@Hand program completed the important work of defining and selecting the measurement constructs to assess mental health stigma.

A panel of five community Peers, individuals with lived experience and/or family member experience, and six academics with expertise in developing stigma measures was convened. The panel came to consensus on the dimensions of stigma that were important to measure as part of Help@Hand, specifically the following three areas:

- 1) **Internalized stigma:** one's own stigma toward their mental health condition;
- 2) **Resilience:** one's hope and positive attitude toward living with or recovering from one's mental health condition; and
- 3) **Mental health treatment stigma:** one's stigma toward seeking treatment for one's mental health condition.

The result of the effort was to identify 28 questions to be incorporated in the Help@Hand evaluation:

Background:

There are many measures of mental health stigma that focus on the broad perspectives of the stigmatizer versus the perspectives of the stigmatized. A community participatory approach was adopted in late 2019 to select the guiding instruments for the Help@Hand program. The effort ensured that the instruments:

- 1) were sensitive to the type of impact expected of Help@Hand apps;
- 2) met the stigma dimensions of interest of counties/cities; and
- 3) were scientifically valid.

DOMAIN / SCALE		SUBSCALE	ITEMS
Internalized Stigma	ISMI	Alienation	I feel out of place in the world because I have a mental illness Having a mental illness has spoiled my life People without mental illness could not possibly understand me I am embarrassed or ashamed that I have a mental illness I am disappointed in myself for having a mental illness I feel inferior to others who don't have a mental illness
		Social Withdrawal	I don't talk about myself much because I don't want to burden others with my mental illness I don't socialize as much as I used to because my mental illness might make me look or behave 'weird' Negative stereotypes about mental illness keep me isolated from the 'normal' World Stay away from social situations in order to protect my family or friends from embarrassment Being around people who don't have a mental illness makes me feel out of place or inadequate I avoid getting close to people who don't have a mental illness to avoid rejection
Resilience	RAS-R	Willingness to ask for help	I know when to ask for help I am willing to ask for help I ask for help when I need
		Not dominated by symptoms	Coping with my mental illness is no longer the main focus of my life My symptoms interfere less and less with my life My symptoms seem to be a problem for shorter periods of time each time they occur
Mental Health Treatment Stigma	SSOSH		I would feel inadequate if I went to a therapist for psychological help My self-confidence would NOT be threatened if I sought professional help Seeking psychological help would make me feel less intelligent My self-esteem would increase if I talked to a therapist My view of myself would not change just because I made the choice to see a therapist It would make me feel inferior to ask a therapist for help I would feel okay about myself if I made the choice to see professional help If I went to a therapist, I would be less satisfied with myself My self-confidence would remain the same if I sought professional help for a problem I could not solve I would feel worse about myself if I could not solve my own problems

Tehama County, in their pilot launch of myStrength, included the reduction of mental health stigma as an anticipated primary outcome of their technology implementation. The Tehama team turned to the work of tailoring their survey instruments to include items to measure mental health stigma in order to capture changes.

Led by Travis Lyon, Mental Health Services Act Coordinator, Behavioral Health, and in partnership with Ron Culver, Northern Valley Catholic Social Service (NVCSS) Supervisor, Tehama County Peer Programs, and a team of participating Peers, a workgroup was developed. This workgroup identified and commented on the limitations of the provided items that had been identified in the prior year.

Two primary limitations of the recommended survey items were identified by the workgroup. The first limitation was the overall length of the recommended items. Given the demographic questions that Tehama planned to include, surveys needed to be kept short to ensure that they could be reasonably completed. The second limitation was the lack of inclusivity and potential offensive wording of some of the items in the scales. For example, the surveys items were developed and guided by evidence-based practices to maximize the reliability and validity of the survey instruments. The Peers, however, were uncomfortable with some of the wording choices. Including questions with words like looking “weird” or “having one’s life spoiled” were noted as potentially being stigmatizing themselves.

With guidance from the Help@Hand evaluation team, the Peer workgroup sought to understand and respond to these limitations. Three areas were explored by the workgroup:

1. Which stigma topics/constructs, if any, were important to include in their evaluation?
 - a) Internalized Stigma (subtopics: Alienation, Social Withdrawal)
 - b) Resilience (subtopics: willingness to ask for help; not dominated by symptoms)
 - c) Mental Health Treatment Seeking Stigma
2. How many questions did they want to include in their survey? What was feasible and appropriate when considering respondent burden?
3. What wording options seemed best for promoting cultural competency and inclusiveness?

The next step involved selecting the specific items to be used for each area of inquiry. To facilitate the discussion, the evaluation team shared data collected as part of the Help@Hand evaluation around survey wording and measurement with the Tehama workgroup. The workgroup reviewed the scree plot analysis for each construct to see how many unique groups of questions were present in each scale.

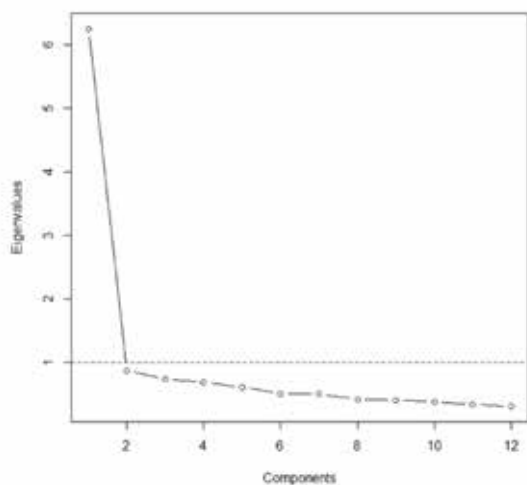


Figure 1: Scree plot for the 12 items of the ISMI section

The reason the Peers and I wanted to include all three areas of internalized stigma, resilience, and mental health treatment seeking stigma is because they all go hand in hand. Internalized stigma, the belief that there is “something wrong with me,” can lead to not seeking treatment; “there is something wrong with me because I need help,” which in turn makes it very difficult to foster any sense of resilience, making it exceedingly challenging to break the cycle.

– Ron Culver, Northern Valley Catholic Social Service (NVCSS) Supervisor, Tehama County Peer Programs

Figure 1 shows the scree plot for the 12-items that are part of the ISMI scale. A scree plot displays how much variation each component captures from the data. The general rule, when using a scree plot, is to drop the components after the one starting the elbow. As shown in the figure, the scree plot indicated that there was one significant cluster (or group of items) and perhaps a second less meaningful cluster.

The workgroup then walked through different ways to consider the influence of each individual item on the total scale – or the item total correlation. For example, this was done by creating a total score for each scale, and then correlating each item’s score with the total score (at the participant level).

Table 1 shows an example of Item I12 (which came from the social withdrawal subscale), which had the highest item total correlation with the ISMI scale (0.79), and that all the items had a relatively high total correlation ($r > .5$).

Table 1

7.1 The ISMI items

- I1: I feel out of place in the world because I have a mental illness.
- I2: Having a mental illness has spoiled my life.
- I3: People without mental illness could not possibly understand me.
- I4: I am embarrassed or ashamed that I have a mental illness.
- I5: I am disappointed in myself for having a mental illness.
- I6: I feel inferior to others who don't have a mental illness.
- I7: I don't talk about myself much because I don't want to burden others with my mental illness.
- I8: My mental illness might makes me look or behave "weird".
- I9: Negative stereotypes about mental illness keep me isolated from the 'normal' world.
- I10: I stay away from social situations in order to protect my family or friends from embarrassment.
- I11: Being around people who don't have a mental illness makes me feel out of place or inadequate.
- I12: I avoid getting close to people who don't have mental illness to avoid rejection.

Ranks	California dataset		Other States dataset	
	Item and category	Correlation with the ISMI total score	Item and Category	Correlation with the ISMI total score
1	I12 (Social Withdrawal)	0.79	I12 (Social Withdrawal)	0.80
2	I9 (Social Withdrawal)	0.77	I11 (Social Withdrawal)	0.77
3	I11 (Social Withdrawal)	0.76	I9 (Social Withdrawal)	0.77
4	I10 (Social Withdrawal)	0.76	I10 (Social Withdrawal)	0.76
5	I6 (Alienation)	0.76	I8 (Social Withdrawal)	0.74
6	I8 (Social Withdrawal)	0.75	I6 (Alienation)	0.74
7	I4 (Alienation)	0.73	I5 (Alienation)	0.74
8	I2 (Alienation)	0.73	I4 (Alienation)	0.72
9	I5 (Alienation)	0.71	I2 (Alienation)	0.70
10	I1 (Alienation)	0.68	I1 (Alienation)	0.67
11	I7 (Social Withdrawal)	0.62	I7 (Social Withdrawal)	0.64
12	I3 (Alienation)	0.60	I3 (Alienation)	0.59

In addition to considering the psychometric properties of each item, the Peer Workgroup also balanced their item selection by considering the language used in each item.

The final selection of items included the following:

Original Item Wording (Peer Selected)

1. Internalized Stigma (ISMI)
 - A. Alienation
 - 1) I4: I am embarrassed or ashamed that I have a mental illness.
 - 2) I6: I feel inferior to others who don't have a mental illness.
 - 3) I2: Having a mental illness has spoiled my life.
 - B. Social Withdrawal

- 1) I7: I don't talk about myself much because I don't want to burden others with my mental illness.
 - 2) I11: Being around people who don't have a mental illness makes me feel out of place or inadequate.
 - 3) I12: I avoid getting close to people who don't have mental illness to avoid rejection.
2. Resilience (RAS-R) - Willingness to ask for help and not dominated by symptoms
 - 1) R1: I know when to ask for help.
 - 2) R5: My symptoms interfere less and less with my life.
 - 3) R6: My symptoms seem to be a problem for shorter periods of time each time they occur.
 3. Mental Health Treatment Stigma (SSOSH) - Self-Perception concerning Treatment
 - 1) S2: My self-confidence would NOT be threatened if I sought professional help.
 - 2) S4: My self-esteem would increase if I talked to a therapist.
 - 3) S9: My self-confidence would remain the same if I sought professional help for a problem I could not solve.

Peer Driven Item Reduction and Wording

1. Internalized Stigma (ISMI)
 - A. Alienation
 - 1) I4: I am embarrassed or ashamed that I have mental health challenges.
 - 2) I6: I feel inferior to others who don't have mental health challenges.
 - 3) I2: Having mental health challenges has spoiled my life.
 - B. Social Withdrawal
 - 1) I7: I don't talk about myself much because I don't want to burden others with my mental health challenges.
 - 2) I11: Being around people who don't have mental health challenges makes me feel out of place or inadequate.
 - 3) I12: I avoid getting close to people who don't have mental health challenges to avoid rejection.
2. Resilience (RAS-R) - Willingness to ask for help and not dominated by symptoms
 - 4) R1: I know when to ask for help.
 - 1) R5: My symptoms interfere less and less with my life.
 - 2) R6: My symptoms seem to be a problem for shorter periods of time each time they occur.
3. Mental Health Treatment Stigma (SSOSH) - Self-Perception concerning Treatment
 - 1) S2: My self-confidence would NOT be threatened if I sought professional help.
 - 2) S4: My self-esteem would increase if I talked to a therapist.
 - 3) S9: My self-confidence would remain the same if I sought professional help for a problem I could not solve.

In sum, there are several learnings that came out of this process:

- Including Peers in the decision-making process around measurement in evaluation is critical for selecting appropriate evaluation items.
- Developing the necessary understanding to make such decisions takes time.
- The availability of data gathered as part of the Help@Hand evaluation was critical for using a data-driven approach for shortening the survey instruments.
- When presented with materials that are explained using minimal jargon, it is possible for people with limited training in statistics to understand the core issues and be able to make informed and insightful decisions.
- Evaluation efforts must always find a balance between what is scientifically valid and what is feasible – a partnered Peer-driven approach is an effective strategy for striking this balance.

I believe it was an extremely worthwhile process. It was great to see how the Peers and the UCI team were willing to learn from each other, and how open the creative space was that allowed for a rich and meaningful dialogue. A genuinely enjoyable experience!

– Ron Culver, Northern Valley Catholic Social Service (NVCSS) Supervisor, Tehama County Peer Programs

The evaluation team wishes to extend a thanks to Travis for creating the time and space to do this work. We also wish to extend a special thanks to Ron and the Peers for so generously sharing their viewpoints and being open to learning about scale construction and item selection.

IMPLEMENTATION (LOS ANGELES, ORANGE)

An implementation is the launch of a single product with the focus on the county/city scaling it across their target population or using it for the remainder of the Help@Hand project. Los Angeles and Orange Counties implemented Mindstrong in different ways.

Los Angeles Implementing

In 2020, Los Angeles County decided to discontinue the use of Mindstrong DBT diary cards, which are tools used as part of Dialectical Behavioral Therapy (DBT) to track symptoms and coping skills (Linehan, 1993), at their Harbor-UCLA DBT clinic. The decision was made for two reasons: 1) Mindstrong changed its business model to only support the full Mindstrong Care product line (not the DBT diary cards); and 2) Los Angeles County wanted a product that they could manage “in-house” in order to easily make customizations that meet client and county needs, such as having more active assessments. Los Angeles County also decided to work with MindLAMP to provide diary cards for their clients. A contract with MindLAMP was executed in October 2020 and the teams began transitioning patients from Mindstrong to MindLAMP into the new year.

COUNTY LEADERSHIP AND PROVIDER INTERVIEWS

The Help@Hand evaluation team interviewed Los Angeles County’s leadership (n=2) and providers who used Mindstrong with their clients (n=2) in order to identify lessons learned and recommendations for counties/cities planning to or currently implementing Mindstrong. Interviewees identified **lessons learned**, including:

- **Lack of communication on client use:** Mindstrong was perceived as “a black box” in that providers had limited knowledge of client use (e.g., they did not know what information or services clients were offered, or which clients engaged with Mindstrong unless clients directly informed the providers). This was a significant challenge that helped inform the decision to discontinue Mindstrong.
- **Confusion on biomarker features:** Leadership, providers, and clients did not fully understand Mindstrong’s biomarker function. This also informed the decision to discontinue Mindstrong.
- **Better alignment with county services:** LA County wanted a technology that they could use as part of the clinical services they offer. LA County was especially interested in alignment with other initiatives such as expansion of DBT across LA County. Examples of the features they thought would be beneficial to their clinical services include more directly incorporating the DBT diary card and providing real-time assessments, such as client self-report questionnaires.
- **Issues with accessing Mindstrong:** Use of Mindstrong’s DBT diary card required consistent access to a smart phone or computer. Clients who did not have consistent access were unable to use Mindstrong.

Recommendations based on these lessons learned include:

- **Start planning implementation of Mindstrong early:** Early and ongoing planning with clinics and implementation settings is essential for collaborative problem-solving. Expected implementation challenges include smartphone and computer access, which should be anticipated early.
- **Request Mindstrong trainings:** For those counties/cities proceeding with Mindstrong implementations, Mindstrong can provide specific trainings to providers and other stakeholders within counties/cities on: 1) where to find information about client use and progress (e.g., what clients are doing in their sessions, what resources are offered to clients, and what progress clients are making in their recovery); 2) the biomarker feature and how Mindstrong is using biomarker data; and 3) how to discuss the use and value of biomarkers to clients.

Orange County Implementing

Orange County launched Mindstrong at UCI Health Psychiatry Services in May 2020. The launch began with only two providers referring eligible clients to Mindstrong Care, but later included an additional 22 resident providers

referring eligible clients. After clients are offered a referral, Orange County’s Peers connect with clients to answer questions and gain the consent of clients interested in participating. Mindstrong only contacts those clients interested in participating.

RESIDENT PROVIDER SURVEYS AND INTERVIEWS

In December 2020, 16 resident providers involved in the implementation completed a survey and four participated in interviews. The survey and interview aimed to identify early learnings from the initial few months of implementation, and also elicit strategies to improve the implementation. Findings included:

<p>Survey Findings</p>	<p>Providers had positive impressions of Mindstrong including high acceptability, feasibility, and appropriateness.</p> <p>Providers felt that they had the necessary training, knowledge, resources, support, and leadership necessary to use Mindstrong.</p> <p>Providers felt that it would be important to have additional clarification on different aspects of the Mindstrong product and its care support to better understand who might be most appropriate to use it and why it could be useful to that client.</p>
<p>Interview Findings</p>	<p>Providers had a positive impression of Mindstrong, especially given potential for technology–delivered care during COVID–19.</p> <p>Some barriers identified were onboarding procedures (i.e., blocked numbers, research study framing), clinical and front desk staff having limited knowledge of the Mindstrong implementation, and a lower Mindstrong adoption rate among clients.</p> <p>Additional training could help support better familiarity with the Mindstrong platform. Additional incentives could be provided for referring clients to Mindstrong.</p>

CLIENT SURVEYS AND INTERVIEWS

In addition to resident providers, adopters (e.g., clients who use Mindstrong) will be invited to complete surveys²⁶ and interviews on a regular basis to understand their experience with Mindstrong and to inform learnings and recommendations for the implementation. Non-adopters (e.g., clients referred to Mindstrong, but opt not to participate) will be asked to complete one survey and one interview to understand what factors influenced their decision to not use Mindstrong, and to further inform client outreach improvements.

All client surveys and interview guides were vetted by Orange County’s Tech Leads and Peers as well as UCI Health Psychiatry Services’ clinical champion. The evaluation team began surveying adopters and non-adopters in November 2020. Surveys will continue in 2021.

LEARNINGS FOR THE HELP@HAND COLLABORATIVE: IMPLEMENTATION (LOS ANGELES, ORANGE)

Learnings were identified from Los Angeles and Orange County’s implementation of Mindstrong. The experience with Mindstrong in both counties, however, varied.

Los Angeles Implementation

Interviews with Los Angeles County on their Mindstrong implementation identified several lessons learned.

- Lack of communication on client use: Mindstrong was perceived as “a black box” in that providers had limited knowledge of client use (e.g., they did not know what information or services clients were offered, or which clients engaged with Mindstrong unless clients directly informed the providers).

²⁶ Most surveys are collected via phone in order to ensure as much relevant data is gathered in real time.

- Confusion on biomarker features: Mindstrong’s biomarker function is not clear to the general consumer or their provider.
- Need for better alignment with county services: Los Angeles County wanted a technology that could be used as part of their clinical services they offer. Features that could not be incorporated with Mindstrong were more directly incorporating the DBT diary card and providing real-time assessments, such as client self-report questionnaires.
- Issues accessing Mindstrong: The use of the Mindstrong DBT diary card feature required consistent access to a smart phone or computer. Clients who did not have consistent access were unable to use Mindstrong.

Orange County Implementation

The implementation in Orange County of Mindstrong has focused on a wide-scale roll-out with full use of the Mindstrong product. Interviews conducted in Orange County identified several lessons learned:

- Positive impressions of Mindstrong: Providers had positive impressions of Mindstrong including high acceptability, feasibility, and appropriateness.
- Support and readiness for implementation: Providers felt that they had the necessary training, knowledge, resources, support, and leadership necessary to use Mindstrong.
- Areas for additional information: Providers felt that it would be important to have additional clarification on different aspects of the Mindstrong product and its care support to better understand who might be most appropriate to use it and why it could be useful to that client.
- Identification of early barriers: Some barriers identified were onboarding procedures (i.e., blocked numbers, research study framing), and clinical and front desk staff having limited knowledge of the Mindstrong implementation.

COVID-19 RAPID RESPONSE (LOS ANGELES, RIVERSIDE, SAN FRANCISCO, SAN MATEO)

The impact of COVID-19 required counties/cities to respond in new ways in order to rapidly support their communities. The Help@Hand project management team acknowledged this and developed the COVID-19 Rapid Response framework, which accelerates the process for counties/cities to implement technologies among community members—particularly those most disproportionately affected by COVID-19. In 2020, Riverside County used the framework to launch Take my Hand, while Los Angeles, San Francisco, and San Mateo used it to launch Headspace.

Riverside Implementing Take my Hand

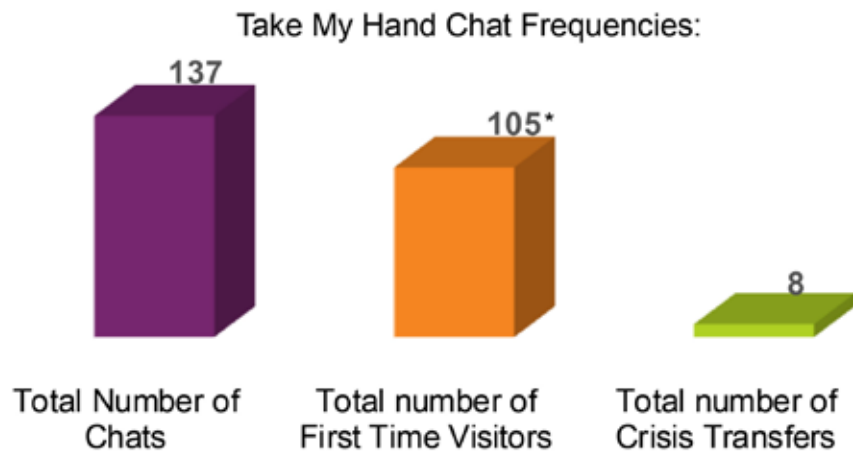
In April 2020, Riverside County developed and launched a peer-chat app called Take my Hand. Peer Support Specialists operated chats and on-call clinicians were available to support individuals whose chats indicated they were in crisis. **Figure 3.5** shows initial peer chat data collected by Riverside County. All figures were presented by Riverside County in their report summarizing Take my Hand’s testing phase between April 17 - June 30, 2020.

Figure 3.5 includes:

- **Chat frequencies:** Riverside County received 137 chats during the testing phase.
- **Time of day chats occurred:** Chats occurred more commonly in the evening than the early morning or afternoon.

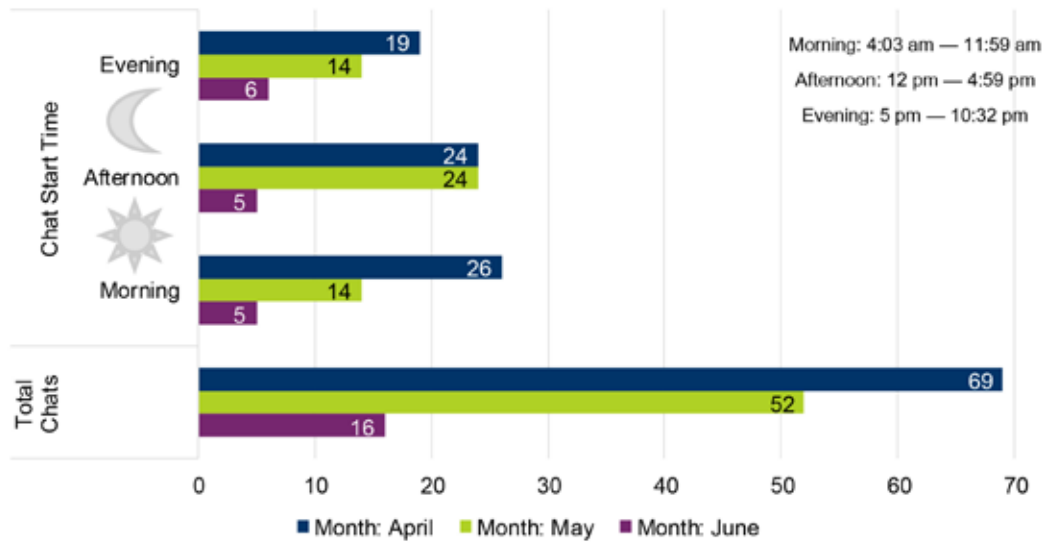
- **Daily chat volume:** Chat volume fluctuated. Most chats occurred early in the testing phase, but the overall volume was fairly low. One reason was due to limited advertising of Take my Hand in order to ensure enough staff capacity to respond to chat requests in the testing phase.
- **Average and sum of all chat duration:** The average chat duration was about 25 minutes.
- **Tags used during chats:**
 “Tags” flagged important topics arising in the chats, and helped Peers and clinicians assist consumers appropriately by informing them of the consumer’s needs. Common tags are shown in the figure.
- **Customer demographic characteristic.** Gender, age, race/ethnicity, zip code, and other characteristics were collected.

Figure 3.5. Peer Chat Data Presented by Riverside County During Take my Hand Testing Phase

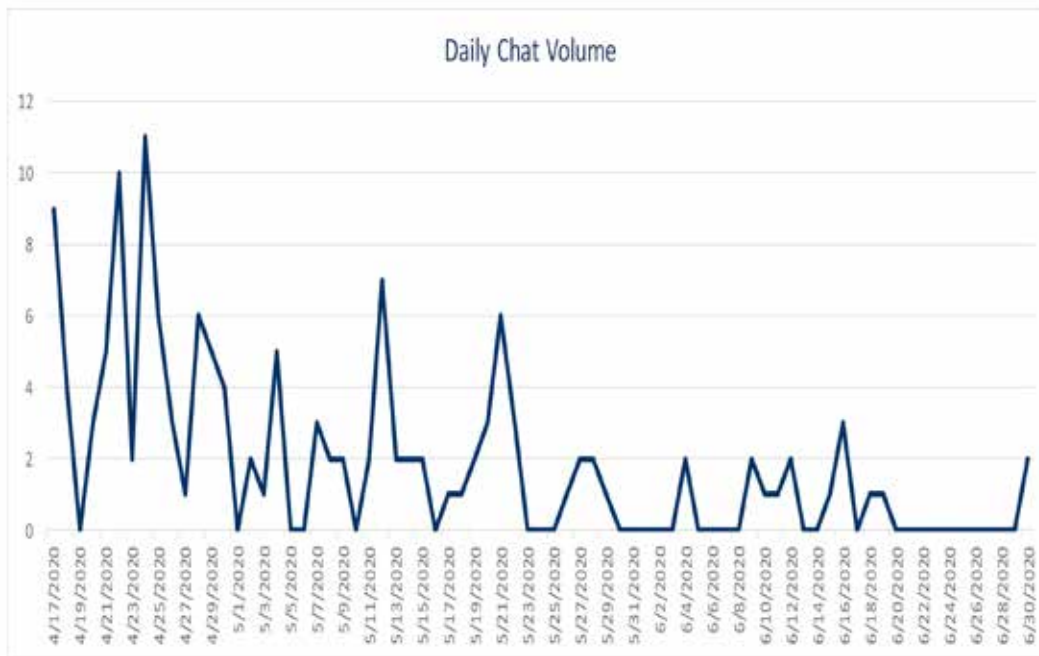


*One Spanish visitor, first timer

Time of Day Chats Occurred:



Daily Chat Volume



Average Chat Duration (n=137):

25.05 min.

(min: 21s, max: 2hr. 40min.)

Average Waiting Time for a Peer to Pick-up a Chat:

31.01s

(min: 4s, max: 12min.)



Average Time for Consumer to Reply in the Chat:

67.73s

(min: 7s, max: 4.3min.)

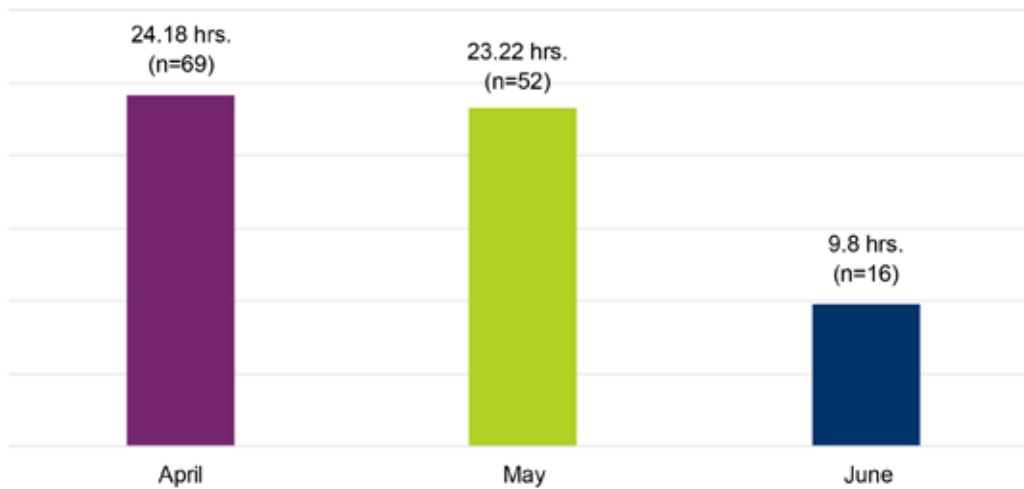
Crisis Transfers

Average Chat Duration (n=8):

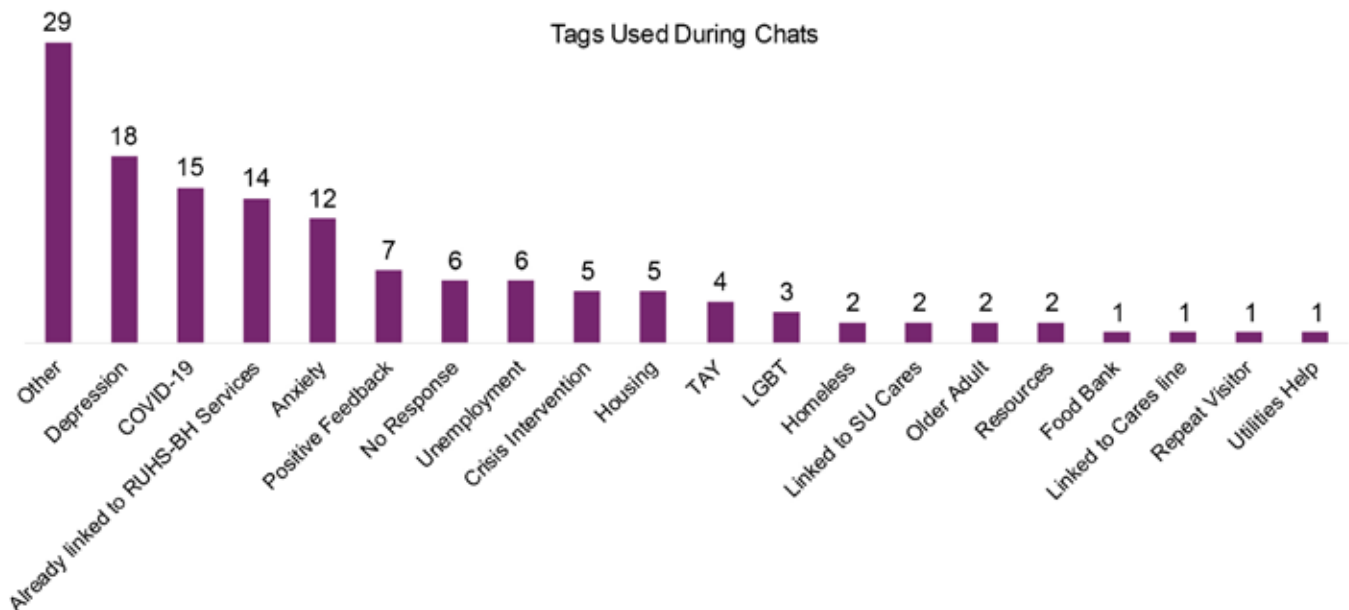
35.03 min.

(min: 3min, max: 1hr. 57min.)

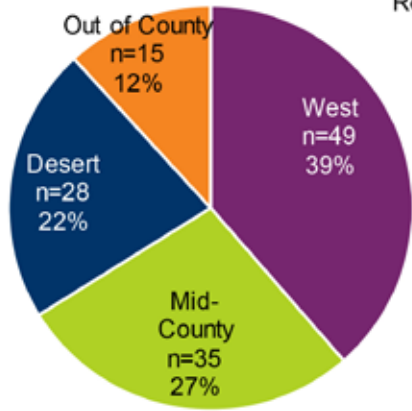
Sum of All Chat Durations per Month (n=137)



Tags Used During Chats



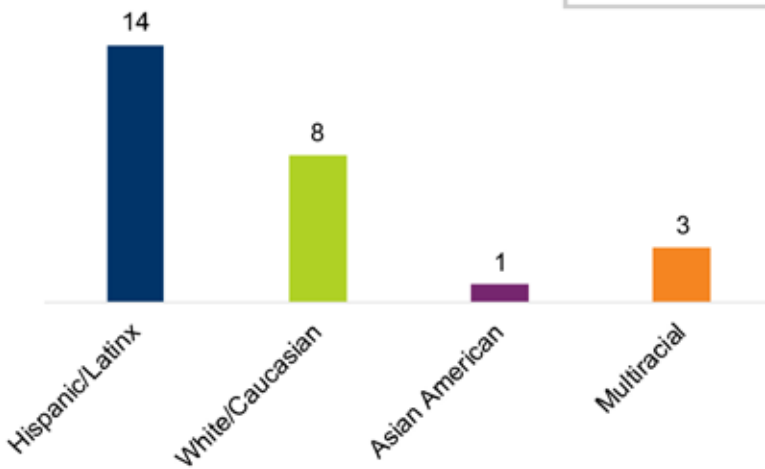
Demographic Characteristics



Region (n=127)

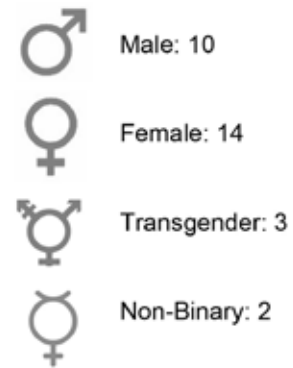
Top 5 Customer Reported Zip codes			
Zip code	City	Region	Count
92507	Riverside	West	n=11
92503	Riverside	West	n=7
92879	Corona	West	n=6
92585	Menifee	Mid-County	n=5
92201	Indio	Desert	n=4

Race/Ethnicity (n=26)

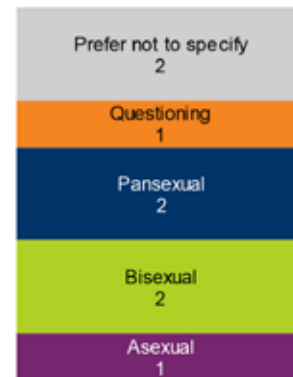


Age Group:
 TAY: 6
 Adult: 13
 Older Adult: 5

Gender (n=26)



LGBTQ+ Community (Yes=8)



	Veteran	Deaf or Hard of Hearing	Disabling Condition
Yes	3	1	4
No	23	25	22



Riverside County developed Take my Hand as a web-based live chat application that provides one-on-one support from a credentialed Peer Support Specialist. It was initially developed for the Help@Hand project but was rapidly deployed as additional support to the community after the 211 and 911 crisis call centers became overwhelmed following the COVID-19 pandemic. Take my Hand entered its public testing phase April 17th, 2020 to June 30th, 2020. Take my Hand was offered 24/7 to the Riverside community and utilized Riverside University Health System-Behavioral Health’s (RUHS-BH) Peer workforce, in addition to clinical therapists in the event of a crisis situation. An evaluation plan was developed for Take my Hand’s trial phase.

Information was synthesized from the rapid deployment of Take my Hand led by RUHS-BH and their Peer team for the purposes of the formative evaluation (see Appendix G). This includes identifying lessons learned and providing recommendations from the Help@Hand evaluation team. Sources of data used for this synthesis included: 1) “RUHS-BH Take my Hand Live Peer Chat COVID-19 Rapid Deployment-Test Phase Report” developed by the Help@Hand Team in Riverside County; 2) “Take My Hand Test Phase Report” developed by Riverside County’s local evaluators; and 3) Riverside County meeting notes from the Help@Hand evaluation team. This synthesis may provide generalizable insights as to how other counties/cities might successfully implement and sustain Take my Hand and/or apply learnings from Riverside’s experience to their own implementations of other technologies.

Los Angeles, San Francisco, San Mateo Planning and/or implementing Headspace

Los Angeles County used the COVID-19 Rapid Response framework to launch free Headspace subscriptions for all county residents in April 2020. San Mateo Headspace is available to all county residents. The San Mateo team chose to focus their outreach on a small, targeted audience first. They will begin a broader outreach in 2021. Meanwhile, San Francisco County plans to provide free Headspace subscriptions to all county residents in 2021.

HEADSPACE IN LOS ANGELES AND SAN MATEO COUNTIES

Below is data from the Headspace roll-out in Los Angeles and San Mateo Counties. Data includes monthly active users, monthly engagement rate, and engagement by content type.³⁰

METRIC	DEFINITION
Monthly Active Users (MAU)	Number of enrolled Headspace members who have engaged with at least 1 piece of content in Headspace in a given month
Monthly Engagement Rate	Percent of total enrolled Headspace members who have engaged with at least 1 piece of content in Headspace in a given month (e.g., number of members who have engaged in a given month / total number of enrolled members)
Engagement by Content Type	The number of users engaging with each section in the app (e.g. focus, meditation, sleep, etc.)

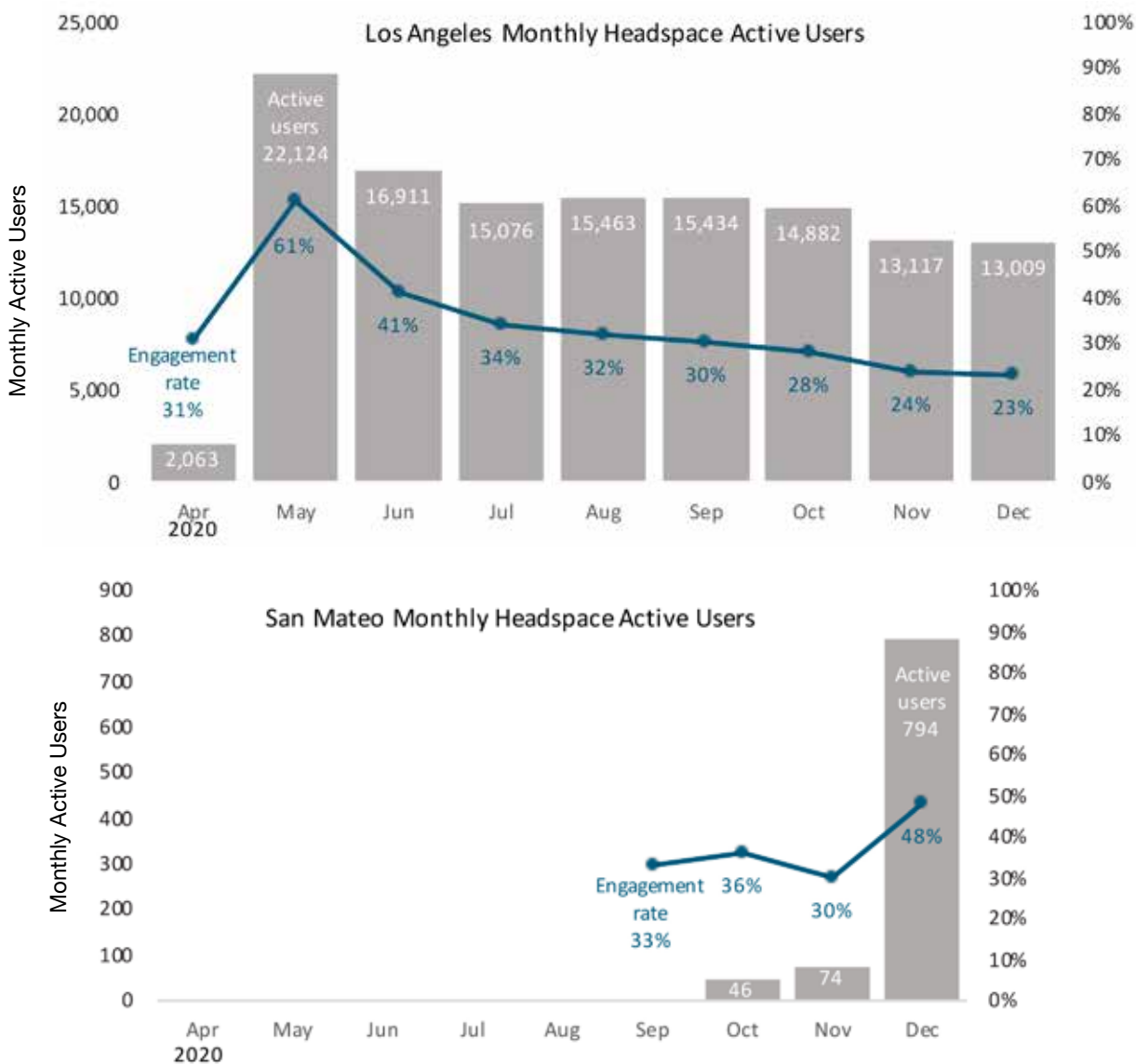
³⁰ Data was from the Headspace Enrollment Report for Los Angeles and San Mateo Counties. This report is available on each counties’ Headspace dashboard.

Monthly Active Users and Monthly Engagement Rate

Figure 3.6 shows monthly active users and monthly engagement rate change from month-to-month, which is typical. This may be due to a number of reasons, including: marketing/advertising from the county and/or Headspace, current events, the time of the year, and more. For example, Netflix released a series on Headspace that may cue people to use the app after watching the show, or make them less likely to use the app and watch the show instead. Note that there are considerable differences between the monthly active users in Los Angeles County compared to San Mateo County because Los Angeles County made Headspace available to the entire county, while San Mateo conducted outreach to a small, targeted population.

The figure also shows that overall users in Los Angeles and San Mateo Counties may have an initial burst of interest in the technology and then later lose interest and be less engaged. These declines in use and engagement over time are common. In fact, use and engagement of Headspace by users across the United States declines over time. Studies have corroborated this pattern and found that nearly 1 in 4 people abandon apps after only one use (Perez, 2016). This suggests that the first few days of use may be when someone is a “motivated audience” and most interested in using a technology, and it is therefore critical for counties/cities to support and encourage people to use the app within the first few days of access.

Figure 3.6. Monthly Active Users for Los Angeles and San Mateo Headspace



Engagement by Content Type

Metrics such as monthly active users do not tell the full story. Engagement data within the app is crucial to understanding what people are using, and potentially benefiting from, in the app. This information might be useful to drive marketing and messaging. For example, the figures below show the types of content people are most engaged with in Los Angeles and San Mateo Counties.

In Los Angeles County, Headspace’s meditation content was most popular from May-August 2020. Content related to sleep then became more popular beginning in September 2020.

Figure 3.7. Los Angeles Headspace – Engagement by Content Type

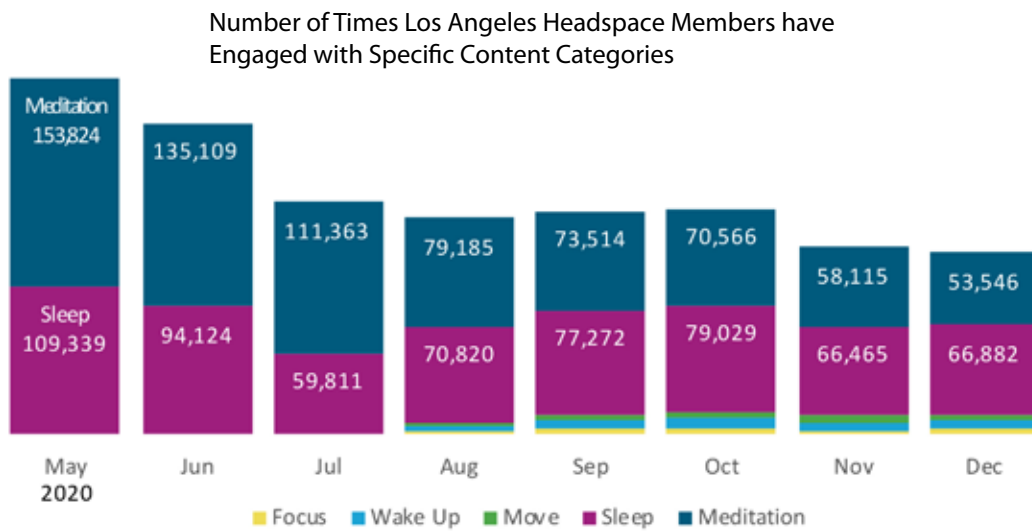
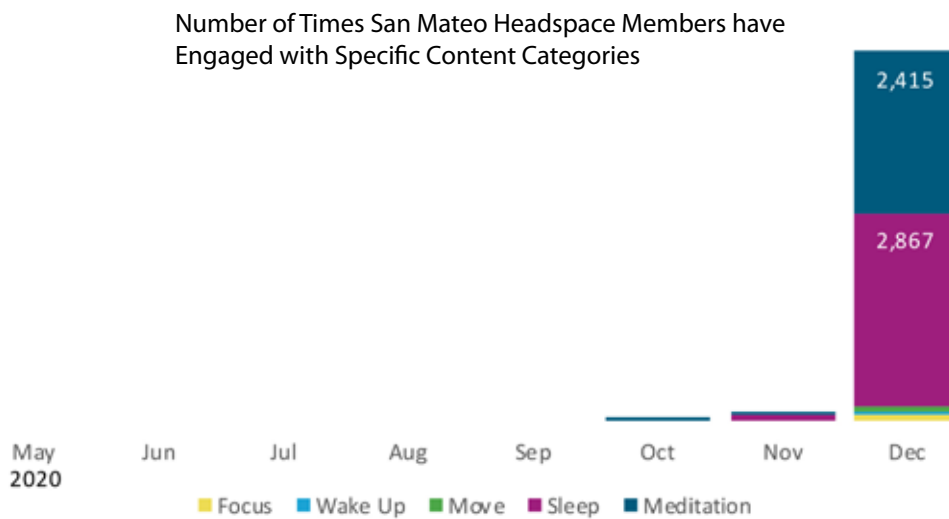


Figure 3.8. San Mateo Headspace – Engagement by Content Type



LEARNINGS FOR THE HELP@HAND COLLABORATIVE: COVID-19 RAPID RESPONSE (LOS ANGELES, RIVERSIDE, SAN FRANCISCO, SAN MATEO)

Various lessons were learned from Los Angeles, Riverside, San Francisco, and San Mateo Counties who used a framework developed by Help@Hand's project management team to accelerate the process of implementing technologies in communities. Riverside County implemented their Take my Hand platform, whereas the other counties implemented Headspace.

Riverside County's Take my Hand

- Importance of a live virtual platform: Riverside County identified a public health need to find a safe alternative to alleviate the growing strain being placed on 911 and 211 crisis call centers at the onset of the COVID-19 pandemic. Offering a support service via a live virtual platform may expand accessibility, support, and mental health services to those within and outside of Riverside County's behavioral health system.
- Training needs: Training varied across Peer Support Specialists, which highlighted the need to identify and define core competencies required for Peer Operators.
- Effective resources: Resources on the Take my Hand platform with Helpline information and "canned responses" to connect users with crisis-related resources were effective ways to help clients until a warm hand-off with clinical staff could be made.

Headspace Rapid Response

- Initial user engagement: The first few days after a client downloads an app may be the most likely time for them to become engaged with the app. Thus, it is critical for counties/cities to support and encourage people to use the app within the first few days of access.
- Value of app-level, county-specific data: App-level, county-specific data provided by app developers can help increase project learnings (for example, data on Headspace Engagement in Los Angeles and San Mateo), and is more valuable to evaluative efforts than looking at marketplace trends overall.

RFI AND RFP DEVELOPMENT (MONTEREY, LOS ANGELES)

Monterey County plans to develop a tool for all county residents that screens for various behavioral health issues and refers users to care. In early 2020, Monterey County developed and released a Request for Information (RFI) that gathered feedback from the vendor community on matters related to the development of the tool. Based on the RFI results, Monterey County developed a Request for Proposals (RFP) to solicit proposals from vendors interested in developing the app. The RFP will be released in 2021. This effort was done in partnership with Los Angeles County. The **spotlight** on page 81 shares more information about Monterey County's RFI and RFP process.

PROJECT COMPLETION (KERN, MODOC)

In 2020, Kern and Modoc Counties announced they completed their projects and would transition off Help@Hand. Exit interviews were conducted with each county's project lead (e.g., Tech Lead) to:

1. **Evaluate their experiences** as part of Help@Hand.
2. **Document lessons learned** from these experiences.
3. **Gather recommendations** for other counties and cities in Help@Hand.

LEARNINGS FOR THE HELP@HAND COLLABORATIVE: PROJECT COMPLETION (KERN, MODOC)

Exit interviews with Kern and Modoc Counties identified collaborative accomplishments from their Help@Hand experience, including:

- **New collaborations:** Counties/Cities forged new partnerships with each other as a result of the Help@Hand program. For example:
 - Kern County was the first to curate an app guide—a list of apps that may benefit its community. Kern collaborated with other counties/cities to adapt and distribute the app guide for various communities.
 - Through opportunities such as Kern County's Peer Summit, Peers strengthened relationships with and learned from Peers in other counties/cities.
- **Awareness of mental health resources and needs:** Overall, the Tech Leads observed increased awareness of mental health resources and of the need for tailored, innovative, and easy to access mental health services.
- **Importance of Peers:** The Help@Hand program highlighted the significant value and contributions of Peers, identifying and providing opportunities to increase Peer visibility and in activities led by counties/cities. Modoc and Kern Counties also identified lessons learned:
- **Peer training and supervision:** Peers are an important workforce within Help@Hand; however, Kern and Modoc Counties struggled to provide sufficient Peer training and supervision that would allow Peers to consistently contribute their skills to needed areas of the project.
- **Private (vendor) and public (county/city) misalignment:** County Tech Leads perceived a misalignment of project goals between private (vendor) and public (county/city) entities. For example, counties/cities prioritize ensuring access to services for those most at need, but vendors prioritize growing their market potential. Also, vendors are generally more experienced in developing novel service delivery methods than in working within existing service systems. This tension has brought about challenges with developing and interpreting contracts between vendors and counties/cities.
- **Balancing implementation needs:** Challenges persisted in counties balancing the necessary resources for implementing within their counties and completing required deliverables for Collaborative-wide project management. These challenges were often perceived to slow progress in implementation and create administrative burden, especially among smaller counties/cities with fewer resources.

Recommendations based on these lessons learned include:

- Facilitate more cross-collaborations: CalMHSA could offer flexible use of supplemental funds to counties/ cities in order to develop and support cross-collaborative subprojects within Help@Hand that may extend beyond technology implementations. CalMHSA may offer operational and project management support for these subprojects.
- Facilitate “communities of practice”³¹: CalMHSA would be instrumental in facilitating the communities of practice due to their unique role as the project manager of the overall Help@Hand project. CalMHSA would not be expected to lead the communities of practice, but to provide the structure in which they could be facilitated. CalMHSA is able to facilitate these communities of practice because they have knowledge of each county/city’s interests and where shared interests might lie.

CalMHSA could facilitate communities of practice or affinity networks within the Help@Hand project to: 1) increase collaborative problem-solving through sharing of resources, experiences, tools, and best practices; 2) increase support to Peers and capitalize on strengthening Peer relations across counties/cities; and 3) speed translation of learnings into practice. Communities of practice may include:

- o Subgroups focused on specific technologies (e.g., Headspace or myStrength) and/or populations (e.g., TAY or isolated older adults). These topics arise in different meetings, but not enough time is available for them. The subgroups would convene in a way that allows time for in-depth learning.
- o Regular topical meetings or interactive web tools that allow for easy sharing and access to resources or plans, which could be particularly beneficial to Peers.³¹
- o Subject matter experts train or facilitate on topics of interest, such as a presentation or case study about a successful implementation of myStrength, along with lessons learned.
- Hire staff to support the Peer component of Help@Hand: Given the need for Peer training and supervision resources, CalMHSA should accelerate efforts to fill the position of Peer Engagement and Community Manager and supplement this position with a second Peer for administrative support, Peer support, and continuity in the event of personnel turnover.

³¹ An example of an online community practice would be the Implementation Science Coordination, Consultation & Collaboration Initiative for HIV/AIDS research, which provides various resources for project planning and implementation in their resource hub: <https://isc3i.isgmh.northwestern.edu/resource-hub/>

SPOTLIGHT

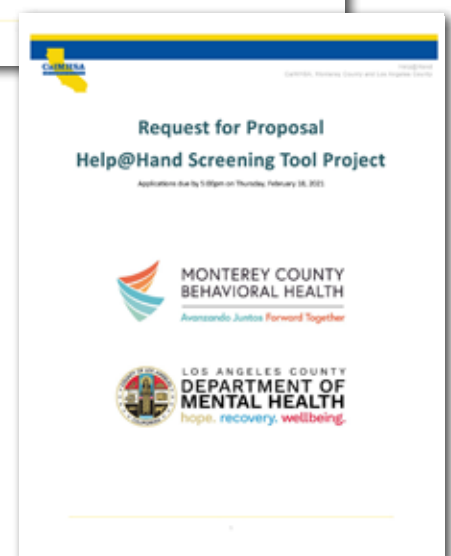
Monterey County's Model for Building a Web-Based Screening Tool



Mental health screenings are often the first step in getting help. However, Monterey County identified an important need faced by many county behavioral health systems -- walk-in clinics and other behavioral health services surpassed the county's capacity to screen clients and refer them to appropriate care and services. In response, Monterey County chose to focus their Help@Hand efforts toward creating a web-based screening tool that would screen for various behavioral health issues and refer people to care.

Wes Schweikhard, Monterey County's Tech Lead, referred to the tool as a *“way to minimize the time spent between someone experiencing symptoms and accessing services. We hope this will be a powerful tool that the public can use without any prior experience with mental health issues or services, providing them with useful information regarding their (or someone else's) symptoms and connect them to care. We also hope this will prove to be an aid to our clinical environments by providing a meaningful and accurate precursory assessment, which may allow for more clinical staff time to be devoted to therapy services.”*

The goal is for the web-based screening tool to be available to all residents from Monterey County, Los Angeles County, and potential other participating California municipalities. This tool is not intended to provide a clinical diagnosis, but rather to guide a person through a series of questions with the purpose of helping them to understand potential symptoms, to give educational information, and to provide an option for referrals to available support resources. Furthermore, those who receive a referral will have their assessment results made available to appropriate care resources in order to expedite intake processes.



Request for Information (RFI) and Request for Proposal (RFP)

As noted in their approved MHSA Innovation Plan Proposal, the tool will be developed around the following core criteria:

Tool to be Developed around Following Core Criteria

- Being able to screen for a broad range of disorders, from low-risk with mild need to severe with urgent need.
- Being easily accessible for use by community-based providers to help individuals acquire treatment.
- Maintaining confidentiality standards.
- Interfacing with MCBH's Avatar electronic health record system to provide more seamless transitions into care.
- Working fluently in Spanish.
- Build upon current evidence-based screening tools with proven validity, and utilize item response theory to minimize the number of questions involved in the assessment.

Monterey County decided to custom build this screening tool, rather than procure and adapt another product. This decision was largely based on a noted absence in the marketplace of a product that offered both a robust assessment functionality and also delivered referrals within the local county environment. Given that Monterey County had no prior experience developing a technology product, they joined the Help@Hand Collaborative to leverage the resources of the project, particularly CalMHSA's procurement processes and expertise in the technology space.

As part of the Collaborative, Monterey County has received extensive support and guidance from CalMHSA and formed a partnership with Los Angeles County Department of Mental Health. To start the work, Monterey County and CalMHSA initially began to develop a Request for Proposal (RFP) to design and build the tool. However, several questions arose while developing the RFP, such as: What are the required vendor qualifications? What does it actually take to develop an app? and, How much should this cost?

Given the number of outstanding questions that needed to be answered prior to selecting a vendor, CalMHSA and Monterey County made an incremental decision to release a Request for Information (RFI) prior to developing the final RFP. We described the RFI as a "rough draft" of the county's vision and needs, meant to solicit responses from vendors with information on the vendors' potential approach. In particular, the RFI was designed to help Monterey County gather information that will be used to define the scope of their product by filling in important details that were previously missing, like the market rate to develop the app and technical approaches. Vendors also raised important questions about the county's current technology infrastructure and data storage requirements, highlighting the need to include the county's information technology team on this project.

The RFI was released on 04/20/20 and concluded on 05/29/20, there were 17 respondents. This foundational work was important as it generated a number of key learnings:

- 1. Confirmed the feasibility of the general approach.** The quality and quantity of the received responses provided evidence of feasibility that the technology vendor community could submit proposals based on the identified requirements within the proposed budget framework.
- 2. Indicated that the clinical and technical requirements of the tool could be addressed by a single vendor.** Prior to the RFI, there was some thought that two or more vendors might be needed to address the design requirements separately of the technical requirements. Responses to the RFI clearly suggested that this work could be accomplished by a single vendor, thus simplifying the overall process.
- 3. Informed licensing.** Technology vendors raised the issue of the complex licensing requirements that might burden counties/cities when trying to make changes to the product and/or raise concerns around ownership of the product in the future. As a result of the RFI, Monterey County identified the need to own the product in partnership with CalMHSA and Los Angeles County.
- 4. Highlighted the value of using the RFI mechanism to test assumptions around technology requirements.**

Monterey County is anticipating that building a digital mental health product will require a team with diverse skillsets with technical and clinical backgrounds. Wes, who has a background in data management and analytics, has been the primary Monterey County employee working on Help@Hand. Jon Drake, the Assistance Bureau Chief of MCBH, has joined the project in recent months to provide additional guidance and support with his extensive procurement experience. It is anticipated that additional county staff, specifically clinical and IT subject-matter experts, will become engaged once development of the tool begins.



Wes Schweikhard,
Monterey County's
Tech Lead

Wes recommended that other counties considering a similar route *“have robust discussions, buy-in, and participation with clinical, IT and peer representatives in your county early on, to identify the specific goals, consumer experience and integrations your tech project will have. This will help articulate your scope in more tangible terms and also help set realistic expectations regarding staff involvement, to ultimately make the RFP and implementation processes go more smoothly.”*

Monterey County, Los Angeles County, and CalMHSA are pleased to announce that the RFP was released on January 8, 2021.

Learnings from the Technology, User Experience, and Implementation Evaluation

The Help@Hand evaluation team worked closely with the Help@Hand Collaborative to support several counties/cities' activities this year. Key learnings include:

- **Engagement Challenges.** Several counties/cities have noted the challenges of engaging with stakeholders remotely given COVID-19 and stakeholders' digital literacy levels, which will influence their ability to engage in a remote process. Additional planning, follow-up with participants, and organization/structure, as well as leveraging partnerships to reach community members, may be needed.
- **Needs Assessment.** As noted by the counties/cities, it is important to engage community stakeholders throughout the project. A needs assessment is one opportunity to engage stakeholders and gather feedback early in the process to better match users' needs with potential technologies.
 - o Through needs assessments with two target audiences—community college students in Los Angeles County and members of the Deaf and Hard of Hearing Community in Riverside County—both accessing professional services and informal support resources for managing their own mental health emerged as desired resources.
- **Technology Exploration and Selection.** Technology explorations in Marin, San Mateo, and Riverside Counties revealed similarities across target audiences in terms of perceptions of technologies.
 - o Both older adults and TAY emphasized the importance of cultural competency in technologies, the value of being able to connect with others within the technologies, the potential of integrating technologies with health services, and the usefulness of a variety of content that is updated regularly.
 - o Consistently across both needs assessments and technology explorations, privacy concerns—in terms of what information is collected and how it is used—has been discussed as a potential barrier to using technologies to support mental health.
 - o Differences across target audiences also emerged through technology explorations in Marin, San Mateo, and Riverside Counties. For older adults, digital literacy, how mental health is perceived, and on-going technical support are key; whereas, for TAY, the visual aesthetic of the technology is an important factor that would influence use.
- o Through technology explorations of myStrength in Marin and San Mateo Counties, participants consistently reported the variety of content within myStrength positively, but had some concerns about the demographic information that users are required to share within the app in order to use it.
- **Los Angeles Implementation.** It should be noted that the Mindstrong implementation in Los Angeles was limited to a small number of clients with limited access to the full product. As such, interviews with Los Angeles County on their Mindstrong implementation identified several lessons learned.
 - o **Lack of communication on client use:** Mindstrong was perceived as “a black box” in that providers had limited knowledge of client use (e.g., they did not know what information or services clients were offered, or which clients engaged with Mindstrong unless clients directly informed the providers).
 - o **Confusion on biomarker features:** Mindstrong's biomarker function is not clear to the general consumer or their provider.
 - o **The need for better alignment with county services:** Los Angeles County wanted a technology that could be used as part of their clinical services they offer. Features that could not be incorporated with Mindstrong were more directly incorporating the DBT diary card and providing real-time assessments, such as client self-report questionnaires.
 - o **Issues accessing Mindstrong:** The use of the Mindstrong DBT diary card feature required consistent access to a smart phone or computer. Clients who did not have consistent access were unable to use Mindstrong.

- **Orange County Implementation.** The implementation in Orange County of Mindstrong has focused on a wide-scale roll-out with full use of the Mindstrong product. Interviews conducted in Orange County with providers identified several lessons learned:
 - o **Positive impressions of Mindstrong.** Providers had positive impressions of Mindstrong including high acceptability, feasibility, and appropriateness.
 - o **Support and readiness for implementation.** Providers felt that they had the necessary training, knowledge, resources, support, and leadership necessary to use Mindstrong.
 - o **Areas for additional information:** Providers felt that it would be important to have additional clarification on different aspects of the Mindstrong product and its care support to better understand who might be most appropriate to use it and why it could be useful to that client.
 - o **Identification of early barriers:** Some barriers identified were onboarding procedures (i.e., blocked numbers, research study framing), and clinical and front desk staff having limited knowledge of the Mindstrong implementation.
- **COVID-19 Rapid Response.** Various lessons were learned across different Counties implementing technologies as a rapid response to COVID-19 (i.e., Riverside, Los Angeles, San Francisco, and San Mateo).

Riverside-Take my Hand for COVID-19

- o Riverside County identified a public health need to find a safe alternative to alleviate the growing strain being placed on 911 and 211 crisis call centers at the onset of the COVID-19 pandemic. Offering a support service via a live virtual platform may expand accessibility, support, and mental health services to those within and outside of Riverside County's behavioral health system.
- o Depth of nature and training varied across Peer Support Programs, thus recognizing a need to identify and define core competencies required for Peer Operators.
- o Accessing resources (on the Take my Hand platform) with Helpline information available and using "canned responses" around connecting the

user with crisis-related resources was an effective alternative until a warm hand off with clinical staff could be made.

Headspace Rapid Response for COVID-19

- o The first few days after a client downloads an app may be the most likely time for them to become engaged with the app. Thus, it is critical for counties/cities to support and encourage people to use the app within the first few days of access.
- o App-level, county-specific data provided by app developers can help increase project learnings (for example, data on Headspace Engagement in Los Angeles and San Mateo), and is more valuable to evaluative efforts than looking at marketplace trends overall.
- **Project Completion.** As part of Kern and Modoc County's experience completing the Help@Hand project, various lessons were learned.
 - o **Peer training and supervision:** Peers are an important workforce within Help@Hand; however, Kern and Modoc Counties struggled to provide sufficient Peer training and supervision that would allow Peers to consistently contribute their skills to needed areas of the project.
 - o **Private (vendor) and public (county/city) misalignment:** County Tech Leads perceived a misalignment of project goals between private (vendor) and public (county/city) entities. For example, counties/cities prioritize ensuring access to services for those most at need, but vendors prioritize growing their market potential. Also, vendors are generally more experienced in developing novel service delivery methods than in working within existing service systems. This tension has brought about challenges with developing and interpreting contracts between vendors and counties/cities.
 - o **Balancing implementation needs:** Challenges persisted in counties balancing the necessary resources for implementing within their counties and completing required deliverables for Collaborative-wide project management. These challenges were often perceived to slow progress in implementation and create administrative burden, especially among smaller counties/cities with fewer resources.

4 OUTCOMES EVALUATION AND DATA DASHBOARDS

Key Points

- The evaluation team worked with experts to identify mental health stigma measures. A report that describes and recommends different mental health stigma measures to be included in the Help@Hand evaluation was developed in Year 2.
- The California Health Interview Survey (CHIS) included questions specifically tailored for the Help@Hand program on the use of on-line mental health resources. An important finding was both teens and adults with high distress levels compared to those with lower distress levels were more likely to have used online tools to connect with others with similar mental health or alcohol/drug concerns.
- Statewide vital statistics data on suicides and drug and alcohol overdoses in California between 2015-2019 were analyzed. Prior to launching technologies in Help@Hand counties, general rates of suicide and overdose are slightly higher in non-Help@Hand counties (those California counties not participating in Help@Hand) than in Help@Hand counties.

OVERVIEW

This section focuses on evaluating the impact of Help@Hand at a statewide level. It presents the following activities and learnings:

- **Outcomes Evaluation**
 - o Measuring Mental Health Stigma
 - o Data from Different Sources
 - o Learnings from the Outcome Evaluation
- **Data Dashboards**

OUTCOMES EVALUATION

The outcomes evaluation assesses Help@Hand's impact in California related to its five shared learning objectives:

1

Detect and acknowledge mental health symptoms sooner;

2

Reduce stigma associated with mental illness by promoting mental wellness;

3

Increase access to the appropriate level of support and care;

4

Increase purpose, belonging, and social connectedness of individuals served;

5

Analyze and collect data to improve mental health needs assessment and service delivery.

Measuring Mental Health Stigma

The evaluation team was able to identify measures for each of the learning objectives, except mental health stigma. In Year 1, the Help@Hand evaluation team performed a literature search of stigma measures and identified a large number of measures (over 400). A community participatory approach was used to ensure that the stigma measures used for this program: 1) capture the type of impact expected of Help@Hand technologies to be implemented; 2) meet the dimensions of stigma of interest to the participating Help@Hand counties/cities; and 3) are scientifically valid.

In Year 1, a panel of five Peers and individuals with lived experience and/or family member experience, as well as six academics with expertise in developing stigma measures, was convened. A report that described the process of identifying and recommending mental health stigma measures to be included in the Help@Hand evaluation was developed in Year 2.

Data from Diverse Sources

Counties/cities and technology vendors collected important data that can help reveal the full impact of Help@Hand in communities and in the state. This work included discussing how to access data from county/city and technology vendor systems.

In addition, the Help@Hand evaluation team worked with stakeholders to collect data from the California Health Interview Survey (CHIS) and California Health and Human Services (CHHS).

CHIS

CHIS is the largest state health survey in the nation. It asks questions on a wide range of health topics to a random sample of teens and adults throughout the state of California. In addition to collecting data from CHIS' routinely asked survey, the Help@Hand evaluation team and CalMHSA worked with CHIS to include additional questions related to Help@Hand. **Appendix H** includes these additional questions.

CHIS fielded their survey with the additional questions from September 2019-December 2019 for adult surveys and from September 2019-January 2020 for teen surveys. Data from the CHIS survey provided insights on the use of mental health technologies in California.³² Overall, Help@Hand counties and non-Help@Hand counties had similar trends. **Appendix I** includes a table of the following data for specific counties.

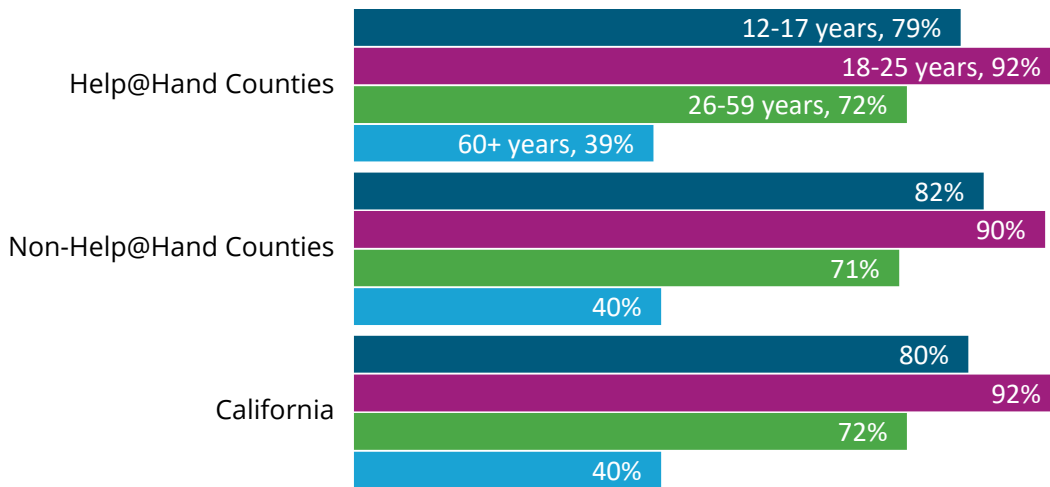
Age

Figure 4.1 shows the percent of people who use the internet and social media almost constantly or many times a day by age group for the Help@Hand counties, the comparison counties, and the State of California. The highest levels of use were among those age 18-25, followed by those age 12-17, and 26-59. People over the age of 60 had the lowest rates of intensive daily use; however, nearly 40% reported accessing the internet constantly or many times per day.

³² The teen analytical sample was restricted to individuals between the ages of 12 to 17 and included 847 participants. The adult analytical sample was restricted to individuals of age 18 and older and included 22,160 individuals.

Figure 4.1. Internet and Social Media Use by Age

Participants who on a daily basis use the internet almost constantly or many times a day



Participants who on a daily basis use a computer or mobile device for social media almost constantly or many times a day

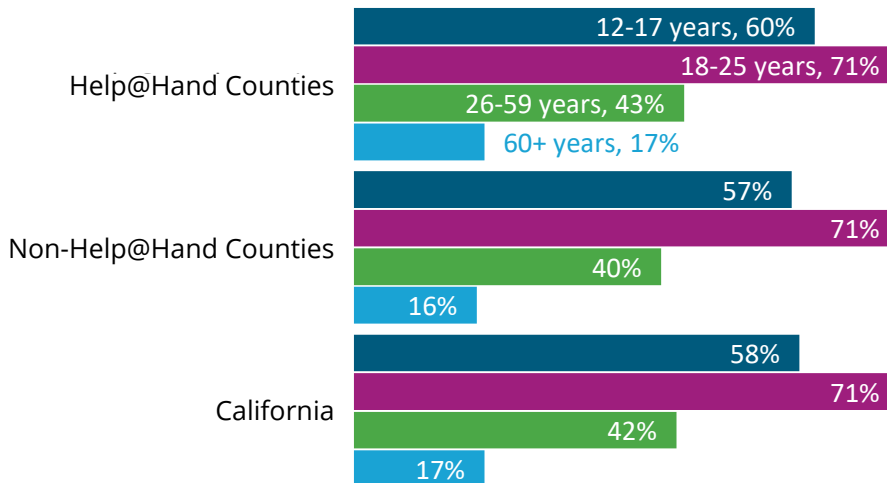
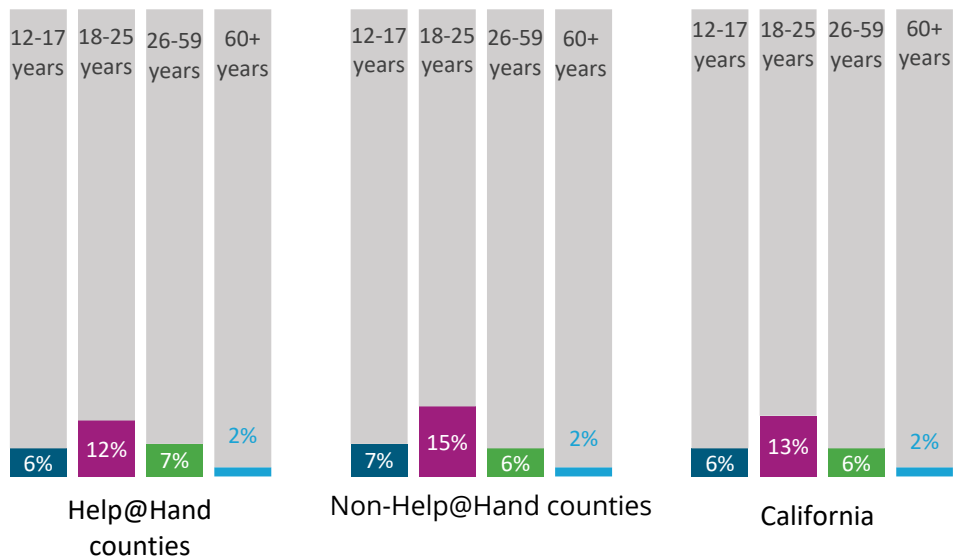


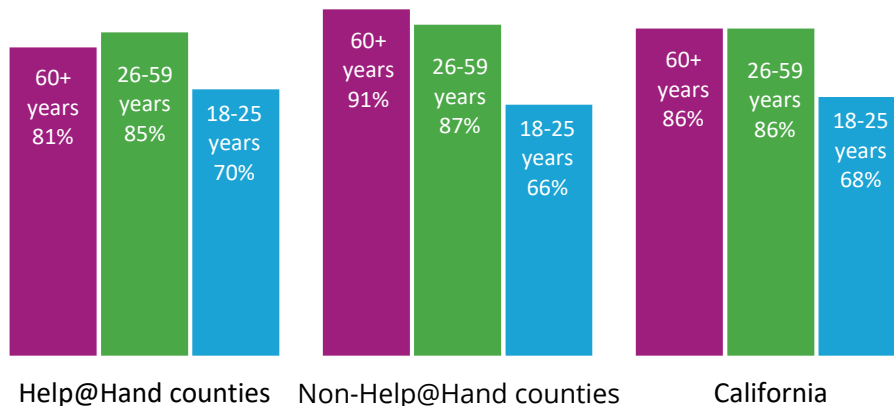
Figure 4.2 shows that 18-25 year olds (13% of them for all counties in California) also reported using online tools for mental health or addiction support more than other age groups in the past year. However, the individuals from age groups 26-59 and 60+ years found these tools more useful than the 18-25 year olds. This may suggest that TAY may be more likely to use online tools. Interestingly, there were generally high levels of usefulness among all people who tried these products, suggesting that understanding the various factors that impede access may be a fruitful area for exploration.

Figure 4.2. Use of Online Tools by Age

Participants who in the past 12 months tried to get help from an online tool for problems with their mental health, emotions, nerves, or use of alcohol or drugs



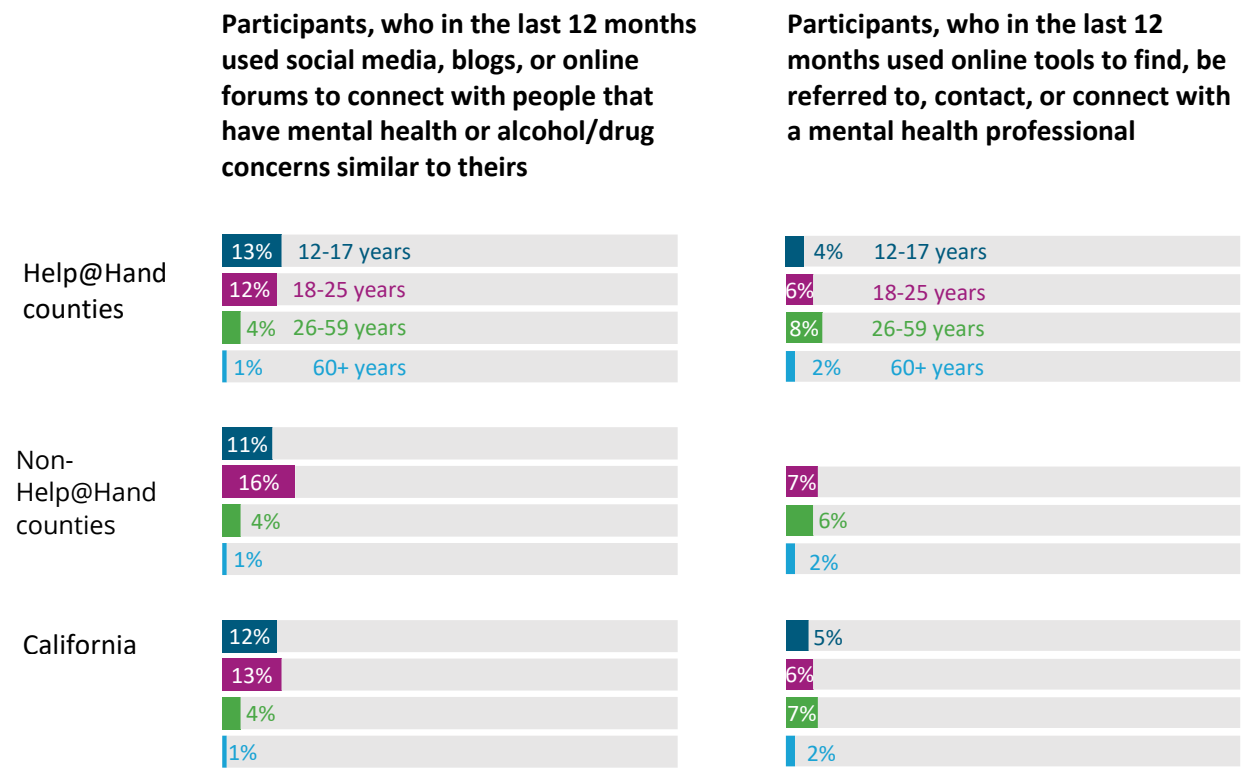
Adults who rated the online tool they used as somewhat or very useful



As shown in **Figure 4.3**, less than 15% of individuals surveyed used social media, blogs, and/or other online tools to connect with people with similar mental health or alcohol/drug concerns and/or connect with a professional. Taken with the findings from **Figure 4.2** above, perhaps people might be more likely to use an online tool to address their emotional needs, rather than using tools to connect to others.

Distress Level

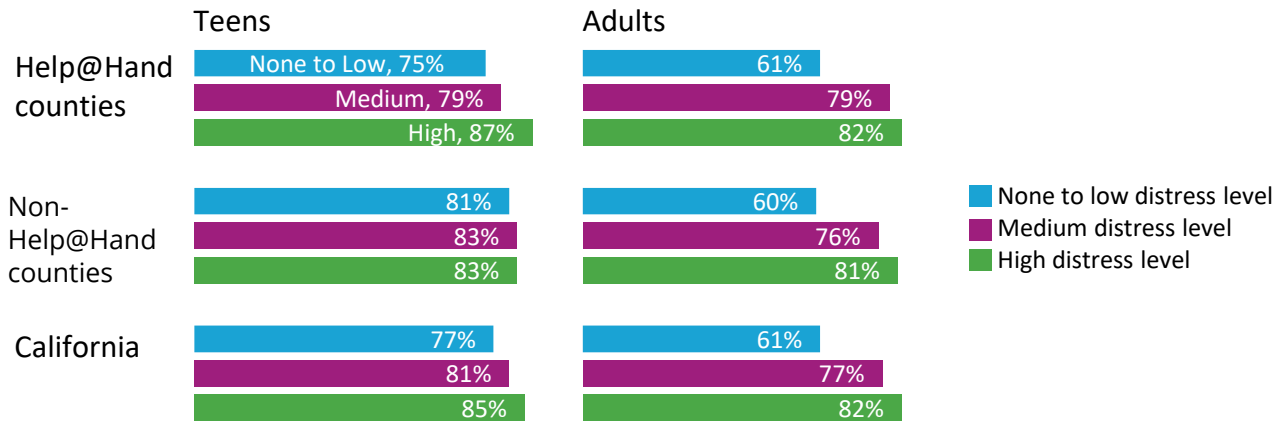
Figure 4.3. Use of Online Tools to Connect with Others by Age



Similar data was analyzed for teens and adults by distress level. For teens, the use of the internet and social media is relatively high for all distress levels (as shown in **Figure 4.4**). For adults, however, there are more notable differences in internet and social media use depending on the distress level. In particular, adults who have no to low distress levels use the internet and social media much less than adults with medium or high distress levels.

Figure 4.4. Internet and Social Media Use by Distress Level

Participants who on a daily basis use the internet almost regularly or constantly



Participants who on a daily basis use a computer or mobile device for social media almost regularly or constantly

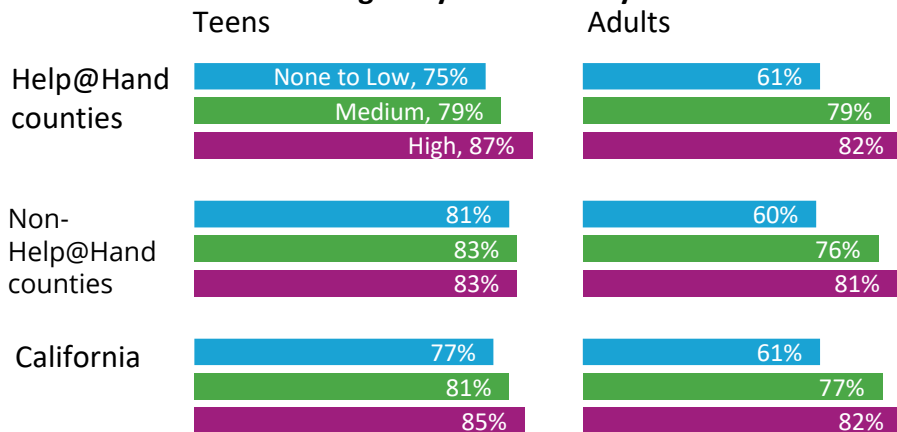
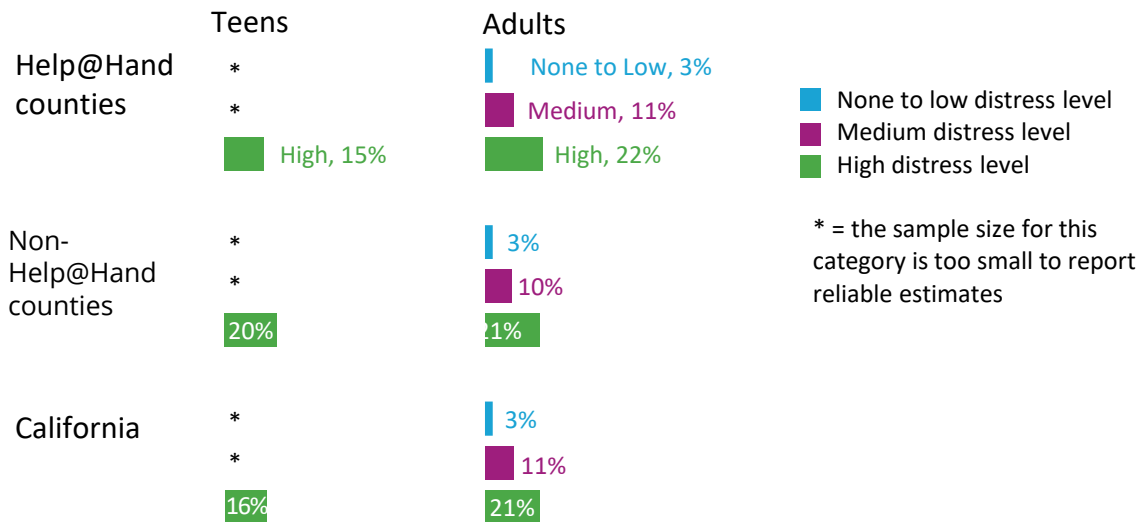


Figure 4.5 shows the percentage of adults that reported using online tools for mental health or alcohol/drug support in the past year increased significantly as the distress level increased. When asked about how useful the online support tools were, adults with high levels of distress reported the lowest levels of usefulness. This suggests that online tools may be more useful among people with low to medium distress levels. There is limited information available for teens due to the small number of participants and the very targeted subject of this survey.

Figure 4.5. Use of Online Tools by Distress Level

Participants who in the past 12 months tried to get help from an online tool for problems with their mental health, emotions, nerves, or use of alcohol or drugs



Adults who rated the online tool they used as somewhat or very useful

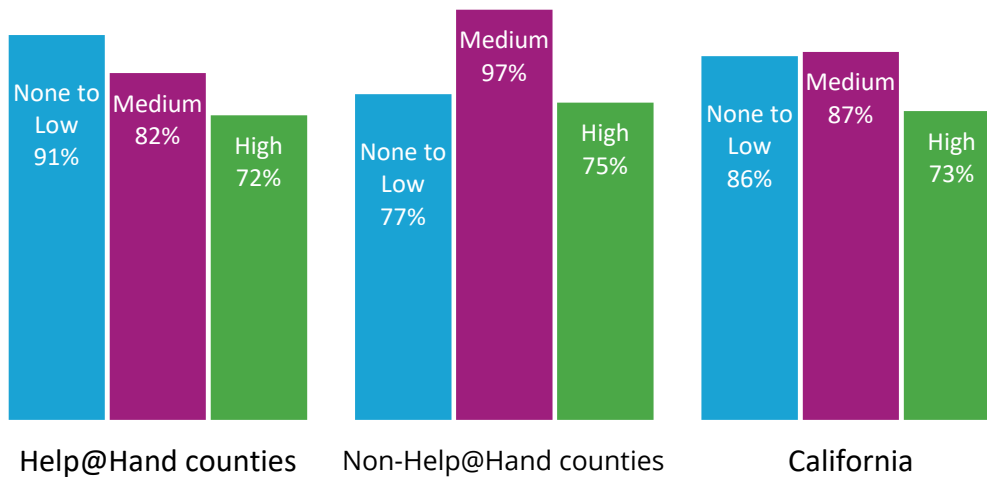
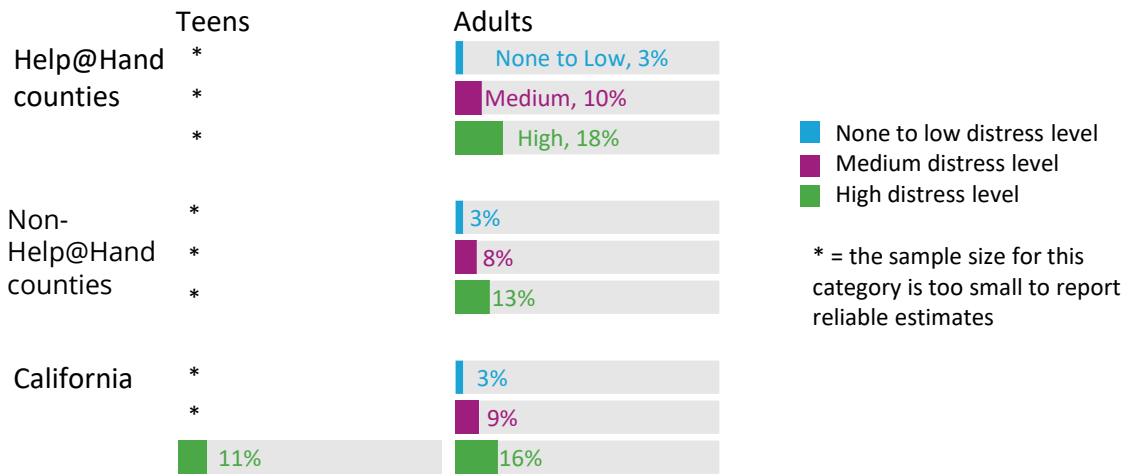


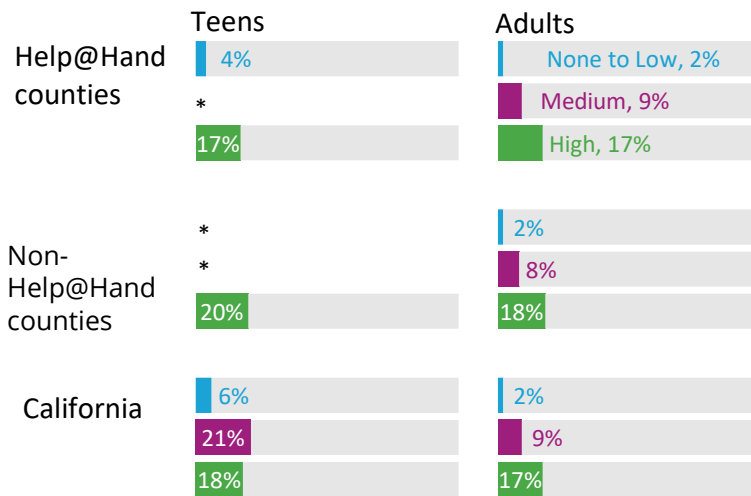
Figure 4.6 reveals that both teens and adults with higher distress levels were more likely to have used social media, blogs, or online forums to connect with people with similar mental health or alcohol/drug concerns: statewide, 18% of teens with high distress and 17% of adults with high distress. The same pattern was observed for adults who used online tools to connect with a mental health professional: 16% of adults with high distress, compared to 3% of adults with no to low distress. Due to the small number of teen participants and the nature of the survey, data is limited for some variables.

Figure 4.6. Use of Online Tools to Connect with Others by Distress Levels

Participants, who in the last 12 months used online tools to find, be referred to, contact, or connect with a mental health professional



Participants, who in the last 12 months used social media, blogs, or online forums to connect with people that have mental health or alcohol/drug concerns similar to theirs



VITAL STATISTICS

CHHS and its IRB approved the Help@Hand evaluation team to analyze: 1) Office of Statewide Health Planning and Development (OSHPD) inpatient and emergency department data; and 2) vital statistics. Analysis of inpatient, emergency department, and vital statistics data can compare access to care, access to appropriate levels of care, and outcomes across Help@Hand counties/cities. It can also draw comparisons with non-Help@Hand counties.

The following is a presentation of suicides and overdoses in California from vital statistics data between 2015-2019. Suicide and drug and alcohol overdoses claim thousands of lives each year in California. Underlying causes that lead to these deaths include depression, loneliness, bullying, histories of mental illness, and post-traumatic stress disorder (PTSD). This data serves to inform the Help@Hand counties/cities about the prevalence of deaths due to these causes in their respective area relative to the rest of the state.

It also establishes a baseline. The Help@Hand program aims to address such deaths by improving access to mental health resources and reducing mental health stigma. As a result, suicides and drug and alcohol overdoses may decrease as counties/cities participating in Help@Hand implement mental health technologies in the years to come.³³

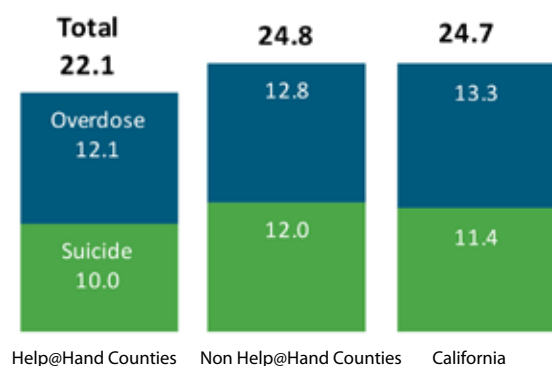
Because it is difficult to establish in cases of overdose whether death was accidental or intentional, determination of final cause of death as suicide by medical examiners is imprecise and varies substantially across counties. Therefore, the analysis considered a lower bound, defined as those reported by the medical examiners as suicides, and an upper bound, defined as those reported as suicide plus those reported as overdose.³⁴

General Trends

Figure 4.7 shows that the average annual suicide rate between 2015-2019 was 11.4 deaths per 100,000 residents, and the annual average overdose rate was 13.3 in California. These averages were slightly smaller for the Help@Hand counties than for non-Help@Hand counties. For Help@Hand counties, the average annual suicide rate and overdose rate were 10.0 and 12.2 per 100,000 Californians, respectively. For non-Help@Hand counties, the average annual suicide rate and overdose rate were 12.0 and 12.8 per 100,000 Californians, respectively.

It is important to keep in mind that these rates are for the period prior to the implementation of mental health apps in the Help@Hand counties/cities. As Help@Hand implements technologies in future years, the analysis of this data may reflect differences in the baseline rates of Help@Hand and non-Help@Hand counties as a result.

Figure 4.7. Suicide and Overdose Death Rates per 100,000 Residents



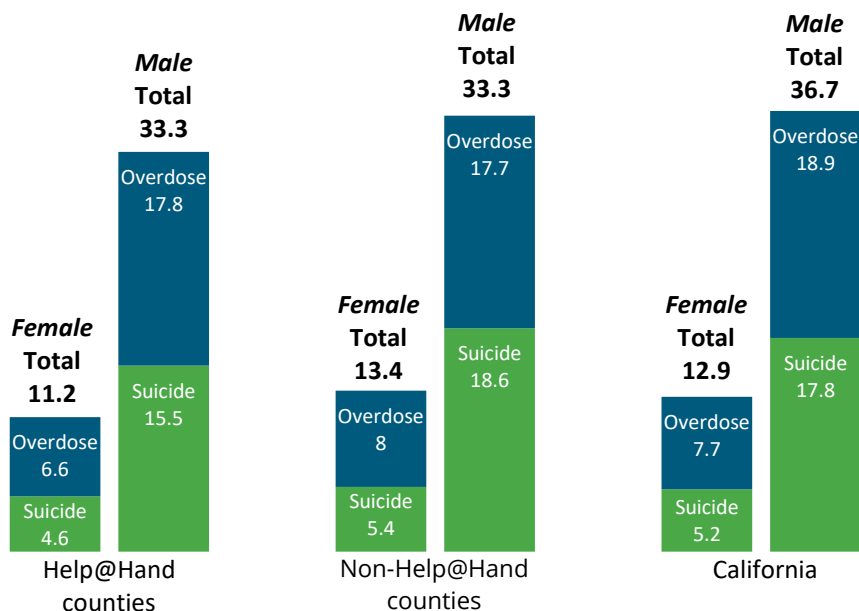
Gender

As shown in **Figure 4.8**, men are at a substantially higher risk for suicide and overdose than women. Men in California had an average annual suicide rate of 17.8 deaths per 100,000 residents and an average annual overdose rate of 18.9 per 100,000 residents.

³³ Data was aggregated to the county level and merged with population data from the United States Census Bureau to calculate population based rates for each year and for population subgroups. The annual rates were averaged over the 5-year period (e.g., 2015-2019) and are shown per 100,000 residents.

³⁴ Because it is difficult to establish in cases of overdose whether death was accidental or intentional, determination of final cause of death as suicide by medical examiners is imprecise and varies substantially across counties. Therefore, the analysis considered a lower bound, defined as those reported by the medical examiners as suicides, and an upper bound, defined as those reported as suicide plus those reported as overdose. Death with a final cause of suicide have ICD-10 codes X60-X84. Deaths with a final cause of overdose by drugs or alcohol have ICD-10 codes of X40-X45 (accidental poisoning) and Y10-Y15 (poisoning with undetermined intent).

Figure 4.8. Suicide and Overdose Death Rates per 100,000 Residents by Gender

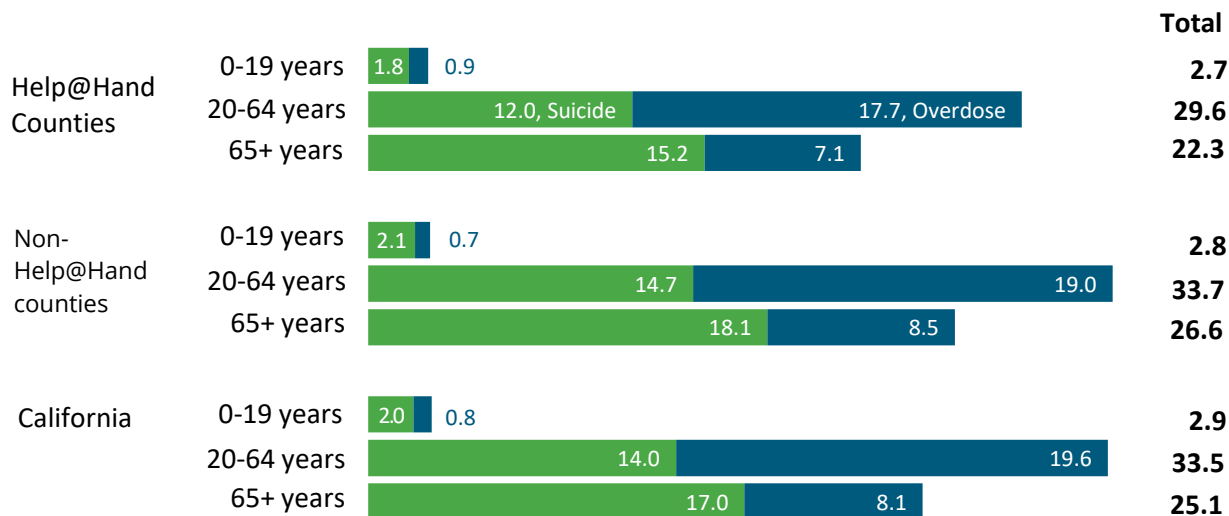


Age

Figure 4.9 shows that the age group in California with the highest rate of suicides was 65 and over, with an average annual rate of suicide of 17.0 deaths per 100,000 residents. The group with the second highest rate was the 20-64 year olds. In terms of drug and alcohol overdoses, 20-64 year olds had the highest rates by far.

Although deaths by overdose had small differences between counties, there were larger differences between counties for suicide. In particular, adults 65 and over had an average annual suicide rate in Help@Hand counties of 15.3 deaths per 100,000 residents, compared to 19.0 in non-Help@Hand counties.

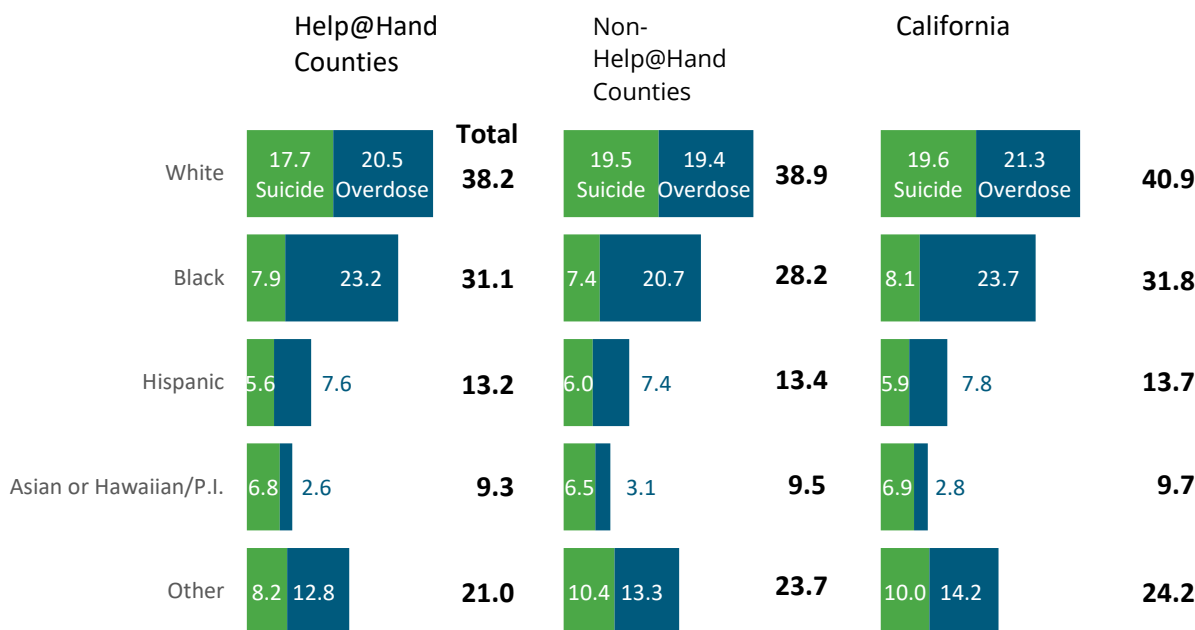
Figure 4.9. Suicide and Overdose Deaths Per 100,000 by Age



Race

Non-Hispanic Whites had the highest suicide rate, but non-Hispanic Blacks or African-Americans had the highest overdose rate in California during the period (as shown in Figure 4.10). Non-Hispanic Whites also had high rates of overdose. Overall, the suicide and overdose rates by race were generally similar in the Help@Hand counties and the non-Help@Hand counties.

Figure 4.10. Suicide and Overdose Deaths Per 100,000 by Race



Learnings from the Outcomes Evaluation

The Help@Hand evaluation team examined statewide data and learned:

- **Recent CHIS data shows:**
 - o **Technology Use by Age.** People of all ages used the internet many times a day or almost constantly, which means that they could access online support when needed. However, few people reported using online tools, particularly to connect with others.
 - o **Technology Use by Distress Level.** Both teens and adults with high distress reported using social media, blogs, or online forums to connect with people with similar mental health or alcohol/drug concerns.
- **Vital statistics data from California between 2015-2019 reveals trends in suicide and drug and alcohol overdose:**
 - o **Suicide and Overdose Trends.** Suicide and drug and alcohol overdoses rates in California are shown between 2015 and 2019. Help@Hand counties may want to consider technologies specifically targeting high risk communities.
 - o **Demographics of Suicide and Overdose Trends.** Men had a higher risk of suicide and overdose than women. Older adults over 65 years had higher rates of suicide, while younger adults between 20-64 years had higher rates of overdose.

DATA DASHBOARDS

Orange County and the Help@Hand evaluation team planned to pilot decision support dashboards that would be shared with other counties/cities. This work is paused to allow Orange County to focus on other project priorities and activities.

5 HELP@HAND EVALUATION ADVISORY BOARD

The Help@Hand evaluation received guidance and consultation from a team of state-wide experts and representatives across a broad spectrum of fields, stakeholder groups, and target populations. In particular, the Help@Hand Evaluation Advisory Board ensured that the evaluation:

- Considered key target audiences and addressed county/city-level variability
- Included measures of both process outcomes (implementation) and behavioral/health status outcomes (changes in participants) relevant to Help@Hand's goals
- Used methods appropriate to the project, especially with respect to scope and data collection
- Served as a vehicle for program improvement and program accountability that informed potential replication of the project
- Aligned with promising best practices, and
- Contributed to the existing knowledge base.

In Year 2, the Board met in three virtual meetings, during which the evaluation team provided updates on the Help@Hand evaluation and elicited the Board's feedback and guidance.

The Evaluation Advisory Board is comprised of a diverse group and includes:

- Experts with experience in mental health and/or technology evaluation
- Experts with experience in implementation science and evaluation
- Philanthropic and/or non-profit representatives
- Community mental health advocates
- County/City-level Help@Hand leaders
- Individuals with lived experience of a mental health/co-occurring issue accompanied by the experience of recovery, and
- Mental Health Services Oversight and Accountability Commission representatives

Help@Hand Evaluation Advisory Board Members

- Chair, Sergio Aguilar-Gaxiola, MD, PhD
Director, UC Davis Center for Reducing Health Disparities
Professor of Clinical Internal Medicine, UC Davis
- Ron Culver, BA³⁵
Supervisor II Tehama County Peer and Workforce Programs, Northern Valley Catholic Social Service
- Alex Elliott, MSW³⁶
Psychiatric Social Worker, Los Angeles County Department of Mental Health
- Doris Estremera, MPH
Mental Health Services Act (MHSA) Manager, San Mateo County Health - Behavioral Health & Recovery Services
- Sharon Ishikawa, PhD
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- Brandon Staglin, MS
President, One Mind
- Lindsay Walter, JD
Deputy Director Admin and Operations, MHSA Chief – Santa Barbara County Department of Behavioral Wellness

³⁵ Joined the Help@Hand Evaluation Advisory Board in December 2020

³⁶ Joined the Help@Hand Evaluation Advisory Board in December 2020

RECOMMENDATIONS

Recommendations have been shared in each of the Year 2 quarter reports. Recommendations for the Help@Hand Collaborative have been consolidated, and in some cases repeated here, with learnings presented in this report according to the diverse themes reflected in the project. These recommendations are not meant to be interpreted as exhaustive or complete, but rather reflect knowledge that has been gleaned from some of the major opportunities and challenges of the past year. Furthermore, learnings and recommendations from the Evaluation Advisory Board are also reflected in themes below.

As such, the Help@Hand evaluation team recommends the following for the overall Help@Hand Collaborative and the individual Help@Hand counties/cities.

RECOMMENDATIONS FOR THE HELP@HAND COLLABORATIVE

CONTINUE TO BUILD A COLLABORATIVE AND COOPERATIVE CULTURE THAT FOSTERS RELATIONSHIPS, TRUST, AND RESPECT ACROSS THE COLLABORATIVE:

- **Facilitate more cross-collaborations:** Counties/cities are integrating Collaborative feedback into the work that they do (e.g., Santa Barbara utilizing Riverside's Poster; Kern widely sharing app guide; Los Angeles' recommendations around resources for LifeLine phones). The Help@Hand project management team may want to consider offering flexible use of supplemental funds to counties/cities in order to develop and support cross-collaborative subprojects within Help@Hand that may extend beyond technology implementations. The Help@Hand project management team may offer operational and project management support for these sub-projects.
- **Facilitate “communities of practice”:** CalMHSA would be instrumental in facilitating the communities of practice due to their unique role as the project manager of the overall Help@Hand project. CalMHSA would not be expected to lead the communities of practice, but to provide the structure in which they could be facilitated. CalMHSA is able to facilitate these communities of practice because they have knowledge of each county/city's interests and where shared interests might lie. CalMHSA could facilitate affinity networks, or communities of practice,^{37,38} within the Help@Hand project to: 1) increase collaborative problem-solving through sharing of resources, experiences, tools, and best practices; 2) increase support to Peers and capitalize on strengthening Peer relations across counties/cities; and 3) speed translation of learnings into practice. Communities of practice may include:
 - o Subgroups focused on specific technologies (e.g., Headspace or myStrength) and/or populations (e.g., TAY or isolated older adults). These topics arise in different meetings, but not enough time is available for them. The subgroups would convene in a way that allows time for in-depth learning.
 - o Regular topical meetings or interactive web tools that allow for easy sharing and access to resources or plans (which could be particularly beneficial to Peers).
 - o Subject matter experts providing trainings or facilitation on topics of interest, such as a presentation or case study about a successful implementation of myStrength, along with lessons learned.
- **Facilitate use of SharePoint as a resource.** SharePoint improvements are appreciated by the Collaborative. Locating and accessing information (e.g. navigation) continues to be a challenge. Consider creating a workgroup to develop a model for organization that would be intuitive and useful for counties/cities staff accessing the site.

³⁷ Communities of practice are groups of people who have a similar and strong interest for a specific topic. They engage in joint activities/discussions, help each other, and share information (Centers for Disease Control and Prevention, 2019). Free resources may be found at: <https://www.cdc.gov/phcommunities/resourcekit/resources.html>

³⁸ An example of an online community practice would be the Implementation Science Coordination, Consultation & Collaboration Initiative for HIV/AIDS research, which provides various resources for project planning and implementation in their resource hub: <https://isc3i.isgmh.northwestern.edu/resource-hub/>

CONTINUE TO REFINE AND STREAMLINE PROJECT PROCESSES:

- **Leverage streamlined processes.** Urgency around responding to the COVID-19 pandemic compelled processes to streamline and quickly problem-solve barriers. Identifying and leveraging these streamlined processes will be important for future implementations. The COVID-rapid response technology implementation was a great example of a streamlined process.
- **Adapt project management support and documentation materials** (e.g. implementation meeting agendas or OCM plan templates) with an effort to simplify and make more efficient. These materials will be useful and important for future technology implementations both within Help@Hand and across other similar projects undertaken within counties/cities.
- **Continue to understand and document what information counties/cities value and need from the Technology vendor when selecting technologies.** For example, information about a product's available languages continues to be a common request. The 2019-2020 RFSQ process, Monterey RFI/RFP, and recent contract negotiations, for example, may offer important insights into county/city specific needs and requirements vis-à-vis general customer needs.

CONTINUE TO MEANINGFULLY ENGAGE PEERS IN HELP@HAND'S GOVERNANCE, PLANNING, IMPLEMENTATION, AND EVALUATION:

- **Hire staff to support the Peer component of Help@Hand.** Given the need for Peer training and supervision resources, CalMHSA should accelerate efforts to fill the position of Peer Engagement and Community Manager and supplement this position with a second Peer for administrative support, Peer support, and continuity in the event of personnel turnover.
- **Hire and retain qualified Peers.** Consider creating a workgroup to address barriers and facilitators that have emerged in the Help@Hand project for hiring and retaining qualified Peers (e.g. Human resources (HR)) policies around prior criminal records; need for ongoing support for Peers in recovery; HR limits on type of employment (e.g. extra work); Career pathways for success; High turnover).
- **Facilitate the development of formal pathways for increasing Peer engagement.** Counties/cities can incorporate Peers at different levels of the project (e.g., marketing, social media, video production). Counties/cities should consider how best to include Peers and what additional training can be useful to supporting the Peer workforce. See additional recommendations above pertaining to Communities of Practice.
- **Include Peers in the decision-making process around measurement in evaluation.** When presented with materials that are explained using minimal jargon, it is possible for people with limited training in statistics to understand the core issues and be able to make informed and insightful decisions. However, these efforts often require additional time and resources to support. Nonetheless, evaluation efforts must always find a balance between what is scientifically valid and what is feasible--a partnered Peer-driven approach is an effective strategy for striking this balance.

CONTINUE TO INTEGRATE DIGITAL MENTAL HEALTH LITERACY (DMHL) TRAINING INTO COUNTY/CITY IMPLEMENTATIONS:

- **Analyze available data.** DMHL resources, consisting of 10 videos as well as an Instructor led curriculum which includes the 'Managing your digital presence curriculum' and 'Cyberbullying Curriculum', has been made available on the <https://helpathandca.org/dmhl/> website. Use data available from website analytics and surveys to understand frequency of current use of materials and satisfaction with content. This information will be important for planning efforts around further dissemination.
- **Consider planned expansions and/or efforts to disseminate DMHL videos.** Consider a strategy to expand the use of the DMHL curriculum across the Collaborative – perhaps include link to site in marketing efforts. Providing much needed digital mental health literacy training to appropriate target populations may improve uptake of technology implementations.
- **Consider integration into tech implementations.** Consider additional efforts to integrate DMHL program in county/city pilot projects and implementations.

CONTINUE TO WORK TO STRUCTURE THE RELATIONSHIP BETWEEN TECHNOLOGY VENDORS AND COUNTIES/CITIES IN WAYS THAT PROMOTE A WIN-WIN FOR THE PRIVATE-PUBLIC PARTNERSHIP:

- **Incorporate data collection and sharing plans when contracting with technology vendors.** Because the availability of marketplace data via a third-party analytics platform changes over a relatively short period of time, it is crucial for vendors to directly provide these metrics. Detailed data provided directly from the app developer will yield more consistently available data points to help understand product performance. This data will also allow counties/cities to determine the real-world engagement and effectiveness of the apps and help achieve learning objectives. The Collaborative should negotiate contracts on behalf of counties/cities that ensure the apps provide detailed, individual-level data, including data on adoption, engagement, abandonment, and outcomes.
- **Understand the available resources offered by the vendor.** Consider using the following questions as a guide. These questions are not intended to be comprehensive, but rather used to facilitate a guided conversation:
 - o *Marketing:* What marketing materials are available and have been used to support adoption of product and maintenance of use over time? Who are the target audiences for these materials? Describe any efforts to test the efficacy/usefulness of potential marketing approaches?
 - o *Implementation:* Describe some of the settings for which the product has been successfully implemented? What has been some of the most successful implementation contexts (including target audiences)?
 - o *Data Availability:* Will data be shared at individual level or the aggregate? Identified or de-identified? Is the vendor willing to provide a data dictionary for data to be shared with the county/city? How are data constructs operationalized (including what is the denominator that is used)?
 - o *Dashboard Construction:* How often will data on the dashboard be refreshed? Will archival data be made available? Will the data be exportable?
- **Consider ownership issues, intellectual property, and/or licensing of products when deciding how best to move forward with custom builds.** There are important implications of these early decisions for future customizations of the product and expansions of the product to other markets.

CONTINUE ADOPTING A PERSON-CENTERED APPROACH, MATCHING THE NEEDS OF DIVERSE TARGET AUDIENCE MEMBERS TO APPROPRIATE AVAILABLE TECHNOLOGIES:

- **Consider language and culture.** Assess how the language and content of potential technologies fits the needs of diverse target audience members. Making a technology available to diverse ethnic, language, or cultural groups involves more than just translation.
- **Develop set of questions to assess cultural competency of the technology itself.** Data collection with technology consumers found that cultural competency is important across target audiences. Counties/cities have echoed the need for culturally competent technologies, but technologies explored have been rated low in cultural competency. Developing a set of questions to assess cultural competency of a technology itself early on, as well as evaluate to what extent vendors are able to meet counties/cities' needs regarding cultural competency for a particular target audience.
- **Consider assistive technologies:** Many technology products do not have sufficient assistive technologies. General-use apps which are available on the app stores are unlikely to be a good fit for people with disabilities. Discuss as a Collaborative how to vet potential technologies to meet such criteria. Discuss with chosen vendors their capabilities and capacity to expand accessibility features. Speak with members of the target group to understand what assistive technologies are most relevant across the Collaborative. Discuss as a Collaborative how to vet potential technologies to meet such criteria and discuss with chosen vendors their accessibility capabilities.

INCLUDE IMPORTANT STAKEHOLDERS FOR CONDUCTING CULTURAL TAILORING AND DISSEMINATION:

- **Include Peers and stakeholders in dissemination efforts.** Efforts are currently underway to translate materials for dissemination to key target audiences. As recommended as part of best practices, consider including

Peers and stakeholders in all dissemination efforts to ensure appropriate translation, cultural tailoring, and dissemination of documents and products.

- **Consider the materials to be selected for translation and dissemination.** There are a number of strategies for success, including selecting a medium for dissemination that suits the message (e.g. consider use of video or infographic). Identify the audience and tailor the message – it is important not to overlook the intended audience and consider specifically tailoring each message to that audience.

CONTINUE CONVERSATIONS AND PLANNING AROUND THE EQUITABLE DISTRIBUTION OF DEVICES:

- **Consider forming a Collaborative level workgroup to develop a recommendation or guideline, rather than a prescription.** Counties/cities are seeking a lot of guidance around equitable distribution of devices. Most counties/cities don't have guidelines for providing equitable distribution of technologies. There are concerns around making the program truly equitable, while balancing limited budgets, concerns around how the devices will be used, and liability.
- **Recognize a one size fits all model may not work.** Counties/cities might want to try different methods of distribution (e.g., loan, free devices, etc.) based on specific population needs. It is important for counties/cities to consider what the criteria are for those who will be receiving devices from county/city-specific programs.
- **Consider use of existing or prior programs to model distribution methods after and/or to leverage available resources** (e.g., state of California's distribution of Chromebooks for education, library device loan models, etc.). As noted during Tech Lead (9/8/2020), California Broadband and Digital Literacy office has work that might intersect with or support work being done by the Help@Hand project. California Broadband and Digital Literacy office work focuses on providing broadband internet access (not devices) to stakeholders across California.

RECOMMENDATIONS FOR INDIVIDUAL HELP@HAND COUNTIES/CITIES

Recommendations for individual Help@Hand counties/cities also come from across the quarter reports, as well as include learnings and recommendations from this report.

LOCAL IMPLEMENTATION:

- **Define goals and learning objectives for each technology implementation early in the process.** Participants rate the usefulness of technologies differently, depending on what goals a technology is expected to meet. Counties/cities should clearly define their goals and learning objectives to select and evaluate a technology.
- **Customize implementations for local context.** Implementations will be more likely to succeed when counties/cities deeply understand the problem or need they are trying to solve or address locally - both from the data and input from the community and from understanding the existing work and coalitions that may be working on similar issues.
- **Develop structured processes for eliciting stakeholder engagement.** Counties/cities who wish to engage community members throughout the project should develop structured plans for stakeholder engagement , find and leverage meaningful partnerships to reach and engage stakeholders, especially when utilizing remote processes during COVID-19. Counties/cities have found that working with local agencies that serve their target population can help with outreach and marketing for the project.
- **Remember the 5 key takeaways when engaging people (e.g. in a focus group):**
 - 1) Establish a win-win-win; show benefits to potential participants.
 - 2) "Your ego is not your amigo"³⁹; research team should be humble and know that they might not be the only expert in what is being studied.
 - 3) Be intentional / know target audience for recruitment.

³⁹ Direct quote shared by one of the Help@Hand counties/cities on Tech Lead Call, 11/17/2020.

- 4) Luck is the residue of hard work – there is a lot of work that must go into the planning of any effort to engage stakeholders and community members.
 - 5) One-size does not fit all when it comes to interventions and when it comes to research and/or evaluation.
- **Understand the underlying needs of your target audiences.** Needs assessments can provide important insights in the mental health needs of a target population. If counties/cities do not have a detailed understanding of their target audience yet, a needs assessment is recommended to uncover needs that can inform technology selection. In addition, these needs may inform strategies for marketing and outreach that is appropriate for the target population.
 - **Understand and address barriers to accessing digital technologies.** As many apps do not function offline, work with county/city informational technology to explore potential options, consider workflow integration, and discuss client's internet access to find suitable workarounds. For example, if an app only has downloadable content, where can the client go to download the content? Digital literacy training and resources can also help users better understand connectivity to WiFi and internet data to avoid unexpected charges.
 - **Recognize and plan for the challenge of working remotely.** Providing remote technical support is more challenging than in-person support. When gathering feedback remotely, counties/cities should be prepared to provide additional support and set aside time to collect target audience feedback.
 - **Consider how the communication of informed consent and/or terms of services facilitates transparency among your counties/cities' consumers.** Because privacy concerns were a commonly identified barrier to technology use, maintaining communication and transparency on how app data is collected, stored, and used can help mitigate privacy concerns. As noted by counties/cities, an informed consent process that communicates a technology's terms and conditions in lay terms can also help technology users understand how their information will be used.
 - **Test crisis response within apps.** Many of the apps reviewed did not include a crisis response. Counties/cities are encouraged to test crisis responses within the app to ensure that they meet expectations and respond appropriately. A crisis response plan outside of the app is also essential. If apps do not provide a crisis response, ensure that clients are aware of this and know who they should contact if they are in crisis.
 - **Engage leadership and identify local champions.** Having strong leadership and champions can be crucial to seeing the project move forward. Resilience and stamina are keys to sustaining the project. Also, be sure to identify partners who are ready to be involved and participatory in the process -- "It takes a village."
 - **Align terms.** It is important to ensure a shared understanding of commonly used terms for involved parties. For example, make sure that the technology vendor, participating clinics, county/city, and any other involved partners have a shared understanding of the definition of "Serious Mental Illness (SMI)". Counties/cities, vendors, and clinicians make not use this term in the same way.
 - **Marketing efforts and materials must be on-going to promote continued uptake of products.** Recruitment of consumers and/or clinicians/ and/or other stakeholders must be viewed as being continuous -- not a one-time event if counties/cities want to see sustained growth in technology uptake.
 - **Aim to recruit users in pilot efforts that reflect the target population.** Users can perceive the usefulness of technologies differently when they consider a technology for themselves, versus when considering it for a particular population. For the exploration phase, counties/cities should aim to recruit participants that are as representative as possible of the target audience.

PRODUCT FIT AND ENGAGEMENT:

- **Compare the features of similar products (e.g. myStrength, SilverCloud) during the app selection process.** Many of the products reviewed during the RFSQ process have features that overlap, but have important differences that make some apps a better fit for a particular target audience than other apps.
- **Consider products that connect people together.** Counties/cities should consider whether or not technologies allow users to connect with others, whether professional services or informal support, to receive mental

health support, and to what extent their target audience(s) would like to utilize these types of features, as this was valued by multiple target audiences in both needs assessments and technology explorations.

- **Consider products that connect people to existing systems of care.** Because participants also valued when technologies were integrated into existing systems of care, counties/cities should work with vendors to understand how a technology may work within existing health services but also to what extent the vendor is willing to add customization for connections to local resources and support to be embedded within the technology.
- **Engage early to enhance uptake.** The first few days after a client downloads an app may be the most likely time for them to become engaged with the app. Considering what other active approaches to enhance uptake and engagement may help people use the app within the first few days. For example, if they have technical difficulties or other questions during their first use, is there someone they can reach out to or a resource they can visit to help resolve them?
- **Continually check in with consumers who use a product over time.** Technology explorations indicated that participants valued having a variety of content that is consistently updated. In order to understand user engagement, counties/cities should consider not only capturing users' early impressions of a technology, but also checking in at later time points to evaluate whether the content meets users' long-term needs. Counties/cities can also engage with the vendors to determine if and how often content is updated.

CLINICAL INTEGRATION:

- **Create materials to help provide more training and orientation to residents and other clinic staff.** Perhaps the vendor has materials that are already available that could be disseminated. However, consider if these require adaptations and tailoring for appropriate groups.
- **Support early clinical champions.** Focusing support on “early adopters” might be more beneficial than changing the views of less enthusiastic providers.
- **Address barriers early and share with clinic staff changes made to address their concerns.** Generally, when a product is first introduced into a system, there is an overall positive view of the product. Addressing barriers to implementation early is important to supporting and sustaining early enthusiasm and excitement.

DATA USE:

- **Use data to continuously learn, adapt, and improve.** Design implementation and evaluation plans concurrently to support the collection of important data necessary for informing programmatic decisions.
- **Initiate vendor calls earlier in planning process to allow for better alignment with program and evaluation planning.**

DISSEMINATION AND SUSTAINABILITY:

- **Leverage local resources.** When marketing county/city efforts, it can be useful to work with other divisions within the department (e.g., TAY groups, Substance Use/Addiction recovery, Cultural Competency) to not only reach a wider audience but also to assist with messaging. Relatedly, it is useful to collaborate with local mental health organizations.
- **Be deliberate in where and how you market.** When marketing on digital media/online, it is important to consider the pros and cons of each platform as well as which audiences visit which social media platforms.
- **Start preparing for project end right now.** Consider the vision for what your county/city actually wants to achieve during the remaining time in the Help@Hand program, balancing Help@Hand objectives with project feasibility.
- **Develop long term roadmap.** Developing a long-term roadmap is a critical tool for ensuring sustainability for the programs counties/cities are building. Having a project plan align with a long-term roadmap also provides the opportunity to get input and buy-in from program staff and external stakeholders. Consider the opportunities for counties/cities to build sustainable infrastructures and roadmaps to support long-term technology integrations.

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APPENDIX A: COUNTY/CITY PROGRAM INFORMATION

Each Help@Hand county/city completed the following tables describing their program information, accomplishments, lessons learned, and recommendations.

City of Berkeley	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	<ul style="list-style-type: none"> • Andrea Bates 	<ul style="list-style-type: none"> • Kirsten White • Karen Klatt 	<ul style="list-style-type: none"> • Kirsten White • Karen Klatt 	<ul style="list-style-type: none"> • Kirsten White • Karen Klatt
Implementation Site	<ul style="list-style-type: none"> • TBD 	<ul style="list-style-type: none"> • TBD 	<ul style="list-style-type: none"> • TBD 	<ul style="list-style-type: none"> • TBD
Team Composition	<ul style="list-style-type: none"> • Tech Lead, Behavioral Health Director, MHSA Coordinator, Peer, Project Coordinator 	<ul style="list-style-type: none"> • Steven, BH Director • Karen, MHSA Coordinator • Jaime, Peer Lead • Kirsten, RDA Consultant • Nicole, RDA Consultant 	<ul style="list-style-type: none"> • Steven, BH Director • Karen, MHSA Coordinator • Jaime, Peer Lead • Kirsten, RDA Consultant • Nicole, RDA Consultant • Jeff Buell, Clinical Coordinator 	<ul style="list-style-type: none"> • Steven, BH Director • Karen, MHSA Coordinator • Jaime, Peer Lead • Kirsten, RDA Consultant • Nicole, RDA Consultant • Jeff Buell, Clinical Coordinator
Target Audience	<ul style="list-style-type: none"> • TBD 	<ul style="list-style-type: none"> • TAY; isolated seniors; communities of color, including African Americans, Latina, etc.; general population of Berkeley 	<ul style="list-style-type: none"> • TAY; isolated seniors; communities of color, including African Americans, Latinx, and API community members; general population of Berkeley 	<ul style="list-style-type: none"> • TAY; isolated seniors; communities of color, including African Americans, Latinx, and API community members; general population of Berkeley
Products in Use/Planned	<ul style="list-style-type: none"> • TBD 	<ul style="list-style-type: none"> • Under review 	<ul style="list-style-type: none"> • Selection in progress 	<ul style="list-style-type: none"> • Berkeley staff completing validation of Headspace and myStrength
Implementation Approach	<ul style="list-style-type: none"> • TBD 	<ul style="list-style-type: none"> • TBD 	<ul style="list-style-type: none"> • TBD 	<ul style="list-style-type: none"> • Rapid Response
Other Unique Qualities (of target audience, implementation, or other program aspect)	<ul style="list-style-type: none"> • TBD 	<ul style="list-style-type: none"> • Prefer to engage minority-owned vendors 	<ul style="list-style-type: none"> • Prefer to engage minority-owned vendors 	<ul style="list-style-type: none"> • Following a review of the vendors qualified through the RSFQ process, no vendor was clearly minority-owned and no product was made specifically for BIPOC consumers.
Milestones	<ul style="list-style-type: none"> • Not applicable 	<ul style="list-style-type: none"> • Peer Lead allocated to project • Local consultants contracted and onboarded to support app selection and developed plans for implementation 	<ul style="list-style-type: none"> • The City Mental Health Team Partners are engaged in the App Technology selection 	<ul style="list-style-type: none"> • Products selected for exploration (Headspace, myStrength) • Internal staff validation to prepare for product launch underway • Developing Peer engagement plans
Lessons Learned	<ul style="list-style-type: none"> • Regular brainstorm and Q&A opportunities, particularly Tech Lead Collaboration meetings, with fellow Help@Hand jurisdictions are valuable for supporting such a dynamic project implementation process • A shared understanding of project objectives is key • Objectives should be revisited with stakeholders on an ongoing basis 			
Recommendations	<ul style="list-style-type: none"> • Regularly reteach and reinforce expectations regarding the required implementation documentation, both as a best practice and also to support counties/cities experiencing staff turnover or project pauses; • Consider offering support to connect smaller cohorts of similarly-sized/similarly-resourced jurisdictions on a quarterly or biannual basis, as progress of a very large county might be presented as a watershed project milestone but very inappropriate for a small jurisdiction to aspire to; • Increase transparency of product take-up (and perhaps other metrics) across pilots. It would be helpful to have better access to this data across pilots in order to inform realistic goal-setting at the local level. 			

Kern County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	<ul style="list-style-type: none"> Lamar K. Brandy, LMFT 	<ul style="list-style-type: none"> Lamar K. Brandy, LMFT 	<ul style="list-style-type: none"> Lamar K. Brandy, LMFT 	<ul style="list-style-type: none"> Lamar K. Brandy, LMFT
Implementation Site	<ul style="list-style-type: none"> Self-Empowerment Team 	<ul style="list-style-type: none"> Self-Empowerment Team 	<ul style="list-style-type: none"> Self-Empowerment Team 	<ul style="list-style-type: none"> N/A
Team Composition	<ul style="list-style-type: none"> Project Lead, Peer Lead, 2 Peers, PIO, Marketing Associate 	<ul style="list-style-type: none"> Project Lead, Peer Lead, 1 Peer, PIO, Marketing Associate 	<ul style="list-style-type: none"> Project Lead, Peer Lead, 1 Peer, PIO, Marketing Associate 	<ul style="list-style-type: none"> N/A
Target Audience	<ul style="list-style-type: none"> Clients with serious mental illness Kern County Residents 	<ul style="list-style-type: none"> Clients with serious mental illness Kern County Residents 	<ul style="list-style-type: none"> Clients with serious mental illness Kern County Residents 	<ul style="list-style-type: none"> N/A
Products in Use/Planned	<ul style="list-style-type: none"> App guide, 2nd Edition – English and Spanish versions App guide, 3rd Edition (planned) 	<ul style="list-style-type: none"> App guide, 2nd Edition – English and Spanish versions App guide, 3rd Edition (planned) 	<ul style="list-style-type: none"> App guide, 2nd Edition – English and Spanish versions App guide, 3rd Edition (planned) 	<ul style="list-style-type: none"> N/A
Implementation Approach	<ul style="list-style-type: none"> Wide distribution of the app guide 	<ul style="list-style-type: none"> Wide distribution of the app guide 	<ul style="list-style-type: none"> Wide distribution of the app guide 	<ul style="list-style-type: none"> N/A
Other Unique Qualities (of target audience, implementation, or other program aspect)	<ul style="list-style-type: none"> Offer clinician education on app guide (planned) Support other Help@Hand Counties/Cities (Mono, Modoc, and Santa Barbara) develop their own tailored app guide Adapt app guide for Nevada, Fresno, San Bernardino, and Inyo Counties to publish their own app guide 	<ul style="list-style-type: none"> Offered clinician education on app guide (planned) Supported other Help@Hand Counties/Cities (Mono, Modoc, and Santa Barbara) develop their own tailored app guide Adapted app guide for Nevada, Fresno, San Bernardino, and Inyo Counties to publish their own app Guide 	<ul style="list-style-type: none"> The state-wide medical emergency declared by the governor has resulted in a pause on all Help@Hand activities 	<ul style="list-style-type: none"> N/A
Milestones	<ul style="list-style-type: none"> Published the 2nd Edition of <i>“The Peers’ Guide to Behavioral Health Apps”</i> app guide in English and Spanish Created a version of the app guide for Modoc, Mono, and Santa Barbara Counties that included content modifications and printing set-up Prepared and implemented a four-hour Peer Workshop on empowerment training for Kern BHRS and contracted Peers Empowered Peers through the app guide development and dissemination Prepared and hosted two-day digital mental health literacy training for Help@Hand Peers Presented app guide to County Board of Supervisors in January Presented to the Kern BHRS Management and to the Kern BHRS contract CEOs Started systemic distribution to other Kern County agencies 	<ul style="list-style-type: none"> The state-wide medical emergency declared by the governor has resulted in a pause on all Help@Hand activities. 		<ul style="list-style-type: none"> Kern County has completed their participation in the Help@Hand project.
Lessons Learned	<ul style="list-style-type: none"> The proposed apps need to be thoroughly vetted prior to piloting with clients. A prime role of County mental health is to assure the provision of safe products to their vulnerable population. Digital literacy takes one-on-one coaching which is time consuming and labor intensive. Consumers benefit from basic digital literacy training. Collaborating with fellow counties is fruitful and productive. Working with County agencies requires an abundance of patience and perseverance. It is vital that the peer employees not only have lived experience, but that they will have progressed sufficiently in their recovery that they feel free to share details of their journey. This sharing of surviving and thriving in their recovery is a prime issue to benefit our consumers and members. 			
Recommendations	<ul style="list-style-type: none"> Focus on producing a product. Time and energy can be spent on process and procedures with no resulting product 			

Los Angeles County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	<ul style="list-style-type: none"> Katherine Steinberg, MPP, MBA Alex Elliott, MSW Ivy Levin, LCSW 	<ul style="list-style-type: none"> Katherine Steinberg, MPP, MBA – Reassigned mid May 2020 Alex Elliott, MSW – Served as a liaison for Painted Brain/ Peer contributions 	<ul style="list-style-type: none"> Alex Elliott, MSW. Served as a liaison for Painted Brain/Peer contributions 	<ul style="list-style-type: none"> Alex Elliott, MSW. Served as member of Evaluation State-Wide Advisory Board
Implementation Site	<ul style="list-style-type: none"> Harbor UCLA DBT program Peer Resource Center (planned) Geriatric Evaluation Networks Encompassing Services Intervention Services (GENESIS) outpatient program for older adults (projected for pilot) Telecare Los Angeles Older Adults (LAOA) Full Service Partnership (FSP) program (projected for pilot) 	<ul style="list-style-type: none"> Harbor UCLA DBT program Peer Resource Center (planned) All pilots were placed on hold due to COVID 	<ul style="list-style-type: none"> Harbor UCLA DBT program Peer Resource Center (planned) All pilots were placed on hold due to COVID 	<ul style="list-style-type: none"> Harbor UCLA DBT program LAC DMH DBT Programs LAC DMH will be moving forward with contracting with Prevail for a full LA community roll out to commence February 2021.
Team Composition	<ul style="list-style-type: none"> Program Lead/Project Manager, Chief Medical Officer (Executive Sponsor), Behavioral Health Director, 2 Tech Leads, Chief Information Officer, IT Project POC, Chief of Peer Services, Evaluation Lead, Privacy SME, IT Security SME, Harbor UCLA Clinical Champion, Public Information Officer 	<ul style="list-style-type: none"> Program Lead/Project Manager, Chief Medical Officer (Executive Sponsor), Behavioral Health Director, 2 Tech Leads, Chief Information Officer, IT Project POC, Chief of Peer Services, Evaluation Lead, Privacy SME, IT Security SME, Harbor UCLA Clinical Champion, Public Information Officer 	<ul style="list-style-type: none"> Program Lead/Project Manager, Chief Medical Officer (Executive Sponsor), Behavioral Health Director, Chief Information Officer, IT Project POC, Chief of Peer Services, Evaluation Lead, Privacy SME, IT Security SME, Harbor UCLA Clinical Champion, Public Information Officer, Additional DMH staff/SMEs, as needed 	<ul style="list-style-type: none"> All other pilots were placed on hold due to COVID MindLAMP: Chief Information Officer, IT Project POC, Harbor UCLA Clinical Champions, DBT Project Liaison, Evaluation Advisory Board Member
Target Audience	<ul style="list-style-type: none"> Transitional age youth and college students County employees Complex needs individuals (i.e., those with multiple and repeated hospitalizations) Individuals and family members uncomfortable accessing community mental health services seeking de-stigmatized care and supports for well-being Existing mental health clients seeking additional support or seeking care/support in a non-traditional mental health setting 	<ul style="list-style-type: none"> All Los Angeles County residents in need of support due to COVID County employees Existing mental health clients seeking additional support or seeking care/support in a non-traditional mental health setting 	<ul style="list-style-type: none"> All Los Angeles County residents in need of support due to COVID County employees Existing mental health clients seeking additional support or seeking care/support in a non-traditional mental health setting 	<ul style="list-style-type: none"> All Los Angeles County residents in need of support due to COVID County employees Existing mental health clients seeking additional support or seeking care/support in a non-traditional mental health setting
Products in Use/Planned	<ul style="list-style-type: none"> Headspace (planned) Modified Mindstrong Health App CredibleMind (projected for pilot) Uniper (projected for pilot) MindLAMP (projected for pilot) 	<ul style="list-style-type: none"> Headspace for COVID-19 response made available Modified Mindstrong Health App 	<ul style="list-style-type: none"> Headspace for COVID-19 response continued Began transition from Mindstrong Health App to MindLAMP (diary cards) 	<ul style="list-style-type: none"> Headspace for COVID-19 response continued Continued transition from Mindstrong Health App to MindLAMP (diary cards)
Implementation Approach	<ul style="list-style-type: none"> Headspace for current DBT clients (possible COVID-19 response) Headspace for individuals visiting the DMH Peer Resource Center CredibleMind for isolated populations at higher risk for more serious complications from COVID-19 Uniper for current DMH clients in the GENESIS outpatient program for older adults Uniper for current older adult clients with internet access enrolled in the Telecare Los Angeles Older Adults (LAOA) Full Service Partnership (FSP) program MindLAMP for clients in Harbor UCLA DBT program 	<ul style="list-style-type: none"> Headspace for COVID-19 response made available to all county residents MindLAMP for clients in Harbor UCLA DBT program Headspace for individuals visiting the DMH Peer Resource Center 	<ul style="list-style-type: none"> Headspace for COVID-19 response, available for all LA County residents MindLAMP for clients in DBT programs in LA County, in development 	<ul style="list-style-type: none"> Headspace for COVID-19 response, available for all LA County residents MindLAMP for clients in DBT programs in LA County, in development

Los Angeles County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
<p>Other Unique Qualities (of target audience, implementation, or other program aspect)</p>	<ul style="list-style-type: none"> LAC DMH is exploring how to use apps and platforms that have already gone through internal review to meet the increased needs of those impacted by COVID-19 (COVID-19 response) 	<ul style="list-style-type: none"> Rapid deployment, without pilot process, of Headspace to meet the increased needs of the community due to COVID-19 Streamlined all DMH communications to ensure community is aware of resources available 	<ul style="list-style-type: none"> Transition in progress to use MindLAMP to meet the increased needs of clients receiving DBT MindLAMP is a unique open source solution MindLAMP is developing a Digital Diary Card for LACDMH DMH is developing the technical infrastructure to host MindLAMP within LACDMH's IT ecosystem via Microsoft Azure 	<ul style="list-style-type: none"> Transition in progress to use MindLAMP to meet the increased needs of clients receiving DBT MindLAMP is a unique open source solution MindLAMP is developing a Digital Diary Card for LACDMH MindLAMP is translated into Spanish DMH is developing the technical infrastructure to host MindLAMP within LACDMH's IT ecosystem via Microsoft Azure
<p>Milestones</p>	<ul style="list-style-type: none"> Continued development and refinement of pilot proposal documents Coordinated calls between vendors, LAC IT security, LAC program leads, and CalMHSA to get questions answered Began evaluation planning and proposal refinement with UCI and CalMHSA Learning collaborative at PRC: Discussion for the Development of a Guide to Wellbeing app guide Development of Painted Brain App Evaluation Matrix Finalized Guide to Wellbeing app guide and shared with the Help@Hand Collaborative Gathered free resources offered in response to COVID-19 and shared with the Help@Hand Collaborative Created a dynamic QR code for app guide Presented pilot plans to Help@Hand leadership group (all pilots approved by Collaborative) Development of Digital Health Literacy Modules by Painted Brain and associated DMH review Forum Headspace on-site meeting: Getting started with Headspace with Tom Freeman, Engagement Manager Development of request for information (RFI) Screening Tool w/ Monterey County Participated in Help@Hand Language/Monolingual Working Group Clinical Peer Review Presentation for the Quality Outcomes and Training Division: Resources to help Deaf, Hard of Hearing, Blind and Physically Disabled Populations access and use Assistive Technology Updated Help@Hand LA Charter and committee structure Collaborated with UCI to develop the Community College students digital mental health baseline needs assessment 	<ul style="list-style-type: none"> The Leadership Committee reviewed and approved three pilot proposals from LA County on April 9th, 2020 Headspace Plus subscription made available to all Los Angeles County residents as part of COVID rapid response in early May Updated Peer-developed Digital Mental Health Literacy Modules to adapt for virtual training sessions Engaged in the development of specific modules of digital health literacy curriculum and training to include telehealth etiquette and use of selected DMH telehealth platform (Vsee) by Peers Held Digital Mental Health Literacy virtual trainings for Service extenders, Community Health Workers, and Peers champion Translated Guide to Wellbeing app guide to Spanish and disseminated to the Help@Hand Collaborative Various outreach and communication efforts to increase awareness and engagement with Headspace and the Guide to Wellbeing Apps LACDMH LE provider completed interview on Apps to Support Wellbeing at Compton Pride 	<ul style="list-style-type: none"> Held Digital Mental Health Literacy virtual trainings for Service extenders, Community Health Workers, and Peers champion. Virtual trainings included Telehealth connection and support training for the peer champions Held office hours to provide support and technical assistance for Service extenders, Community Health Workers, Peer Resource Center staff, and Peer champions Presentation at 8/20 Peer Lead Collaboration meeting: Painted Brain: Peer roles in Telehealth 	
<p>Lessons Learned</p>				
<p>Recommendations</p>				

Marin County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	<ul style="list-style-type: none"> Chandrika Zager, LCSW MPH Lorraine Wilson, MSW 	<ul style="list-style-type: none"> Chandrika Zager, LCSW MPH Lorraine Wilson, MSW 	<ul style="list-style-type: none"> Chandrika Zager, LCSW MPH 	<ul style="list-style-type: none"> Chandrika Zager, LCSW MPH Lorraine Wilson, MSW
Implementation Site	<ul style="list-style-type: none"> Not applicable 	<ul style="list-style-type: none"> Not applicable 	<ul style="list-style-type: none"> Not applicable – working through partner CBOs 	<ul style="list-style-type: none"> Not applicable – working through partner CBOs
Team Composition	<ul style="list-style-type: none"> Behavioral Health Director, Peer, MHSA Coordinator, Tech Lead 	<ul style="list-style-type: none"> Behavioral Health Director, Peer, MHSA Coordinator, Tech Lead 	<ul style="list-style-type: none"> Behavioral Health Director, MHSA Coordinator, Tech Lead, Peer Lead 	<ul style="list-style-type: none"> Behavioral Health Director, MHSA Coordinator, Tech Lead, Peer Lead
Target Audience	<ul style="list-style-type: none"> Older Adults (particularly those who are isolated) 	<ul style="list-style-type: none"> Older Adults (particularly those who are isolated) 	<ul style="list-style-type: none"> Older Adults (particularly those who are isolated) 	<ul style="list-style-type: none"> Older Adults (particularly those who are isolated)
Products in Use/Planned	<ul style="list-style-type: none"> Uniper (Testing) myStrength (Testing) Happify (Testing) Wysa (Testing) 	<ul style="list-style-type: none"> Uniper myStrength 	<ul style="list-style-type: none"> Uniper myStrength 	<ul style="list-style-type: none"> myStrength
Implementation Approach	<ul style="list-style-type: none"> TBD 	<ul style="list-style-type: none"> TBD 	<ul style="list-style-type: none"> In development 	<ul style="list-style-type: none"> Coordinated partnership with Telehealth Nurse Interns – blend of home visiting and virtual support
Other Unique Qualities (of target audience, implementation, or other program aspect)	<ul style="list-style-type: none"> Builds an intergenerational component (planned) Obtain stakeholder feedback through online venues (COVID-19 response), will require both group and individual coaching and a much more drawn out process 	<ul style="list-style-type: none"> Virtual Focus Groups (200 hours, 12 participants) All data gathered remotely – Zoom, Doodle, Online Surveys, DocuSign 	<ul style="list-style-type: none"> Concurrent dual pilots planned Piloting both apps with monolingual Spanish-speaking population 	<ul style="list-style-type: none"> Piloting myStrength with English and monolingual Spanish-speaking population. Digital literacy is a major focus of the pre-pilot launch.
Milestones	<ul style="list-style-type: none"> Business Advisory Committee established and will hold first meeting 4/16 Identified two groups of stakeholder testers (congregation of older adults and peers) Request for proposal issued to identify a trainer experienced with older adults to assist with digital literacy training Recruitment is underway to hire a Peer for the project 	<ul style="list-style-type: none"> Advisory Committee met 4 times and helped recruit focus group members, outline outreach plan, and shared additional considerations for local evaluation Tech4Life hired – contractor experienced in remote coaching in use of tech for older adults Peer recruitment – Anticipated start mid-late August 	<ul style="list-style-type: none"> Peer Lead hired and onboarded Dual pilot proposal approved by compliance, county counsel, and IT 	<ul style="list-style-type: none"> Telehealth Equity Partnership formalized which bring in university nurse interns to provide intergenerational in-home and virtual support Training plans for partners developed and digital literacy curriculum and training formalized Pilot preparation completed and approved Intern training manual developed Established online system for enrolling community members through CBOs
Lessons Learned	<ul style="list-style-type: none"> Increasing digital literacy during a pandemic with a target population where more than 50% do not have devices and many require internet requires a significant investment of staff resources and logistical coordination to overcome. IT direct tech support would have dramatically enhanced efficiency of Help@Hand staff, allowing them to focus on program logistics rather than technical aspects of the project, such as configuring devices and establishing G-mail accounts. Establishing tech accounts on behalf of participants requires careful consideration and legal agreements that would be enhanced/ simplified with coordinated tech support – Google Work Space County systems are not accustomed to flexibly responding to technology needs of residents – how do we design systems from an equity lens when it involves purchasing equipment for residents or supporting internet? Payment systems don't align with program needs. Partnerships are key to add capacity needed to reach isolated populations Outreach for individuals who are isolated and monolingual speakers require targeted strategies – finding the partners who know where they are in the community; for Spanish Speaking population, despite multiple outreach strategies, the only one that led to participants enrolling were through Promoters who are out talking to people (YouTube, texts with IHSS and other strategies did not yield results). For English Speakers, 2 CBOs identified all participants in a very short period of time. Knowing the target audience was critical. Defining "isolation" is a complex concept to define in a pandemic and cultural considerations need to be considered Use of University interns to work in small County is key to providing a labor force to engage isolate populations where Peer workforce is part time – if population had tech experience, project would be tremendously simplified (majority of resource intensity is onboarding participants to tech so that they can use an app/device) Balancing varying system requirements of multiple partners is time intensive (e.g., onboarding interns, compliance, legal, training). Being clear on where decision making resides up front is important. Collaborating across multiple agencies (7 County Departments-- IT, Compliance, HR Volunteer Coord., County Counsel, Aging and Adult Services, BHPS, Fiscal, two CBOs- Tech4Life and West Marin Senior Services, Two Universities, CalMHSA and UCI as well as Promoters requires lots of planning, coordination and communication; deadlines need to factor in the needs of multiple partners and approval processes. Multiple legal agreements were required to onboard participants, involving remote acceptance of Google Terms and Privacy Policies, Help@Hand Participation Agreements and Device Use Agreements, all of which needed combinations of IT, Compliance and County Counsel approval. Using data to find out where your population resides (Census and other key agencies like IHSS was key). 	<ul style="list-style-type: none"> Peer Lead hired and onboarded Dual pilot proposal approved by compliance, county counsel, and IT 	<ul style="list-style-type: none"> Peer Lead hired and onboarded Dual pilot proposal approved by compliance, county counsel, and IT 	<ul style="list-style-type: none"> Peer Lead hired and onboarded Dual pilot proposal approved by compliance, county counsel, and IT

Marin County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Lessons Learned	<ul style="list-style-type: none"> • The field of digital behavioral health appears to not have experience responding in depth to issues of language and culture. Products are rolled out to Spanish Speakers are lacking in some critical areas. • Flexibility and creativity of research team were instrumental in influencing project design and in supporting data gathering for populations that are unable to access technology on the front -end. • New limitations of Spanish functionality of myStrength identified (no privacy practices or terms of service in Spanish) • Logistics of reaching older adults in Covid are complex – how to get sign off on release of information for those with no digital literacy? • Reaching the Spanish Speaking population requires more individualized approach – traditional flyers are not enough; one-on-one communication and outreach is necessary • County system not experienced/designed to administratively do things like pay for internet (limited-term for pilot) Processes need to be memorialized. • Only two nurse interns speak Spanish, leaving staffing challenges to work with those participants who need assistance in Spanish 			
Recommendations	<ul style="list-style-type: none"> • Since additional IT support is necessary, establishing a technical support agreement with HHS IT and/or budgeting for and bringing on contracted IT support would help to accommodate project support needs. • Design future project timelines and goals to align better with staffing structure. 			

Modoc County		Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead		<ul style="list-style-type: none"> Rhonda Bandy, PhD 	<ul style="list-style-type: none"> Rhonda Bandy, PhD 	<ul style="list-style-type: none"> Rhonda Bandy, PhD 	<ul style="list-style-type: none"> Rhonda Bandy, PhD
Implementation Site		<ul style="list-style-type: none"> Modoc County Behavioral Health (MCBH) 	<ul style="list-style-type: none"> Modoc County Behavioral Health (MCBH) 	<ul style="list-style-type: none"> Modoc County Behavioral Health (MCBH) 	<ul style="list-style-type: none"> Modoc County Behavioral Health (MCBH)
Team Composition		<ul style="list-style-type: none"> MCBH Branch Director, MCBH MHSA Coordinator, Behavioral Health Specialist 	<ul style="list-style-type: none"> MCBH Branch Director, MCBH MHSA Coordinator, Behavioral Health Specialist 	<ul style="list-style-type: none"> MCBH Branch Director, MCBH MHSA Coordinator, Behavioral Health Specialist, Peers, Health Services IT 	<ul style="list-style-type: none"> MCBH Branch Director, MCBH MHSA Coordinator, Behavioral Health Specialist, Peers, Health Services IT
Target Audience		<ul style="list-style-type: none"> Current clients County residents 	<ul style="list-style-type: none"> Current clients County residents 	<ul style="list-style-type: none"> Current clients County residents 	<ul style="list-style-type: none"> Current clients County residents
Products in Use/Planned		<ul style="list-style-type: none"> DBT Diary Cards from Mindsstrong (tentative) Apps vetted by other Counties that Modoc chooses off the bench (planned) 	<ul style="list-style-type: none"> Apps vetted by other Counties that Modoc chooses off the bench (planned) 	<ul style="list-style-type: none"> Waiting for apps vetted by other Counties that Modoc will choose off the bench Appy Hours training is beginning to be translated into Spanish by local peer due to process taking too long through H@H administrative coordination. If the translation arrives before we are finished, we'll be happy to use it, especially since we are paying money through the collaborative for the translation 	<ul style="list-style-type: none"> None
Implementation Approach		<ul style="list-style-type: none"> None until apps available on bench Starting up Appy Hours for Digital Literacy Training in preparation for app implementation 	<ul style="list-style-type: none"> None until apps available on bench Appy Hours for Digital Literacy Training on hold due to COVID-19 in preparation for app implementation 	<ul style="list-style-type: none"> None, stakeholders expressing impatience Appy Hours for Digital Literacy Training on hold due to COVID-19 	<ul style="list-style-type: none"> None
Other Unique Qualities (of target audience, implementation, or other program aspect)			<ul style="list-style-type: none"> Phones not offered until apps are implemented 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> None
Milestones		<ul style="list-style-type: none"> Developed Appy Hours 	<ul style="list-style-type: none"> None this quarter due to COVID-19 	<ul style="list-style-type: none"> None, can't move forward until all paperwork is completed by other counties and approved by CalMHSA and H@H Leadership 	<ul style="list-style-type: none"> Gave notice to exit from H@H April 7, 2021.
Lessons Learned		<ul style="list-style-type: none"> Stakeholder's patience has limits, especially when they view an INN as an expensive endeavor and are not seeing any tangible benefits. 			
Recommendations		<ul style="list-style-type: none"> Unencumber the app pilot processes so change can happen. Address leadership issues at CalMHSA. Finalize contracts around budgetary items, such as evaluation, etc. 			

Mono County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	<ul style="list-style-type: none"> • Amanda Greenberg, MPH • Stephany Valadez 	<ul style="list-style-type: none"> • Amanda Greenberg, MPH • Stephany Valadez 	<ul style="list-style-type: none"> • Amanda Greenberg, MPH • Stephany Valadez 	<ul style="list-style-type: none"> • Amanda Greenberg, MPH • Stephany Valadez
Implementation Site	<ul style="list-style-type: none"> • TBD 	<ul style="list-style-type: none"> • TBD 	<ul style="list-style-type: none"> • TBD 	<ul style="list-style-type: none"> • TBD
Team Composition	<ul style="list-style-type: none"> • Behavioral Health Program Manager, Behavioral Health Services Coordinator 	<ul style="list-style-type: none"> • Behavioral Health Program Manager, Behavioral Health Services Coordinator 	<ul style="list-style-type: none"> • Behavioral Health Program Manager, Behavioral Health Services Coordinator 	<ul style="list-style-type: none"> • Behavioral Health Program Manager, Behavioral Health Services Coordinator
Target Audience	<ul style="list-style-type: none"> • Individuals in remote, isolated areas of the County who have less access to social support and mental health services • Students attending Cerro Coso Community College in Mammoth Lakes 	<ul style="list-style-type: none"> • Individuals in remote, isolated areas of the County who have less access to social support and mental health services • Students attending Cerro Coso Community College in Mammoth Lakes 	<ul style="list-style-type: none"> • Individuals in remote, isolated areas of the County who have less access to social support and mental health services • Students attending Cerro Coso Community College in Mammoth Lakes 	<ul style="list-style-type: none"> • Individuals in remote, isolated areas of the County who have less access to social support and mental health services • Students attending Cerro Coso Community College in Mammoth Lakes
Products in Use/Planned	<ul style="list-style-type: none"> • TBD (awaiting larger County/City pilots to be completed) 	<ul style="list-style-type: none"> • TBD (awaiting larger county/city pilots to be completed) 	<ul style="list-style-type: none"> • TBD (awaiting larger county/city pilots to be completed) 	<ul style="list-style-type: none"> • TBD (awaiting larger county/city pilots to be completed)
Implementation Approach	<ul style="list-style-type: none"> • TBD (awaiting larger County/City pilots to be completed) 	<ul style="list-style-type: none"> • TBD (awaiting larger county/city pilots to be completed) 	<ul style="list-style-type: none"> • TBD (awaiting larger county/city pilots to be completed) 	<ul style="list-style-type: none"> • TBD – considering “ready-made”, out of the box, implementation specific products
Other Unique Qualities (of target audience, implementation, or other program aspect)	<ul style="list-style-type: none"> • Mono County is very small, remote and rural, so we will have some challenges around implementation in our outlying areas 	<ul style="list-style-type: none"> • Mono County is very small, remote and rural, so we will have some challenges around implementation in our outlying areas 	<ul style="list-style-type: none"> • Mono County is very small, remote and rural, so we will have some challenges around implementation in our outlying areas 	<ul style="list-style-type: none"> • Mono County is very small, remote and rural, so we will have some challenges around implementation in our outlying areas
Milestones	<ul style="list-style-type: none"> • Awaiting pilots 	<ul style="list-style-type: none"> • Awaiting pilots 	<ul style="list-style-type: none"> • Awaiting pilots • Peer Lead assigned to Project 	<ul style="list-style-type: none"> • Awaiting pilots
Lessons Learned	<ul style="list-style-type: none"> • As a small county, MCBH asks staff to wear many different hats. One of the lessons learned from being part of this collaborative and other Innovation projects is that MCBH needs to ensure that staff assigned to lead certain projects have the capacity to do so. If they do not, then MCBH needs to consider what other staffing/consultants may be needed to take the project forward 			
Recommendations	<ul style="list-style-type: none"> • We appreciate the move toward “ready made” apps. 			

Monterey County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr–Jun 2020)	Quarter 3 (Jul–Sept 2020)	Quarter 4 (Oct–Dec 2020)
Tech Lead	<ul style="list-style-type: none"> Wesley Schweikhard 	<ul style="list-style-type: none"> Same as Q1 	<ul style="list-style-type: none"> Same as Q1 	<ul style="list-style-type: none"> Same as Q1
Implementation Site	<ul style="list-style-type: none"> Family Member / Friend of an individual that experiences a Mental Health Disorder Individual entering Mental Health Clinic Community Service Provider conducting outreach activities 	<ul style="list-style-type: none"> Same as Q1 	<ul style="list-style-type: none"> Same as Q1 	<ul style="list-style-type: none"> Same as Q1
Team Composition	<ul style="list-style-type: none"> Behavioral Health Director, Tech Lead, Subject Matter Experts (Legal, IT) 	<ul style="list-style-type: none"> Same as Q1 	<ul style="list-style-type: none"> New Interim Behavioral Health Director (Lucero Robles) 	<ul style="list-style-type: none"> Jon Drake, Asst Bureau Chief assisting with procurement process
Target Audience	<ul style="list-style-type: none"> Adults Monolingual Spanish adults 	<ul style="list-style-type: none"> Same as Q1 	<ul style="list-style-type: none"> Same as Q1 	<ul style="list-style-type: none"> Same as Q1
Products in Use/Planned	<ul style="list-style-type: none"> Custom build behavioral health screening tool (planned) 	<ul style="list-style-type: none"> Same as Q1 	<ul style="list-style-type: none"> Same as Q1 	<ul style="list-style-type: none"> Same as Q1
Implementation Approach	<ul style="list-style-type: none"> Not Applicable 	<ul style="list-style-type: none"> Not applicable; Focus is on custom development vendor procurement 	<ul style="list-style-type: none"> Not applicable; Focus is on custom development vendor procurement 	<ul style="list-style-type: none"> Not applicable; Focus is on custom development vendor procurement
Other Unique Qualities (of target audience, implementation, or other program aspect)	<ul style="list-style-type: none"> Developing a custom build product instead of an existing product 	<ul style="list-style-type: none"> Same as Q1 	<ul style="list-style-type: none"> Same as Q1 	<ul style="list-style-type: none"> Same as Q1
Milestones	<ul style="list-style-type: none"> Developed and release Request for Information (RFI) requesting feedback from vendor community on development of peer chat screening tool Began to analyze RFI results 	<ul style="list-style-type: none"> Completed analysis of RFI results Began to develop Request for Proposals (RFP), which was informed by RFI results Began recruiting RFP review panel to include peers/stakeholders, clinical experts, and technology experts 	<ul style="list-style-type: none"> Same as Q2. RFP release stalled as CalMHSA identifies new county partners to join project. Additional steps also need to be taken to clarify roles and responsibilities of the county, CalMHSA, and vendors during the design/build and implementation phases of the project. 	<ul style="list-style-type: none"> RFP Released!
Lessons Learned	<ul style="list-style-type: none"> County behavioral health staff are generally not familiar with development of technology products. Could have used education on the iterative process from the onset, as the county lacks staff support to monitor/approve the breadth and frequency of deliverables involved. 			
Recommendations				

Orange County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	<ul style="list-style-type: none"> Sharon Ishikawa, PhD Flor Yousefian Tehrani, PsyD, LMFT 	<ul style="list-style-type: none"> Sharon Ishikawa, PhD Flor Yousefian Tehrani, PsyD, LMFT 	<ul style="list-style-type: none"> Sharon Ishikawa, PhD Flor Yousefian Tehrani, PsyD, LMFT 	<ul style="list-style-type: none"> Sharon Ishikawa, PhD Flor Yousefian Tehrani, PsyD, LMFT
Implementation Site	<ul style="list-style-type: none"> UCI Medical Center OC Community Colleges (initial communications begun to explore interest and feasibility of being implementation sites) 	<ul style="list-style-type: none"> UCI Medical Center Community Colleges implementation delayed Re-started conversations with County-operated programs (PACT, esp. CYBH) about MS implementation 	<ul style="list-style-type: none"> UCI Medical Center Continued conversations with County-operated programs (Adult Mental Health) about feasibility of MS implementation Explored opportunities for MS expansion 	<ul style="list-style-type: none"> UCI Medical Center Determined County-operated programs (Adult Mental Health) may not be feasible at this time Re-started internal discussions about feasibility of MS implementation in Community Colleges Explored opportunities for MS expansion
Team Composition	<ul style="list-style-type: none"> Peer Lead, 2 Peers, Compliance, PIO, AQIS, Cambria (3.5 FTE) to support Mindstrong Launch 	<ul style="list-style-type: none"> Peer Lead, 2 Peers, Compliance, PIO, AQIS, Cambria (2.5 FTE) to support Mindstrong Launch; 2 HCA INN Staff to support Informed Consent process; re-initiation of discussions with County managers to determine interest in MS (modified model) for their programs 	<ul style="list-style-type: none"> Peer Lead, 2 Peers, Compliance, Cambria (2.5 FTE) to support Mindstrong implementation; 2 HCA INN Staff to support Informed Consent process Engaged new vendor, Charitable Ventures for marketing collateral and website 	<ul style="list-style-type: none"> Peer Lead, 2 Peers, Compliance, Cambria (2.5 FTE) to support Mindstrong implementation; 2 HCA INN Staff to support Informed Consent process, Charitable Ventures to support marketing collateral and website updates
Target Audience	<p>Mindstrong</p> <ul style="list-style-type: none"> Adults 18+ English fluency Resident of Orange County Diagnosis of Major Depressive Disorder, Bipolar Disorder, Schizophrenia, or Schizoaffective Disorder Anxiety disorders, substance use disorders or co-occurring diagnoses are ok May have a history of psychiatric hospitalization and/or 1+ crisis evaluations within last 12 months Device eligibility: owns a smartphone with unlimited data, talk and text May be expanded depending on research on Lifeline phones and Mindstrong data usage 	<p>Mindstrong</p> <ul style="list-style-type: none"> Adults 18+ English fluency Resident of Orange County Diagnosis of Major Depressive Disorder, Bipolar Disorder, Schizophrenia, or Schizoaffective Disorder Anxiety disorders, substance use disorders or other co-occurring diagnoses are ok May have a history of psychiatric hospitalization and/or 1+ crisis evaluations within last 12 months Device eligibility: owns a smartphone with unlimited data, talk and text May be expanded depending on research on Lifeline phones and Mindstrong data usage 	<p>Mindstrong</p> <ul style="list-style-type: none"> Adults 18+ English fluency Resident of Orange County Diagnosis of Major Depressive Disorder, Bipolar Disorder, Schizophrenia, or Schizoaffective Disorder Co-occurring anxiety disorders, substance use disorders or other secondary diagnoses are ok as long as a qualifying diagnosis is present Use of a smartphone (Android 6/IOS 11 or newer) Internet access: Wi-Fi at home, work, school and/or cellular data plan Primary user of their smartphone device Does not currently have a psychotherapist 	<p>Mindstrong</p> <ul style="list-style-type: none"> Adults 18+ English fluency Resident of Orange County Diagnosis of Major Depressive Disorder, Bipolar Disorder, Schizophrenia, or Schizoaffective Disorder, Post Traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD) Co-occurring anxiety disorders, substance use disorders or other secondary diagnoses are ok as long as a qualifying diagnosis is present Use of a smartphone (Android 6/IOS 11 or newer) Internet access: Wi-Fi at home, work, school and/or cellular data plan Primary user of their smartphone device
Products in Use/Planned	<ul style="list-style-type: none"> Mindstrong Crisis Prevention Services (Planned) 	<ul style="list-style-type: none"> Mindstrong Crisis Prevention Services (In Use as part of soft launch) 	<ul style="list-style-type: none"> Mindstrong Crisis Prevention Services (In Use as part of soft launch) 	<ul style="list-style-type: none"> Mindstrong Health
Implementation Approach	<ul style="list-style-type: none"> Mindstrong (Not in use yet) 	<ul style="list-style-type: none"> Mindstrong launched May 14, 2020 	<ul style="list-style-type: none"> Expanded Mindstrong referring providers at UCI Medical Outpatient Psychiatry to include residents Revisited Mindstrong eligibility criteria to ensure appropriate referrals (i.e., clarified qualifying diagnoses; defined psychotherapist/psychotherapy) 	<ul style="list-style-type: none"> Started discussions on how to move to a broader marketing approach rather than a case by case referral Developed digital consent videos to automate HCA informed consent process

Orange County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Other Unique Qualities (of target audience, implementation, or other program aspect)	<ul style="list-style-type: none"> Serving individuals regardless of insurance type/status Creating plan to pilot/test Lifeline phones Extensive conversations and iterative refinement around informed consent process involving project team, compliance, Peers, UCI Medical Mindstrong and video production company; including digitization of consent form and creating companion video/audio 	<ul style="list-style-type: none"> Proposal for Mobile Innovation and Lifeline Testing going through community planning 	<ul style="list-style-type: none"> Updated HCA Informed Consent document to address Apple/Android privacy alerts Continued discussions on clarity of continuity of care Increased emphasis on sustainability planning UCI Evaluation initiated interviews with referring providers and shared results recommendations with HCA Several provider recommendations were implemented to improve and streamline the referral process Established necessary activities to allow Peers to conduct outreach to complete consumer informed consent (smartphone, BAAs, secure emails, FTP site) Conducted provider training to support full deployment to UCI Psychiatry OC Peer developed Mindstrong consumer information sheet 	<ul style="list-style-type: none"> Created an eligibility and referral guide to help providers with referral process Created physical outreach materials (postcard) to be used when referring providers want to share Mindstrong information with consumers UCI Evaluation conducted interviews with referring providers and consumers to gather their feedback and perspectives on the referral process and to identify potential areas for improvement Increased Peer involvement through participation in tech lead calls and development of outreach materials (brochures, flyers, MS video, FAQs)
Milestones	<p>Mindstrong:</p> <ul style="list-style-type: none"> Tentative pilot launch at UCI Medical Center in Spring 2020 (depending on impact of COVID-19 public health emergency response) Implementation planning for Community Colleges, with preliminary soft pilot launch in Fall 2020 (possibly sooner in response to increased need for telehealth support due to impact of COVID-19 on school closures) 	<ul style="list-style-type: none"> Launched Mindstrong with UCI Medical Outpatient Psychiatry on 5/14/2020 As of June 30, 2020 (end of Q2) UCI MC/UCI Psychiatry referral statistics indicate: <ul style="list-style-type: none"> 2 Referring providers 16 consumers referred 10 completed Mindstrong enrollments 4 consumers could not be contacted by HCA-INN to complete informed consent. 2 consumers in-process 	<ul style="list-style-type: none"> Continuous assessment and adjustment of the rapid deployment response 	<ul style="list-style-type: none"> Evaluated referral flow and numbers and adjusted the process for improvements Started discussions on feasibility of expanding Mindstrong to different target populations and programs
Lessons Learned	<ul style="list-style-type: none"> Communication with vendors, checking in to ensure information, terminology, messaging, and shared vision is accurate and determine appropriate data sharing is transparent Risk, liability, legal counsel, and crisis response protocols are critical elements to the project and must remain an ongoing priority throughout implementation Consumers and providers need easy access to County-specific and Help@Hand project information to learn about the product and what to expect Identify and maintain strategies for effective, transparent communication and decision-making throughout implementation 			
Recommendations	<ul style="list-style-type: none"> Collaborate and prepare early with key stakeholders to support alignment in approaches, definitions, terminology, etc. and continuously revisit throughout implementation or when considering program expansion Involve various subject matter experts (compliance, legal, fiscal, contracts, etc.) to support all stages of project implementation Develop a streamlined process for training providers and project staff about the product to support consistency in communication about the product and with eligible consumers Maintain ongoing and transparent communication between all project partners Determine data access and ownership prior to execution of contracts Actively engage Peers in all project activities Maintain adaptable strategies and workplans; anticipate shifts and be flexible and prepared for changes To the extent possible, maintain consistency in project staff for historical knowledge and continuity Utilize parallel workstreams to more efficiently accomplish project activities 			

Riverside County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	Maria Martha Moreno, MS CIS	Maria Martha Moreno, MS CIS	Maria Martha Moreno, MS CIS	Maria Martha Moreno, MS CIS
Implementation Site	<ul style="list-style-type: none"> Transitional Age Youth Drop-In Centers (in Mid-County, Desert and Western Regions) 	<ul style="list-style-type: none"> Riverside County Community, Transitional Age Youth Drop-In Centers (in Mid-County, Desert and Western Regions) 	<ul style="list-style-type: none"> TakemyHand Live Peer Chat: Riverside County Community Transitional Age Youth (TAY) Drop-In Centers (in Mid-County, Desert and Western Regions), Deaf and Hard of Hearing A4I or FOCUS: TAY, Adult and Older Adult SM/ FSP Focus Participants from Western, Desert and Mid-County Custom App or Existing App (TBD): Deaf and Hard of Hearing. 	<ul style="list-style-type: none"> TakemyHand Live Peer Chat: Riverside County Community Transitional Age Youth (TAY) Drop-In Centers (in Mid-County, Desert and Western Regions), Deaf and Hard of Hearing A4I or FOCUS: TAY, Adult and Older Adult SM/ FSP Focus Participants from Western, Desert and Mid-County Custom App or Existing App (TBD): Deaf and Hard of Hearing. CODIE Representative team
Team Composition	<ul style="list-style-type: none"> Peer Manager, Senior Peer, Peers, Clinical Supervisor, CODIE Representative, crisis intervention Clinicians, Application Developer, Technology Lead 	<ul style="list-style-type: none"> Peer Manager, Senior Peer, Peers, CODIE Representative, crisis intervention Clinicians, Application Developer, Technology Lead 	<p>Leadership Mathew Chang, Director Amy McCann, Assistant Director Brandon Jacobs, Deputy Director Research & Quality David Schoelen, MHSA Administrator</p> <p>IT Tura Morice, Chief Information Officer Jimmy Tran, Chief Information Security Officer Robert Watson, IT System Administrator</p> <p>Compliance Officer Ashley Trevino-Kwong, Compliance Officer</p> <p>Senior Public Information Specialist Thomas Peterson</p> <p>Consumer Affairs Manager Shannon McCleerey-Hooper</p> <p>Senior Peer: Pamela Norton</p> <p>Peers: Dakota Brown, Melissa Vasquez, Peter Kiriakos, Rhonda Taiwo, Carmela Gonzalez-Soto.</p> <p>Social Media: Dylan Colt Robert Youssef</p> <p>Senior Clinical Therapist II Amenze Ogbabor - In recruitment process</p> <p>Evaluation: Suzanna Juarez-Williamson, Supervisor Christy Mota, Research Specialist II.</p>	<p>Leadership Mathew Chang, Director Amy McCann, Assistant Director Brandon Jacobs, Deputy Director Research & Quality David Schoelen, MHSA Administrator</p> <p>IT Tura Morice, Chief Information Officer Jimmy Tran, Chief Information Security Officer Robert Watson, IT System Administrator</p> <p>Compliance Officer Ashley Trevino-Kwong, Compliance Officer</p> <p>Senior Public Information Specialist Thomas Peterson</p> <p>Consumer Affairs Manager Shannon McCleerey-Hooper</p> <p>Senior Peer: Pamela Norton</p> <p>Peers: Dakota Brown, Melissa Vasquez, Peter Kiriakos, Rhonda Taiwo, Carmela Gonzalez-Soto.</p> <p>Social Media: Dylan Colt Robert Youssef</p> <p>Senior Clinical Therapist II Amenze Ogbabor - In recruitment process</p> <p>Evaluation: Suzanna Juarez-Williamson, Supervisor Christy Mota, Research Specialist II.</p>

Riverside County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
	<ul style="list-style-type: none"> Higher Risk Populations (i.e., first onset, re-entry, FSP consumers, eating disorders, suicide prevention) Traditionally Underserved Communities (i.e., Hispanic/Latino, American Indian, African American, Asian-Pacific Islander, LGBTQ, deaf and hard of hearing) Geographic service barriers to rural and frontier communities Hearing and visually impaired communities 	<p>Early Detection: TAY Suicide Prevention: Men over the age of 45, Adults over the age of 65, TAY</p> <p>Improve Outcomes for High Risk Populations: Re-entry Consumers, FSP Consumers, Eating Disorder Consumers</p> <p>Improve Service Access to Underserved Communities and for Rural Regions: Deaf and Hard of Hearing, Visually Impaired, Mid-County & Desert Regions, Ethnic Cultural & LGBT communities.</p>	<p>Early Detection: TAY Adults over the age of 65, TAY</p> <p>Suicide Prevention: Men over the age of 45, Adults over the age of 65, TAY</p> <p>Improve Outcomes for High Risk Populations: Re-entry Consumers, FSP Consumers, Eating Disorder Consumers</p> <p>Improve Service Access to Underserved Communities and for Rural Regions: Deaf and Hard of Hearing, Visually Impaired, Mid-County & Desert Regions, Ethnic Cultural & LGBT communities.</p>	<p>Early Detection: TAY</p> <p>Suicide Prevention: Men over the age of 45, Adults over the age of 65, TAY</p> <p>Improve Outcomes for High Risk Populations: Re-entry Consumers, FSP Consumers, Eating Disorder Consumers</p> <p>Improve Service Access to Underserved Communities and for Rural Regions: Deaf and Hard of Hearing, Visually Impaired, Mid-County & Desert Regions, Ethnic Cultural & LGBT communities.</p>
	<ul style="list-style-type: none"> Take My Hand Peer Chat 	<p>TakeMyHand Peer Chat, A4i, Focus, SageSurfer ManTherapy, FEEL Wearable, custom development for the Deaf and Hard of Hearing community.</p>	<p>TakeMyHand Peer Chat, A4i, Focus, Custom development or existing app for the Deaf and Hard of Hearing community, SageSurfer ManTherapy, FEEL Wearable.</p>	<p>TakeMyHand Peer Chat, A4i, Custom development or existing app for the Deaf and Hard of Hearing community, SageSurfer ManTherapy, FEEL Wearable, myStrength.</p>
<p>Implementation Approach</p>	<ul style="list-style-type: none"> The Take My Hand site will be live during set hours and managed by trained/certified Peer Operators (COVID-19 response) 	<ul style="list-style-type: none"> TakeMyHand Peer chat is available to the Riverside community and promoted within the department via county emails, committees, social media, newsletters, etc. Currently planning for focus groups with stakeholders, recruitment of consumers in app pilot selection process with three different Full-Service Partnership clinics (Desert, West and Mid-County regions). 	<ul style="list-style-type: none"> TakeMyHand Peer chat is available to the Riverside community and promoted within the department via county emails, committees, social media, newsletters, etc. Currently planning for focus groups with stakeholders, to guide the selection of additional apps for piloting. The stakeholders are under recruitment among consumers in three different Full-Service Partnership programs (Desert, West and Mid-County regions) and may include youth at the TAY centers. 	<ul style="list-style-type: none"> TakeMyHand Peer chat is available to the Riverside community and promoted within the department via county emails, committees, social media, newsletters, etc. Pilot A4i - Consumers in Full-Service Partnership programs (Desert, West and Mid-County regions) Phase 1 Takemyhand Peer chat Transitional Age Youth. DMHL – Painted Brain, Senior Peer Support Specialists and regional ambassadors' department-wide.
<p>Other Unique Qualities (of target audience, implementation, or other program aspect)</p>	<ul style="list-style-type: none"> Piloting own in-house product Make Peers available on the app 24/7 (Planned) The peer chat is based on the peer model and people will communicate with a real person; not Artificial Intelligence Chat is anonymous and does not collect and/or store PII or PHI 	<p>Outreach and Education/Training provided by Peer Manager, Senior Peer, Peers, Supervising CT and Tech Lead.</p> <p>Regular collaboration feedback/updates to stakeholders committees/Meetings:</p> <ul style="list-style-type: none"> Adult System of Care Committee, Behavioral Health Commission, Housing Committee, Cultural Competency Reducing Disparities, Committee, Older Adults System of Care Committee, Riverside Resilience 	<p>Outreach and Education/Training provided by Peer Manager, Senior Peer, Peers, Tech Lead.</p> <p>Regular collaboration feedback/updates to stakeholders Committees/Meetings:</p> <ul style="list-style-type: none"> FSP Committee – Melissa, Dakota, Martha Adult System of Care Committee – Melissa Behavioral Health Commission – Martha, Pamela, Melissa Center on Deathness Inland Empire – Dakota 	<p>Outreach and Education/Training provided by Peer Manager, Senior Peer, Peers, Tech Lead.</p> <p>Regular collaboration feedback/updates to stakeholders Committees/Meetings:</p> <ul style="list-style-type: none"> FSP Committee – Melissa, Dakota, Martha Adult System of Care Committee – Melissa Behavioral Health Commission – Martha, Pamela, Melissa Center on Deathness Inland Empire – Dakota

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	<p>community, TAY Collaborative–Desert, Mid, and Western, IEP</p> <p>Plan to collaborate: Children's Committee meetings Criminal Justice Committee Desert Regional Board Eating Disorder, Collaborative Inland Empire Kindness Campaign Mid County Regional Board Model Deaf Community Committee NAMI San Jacinto Promotores Asian American Task Force LGBT PEI Specialized Ethnic Community Initiatives programs</p>	<p>Children's Committee – Melissa Cultural Competency Reducing Disparities Committee – Martha, Pamela, Melissa Desert Regional Board meetings – Dakota Eating Disorder Collaborative meetings – Melissa Legislative Committee – Melissa Mid County Regional Board meetings – Melissa Model Deaf Community Committee – Dakota, Pamela, Martha, Shannon NAMI San Jacinto meetings – Martha Older Adults System of Care Committee – Dakota TAY Collaborative meetings: Desert, Mid, and Western – Melissa, Dakota Housing Committee – Dakota Veterans Committee – Dakota Riverside Resilience community meetings – TBD May is Mental Health Month Fairs- Western & Mid County – TBD Criminal Justice Committee – TBD Inland Empire Kindness Campaign meetings – TBD</p>	<p>Technical:</p> <ul style="list-style-type: none"> Defined and set useful chat tags for reporting purposes (in various Peer Operators groups) Made TMH website searchable by Google Management of Peer Operator user accounts and passwords Authentication via LiveChat (no IP restriction) Configuration of chat routing manual (visitors are picked from the queue) Multiple Changes in Pre-Post, crisis and 1st time visitors (English/Spanish) Chat online surveys Peer Operators TMH groups (Riverside, Riverside Crisis, Riverside 1st time visitors, Riverside Spanish, Riverside Spanish 1st time visitors) setup and configuration April 27 through May 27, 2020- Website Visits 94,861, Unique TMH Website Visitors: 2,867 June 5th through July 5th - Website Visits 63,355, Unique TMH Website Visitors: 2,963. Website Metrics – need to license the software to be able to report on entire testing period. Identified technical functionality to tag "trollys", inappropriate language chat users, and ability to ban users via the Ban User button Complexity of the data files Structure of chats statistics files Create and post Cookie Policy ((English/Spanish) Notice of Privacy Practices (posted) Frequently Asked questions webpage Images management 	<p>Compliance:</p> <ul style="list-style-type: none"> Terms of Service – Approved by Riverside Help@Hand team (Technical lead, Clinical lead, Peer lead, Senior Peer Evaluation Supervisor), HIPAA Compliance Officer and County Counsel Chat engine software (LiveChatInc) approved by County IT, Department IT, HIPAA Compliance Officer, and Executive Team <p>Technical:</p> <ul style="list-style-type: none"> Completed chat platform Accomplished user testing for prototype on two different occasions and feedback was provided Developed app to be able to identify a crisis situation and transfer chat to CT (a professional with specialized training) Defined and set useful chat tags for reporting purposes (in various operators groups) Made site searchable by Google Made Live Chat Security HIPAA-compliant by disabling the ability to email a chat transcript, the ability to send files (Peer Operator/Visitors), hiding chat history from visitors, inactivity timeouts, etc. Made Operator passwords are managed by Take my Hand site administrators Made authentication via LiveChat (no IP restriction) Chat routing manual (visitors are picked from the queue) Useful Links on Take my Hand website (i.e., Resources, Terms of Service)
<p>Milestones</p>	<p>Compliance:</p> <ul style="list-style-type: none"> Terms of Service – Approved by Riverside Help@Hand team (Technical lead, Clinical lead, Peer lead, Senior Peer Evaluation Supervisor), HIPAA Compliance Officer and County Counsel Chat engine software (LiveChatInc) approved by County IT, Department IT, HIPAA Compliance Officer, and Executive Team <p>Technical:</p> <ul style="list-style-type: none"> Completed chat platform Accomplished user testing for prototype on two different occasions and feedback was provided Developed app to be able to identify a crisis situation and transfer chat to CT (a professional with specialized training) Defined and set useful chat tags for reporting purposes (in various operators groups) Made site searchable by Google Made Live Chat Security HIPAA-compliant by disabling the ability to email a chat transcript, the ability to send files (Peer Operator/Visitors), hiding chat history from visitors, inactivity timeouts, etc. Made Operator passwords are managed by Take my Hand site administrators Made authentication via LiveChat (no IP restriction) Chat routing manual (visitors are picked from the queue) Useful Links on Take my Hand website (i.e., Resources, Terms of Service) 	<p>Technical:</p> <ul style="list-style-type: none"> Mobile Devices/Kiosks - Contract Justification Completed Procurement of 400 devices (100 iPads, 100 iPhones, 100 Galaxy Tab A, 100 Android Phones) - completed IT Services and Support - Contract Justification Completed SOW Jaguar Computer Systems -Reviewed/Completed Contract IT Services & Support - Jaguar - Initiated GIM - Kiosk procurement Process- 32 small kiosks, 7 (55") Large kiosks - Initiated Kiosk Uses/Features Summary <p>Take my Hand Peer Chat Target Area: Improve Service Access to Underserved Communities</p>	<p>Target Area: Improve Service Access to Underserved Communities</p> <p>Population: Deaf and Hard of Hearing Focus Group - CODIE Members Needs Community Assessment Survey Contract Justification Completed with Sorenson for Services (Adaptation of the 10 DMHL Videos, Curriculum, Community Survey, TMH Peer Operator training, TMH Terms of Service) Deaf and Hard of Hearing (Focus Group) Needs Assessment Learning Update Report (UO)</p> <p>Technology:</p> <ul style="list-style-type: none"> Mobile Devices/Kiosks - Contract Justification Completed Procurement of 400 devices (100 iPads, 100 iPhones, 100 Galaxy Tab A, 100 Android Phones) - completed IT Services and Support - Contract Justification Completed SOW Jaguar Computer Systems -Reviewed/Completed Contract IT Services & Support - Jaguar - Initiated GIM - Kiosk procurement Process- 32 small kiosks, 7 (55") Large kiosks - Initiated Kiosk Uses/Features Summary <p>Take my Hand Peer Chat Target Area: Improve Service Access to Underserved Communities</p>	

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<ul style="list-style-type: none"> Website content is 90 percent complete in English Website loads testing reports (test 3 response times TakeMyHand.com, test 3 transaction throughout TakeMyHand.com) Creating website content in Spanish (in process) Cookie Policy (in process) <p>Training:</p> <ul style="list-style-type: none"> Developed training materials for Peer Operators (Peer Operator training checklist, training for COVID-19, facilitator's manual for COVID-19, Peer Operator, training PPT script only, print-up manual for Peer Operator COVID-19). This includes a module on strategies to deal with "trolls", inappropriate language and situation-at challenges from malicious participants. Scenario role-plays and a brainstorming solution session is included Provided protocols for risk assessment and crisis protocols (Risk assessment, Questions-to-Assess-Suicide-Risk Handout, Essential Workers Support Line Protocol and Procedure) Consumer resources: Riverside Free App guides (English/Spanish), County Resources (Resources Quick Link on Take my Hand website). Quick list of crisis phone numbers, MS Teams, email, phone, etc. for internal communications among chat operators Chat coverage work schedules Identified protocols for tagging "trolls", inappropriate language chat users, and ability to ban users via the Ban User button Canned responses Established work hours Developed strategy to deal with trolls and visitors using inappropriate language by banning them Developed pre chat survey, post chat survey, post crisis chat survey, and first time visitors post chat survey <p>Marketing:</p> <ul style="list-style-type: none"> Done by word of mouth, via a banner on the department website, and video presentation of product on departments' Facebook, YouTube page, etc. Have internal department and stakeholders' newsletter (in process) <p>Evaluation:</p> <ul style="list-style-type: none"> Developed internal evaluation plan (Evaluation Plan Tech Suite, Surveys (User Survey – post chat survey for participants in English/Spanish, After X number of chats – User Survey (Usability) in English/Spanish, Peer User Operator Survey, Clinician Operator Survey, Innovation Demographics in English/Spanish) 	<ul style="list-style-type: none"> Website design, development and content management took place as we implemented the test phase. Website Spanish translations and design of the TakeMyHand was implemented three weeks into the testing phase Define useful Links on Take my Hand website (i.e., Resources, FAQs, Privacy Practices, Terms of Service, About Us, etc.) Manage website content (English/Spanish) Design of dynamic widgets (English/Spanish) Design of content management website tool TMH Website Load Testing Reports – Response times/Transaction throughout TMH Capacity Framing –Full scale testing- scales improved to 1,000 entries requests per second. 2-Tiers – Chat features in LiveChat engine –AWS/Web hosted Whois. ELMR setup/training: special population /scheduling calendar site, service codes, staff member hours and exceptions Export of chat data files: Total chats, Peer Operators Performance, chat duration, chat rating, chat availability, chat engagement, chat response time, missed chats, tags usage, chat waiting time, chat abandonment, pre and post chat surveys for all groups (English/Spanish, 1st time visitors, & crisis) <p>Marketing:</p> <ul style="list-style-type: none"> All Hands on Deck Newsletters ChatVox Weekly Bulletin for Operators TakeMyHand One Page Conversation Handouts for Clinics/Consumers YouTube TakeMyHand Promotional videos <ul style="list-style-type: none"> Shannon McCleerey-Hooper: https://youtu.be/UZXfnqoX-2E Shannon McCleerey-Hooper: https://youtu.be/ib9lc26oPg Maria Martha Moreno: https://youtu.be/9H94xAPNdc Pamela Norton: https://losangeles.cbslocal.com/video/program/1430/4540496-web-site-provides-mental-health-support/ <p>Training:</p> <p>Training Materials were adjusted/improved as the needed.</p> <p>Peer Operators:</p> <ul style="list-style-type: none"> One-on-One Virtual Peer Chat: A Training Manual for Peer Operators 	<ul style="list-style-type: none"> Alex: https://www.youtube.com/watch?v=G5e0MnRLLx&feature=youtu.be <p>Training Materials:</p> <ul style="list-style-type: none"> TakeMyHand Peer Chat Getting up to speed on Rise & Storyline (trainings) and training Peers in other departments Brainstorming out-of-the-box engagement strategies and "how to make recovery irresistible" Create & deliver Storyline TakeMyHand A.I. Waiting Room presentation "Waiting for a Peer Chat Operator: The Consumer Experience" Update promotional materials to reflect new, shorter, TakeMyHand Operator Hours Resources Materials (Peter) <p><i>Deaf and Hard of Hearing</i></p> <ul style="list-style-type: none"> Create & deliver Storyline Deaf/HOH app presentation, "Gloria Possibilities" Resources Information Gathering (Carmela) <p><i>Digital Mental Health Literacy</i></p> <ul style="list-style-type: none"> Digital Footprints: https://360.articulate.com/review/content/d9535ce9-49c6-4c67-a07d-17ea858cca7/review Adapting DMHL to virtual presentation (part 1 approaching completion; part 2 will be next quarter) Create QR Code narrated PowerPoint module for DMHL <p><i>Other Training</i></p> <ul style="list-style-type: none"> Testing out the Focus & A4i apps via test accounts Continuing to crawl the internet for new MH apps and setting up test accounts with likely candidates Update Free app guide to delete Freemium apps and insert new free ones, like "UCLA Mindful" A4i vs. FOCUS in preparation for focus group PowerPoint presentation: https://rise.articulate.com/share/ddtMB6GdGalukb0E69oH9gTB3Z-kF5ZB3k#/lessons/t7aUHQTEGUKR0MRH7Z-g9y_W__WwRfS <p>Peer Manager Report finalized and shared.</p> <p>The report shares the key players, the steps taken and the lessons learned as Riverside University Health System-Behavioral Health (RUHS-BH) worked to rapidly deploy the test phase of the first, ever, live, one-on-one Peer Support web-based chat platform, in response to the COVID-19 pandemic.</p> <p>EVALUATION:</p> <p><i>Evaluation of TakeMyHand testing phase report finalized and shared.</i></p>	<p>Population: Deaf and Hard of Hearing, Mid-County & Desert Regions, Ethnic Cultural and LGBT</p> <ul style="list-style-type: none"> Take my Hand Peer Chat Operation 8 am to 5 pm Monday through Friday Fulfilled and Implemented Crisis CT Role for Take my Hand Resources Document List Take my Hand Peer Operator: Online USER GUIDE Take my Hand INFOGRAPHICS Take my Hand INFOGRAPHICS - LGBT Take my Hand WIREFRAME Take my Hand Security Questions (TMH Website & LIVECHAT Inc.) Initiated TMH Service Mark (Trademark process) - Initiated process Peer Operator Training completed for 4 new Peer Support Specialists/One Clinical Therapist TechSuite Electronic Health Records new service codes for staff time accounting- add new as needed IEHP County Programs Liaison Behavioral Health and Care Management Department- Arlene Ferrer Take my Hand Newsletter No. 3 December 2020 Convo Take My Hand filer - English Convo Take My Hand filer - Spanish RUHS Social Media - Facebook/Instagram Peer Staff Development (ongoing) Coping skills Resource Binder per Topic (WIP) Articulate tool training to create presentations Searchable spreadsheet for our resource list (WIP) Identified need to create fuller Peer/CT Operator Training for TMH. (WIP) Identified need to train Peer Team regarding emotional response and effective communication in text (WIP) Help@Hand Learning Brief Riverside County Take My Hand <p>A4i/FOCUS</p> <p>Target Area: Improve Outcomes for High Risk Populations.</p> <p>Population: FSP Consumers" A4i and FOCUS -Four Focus Groups (FSP, TAY, Adult, Older Adult) - 22 consumer participants</p> <ul style="list-style-type: none"> Tested & Explored A4i and FOCUS apps Focus Group -files Focus Group Recruitment Activities Apps Focus Groups Presentation - Distributed and presented Executive Team/Managers/Supervisors A4i vs FOCUS Articulate online presentation Recruit and Assist with Focus Group Registration Process 	

Quarter 1
(Jan–Mar 2020)

Quarter 2
(Apr – Jun 2020)

Quarter 3
(Jul – Sept 2020)

Quarter 4
(Oct – Dec 2020)

- Creating a Conversation: Addressing Distress in Peer Support
- Open-ended Questions Quick Reference Handout
- TMH Facilitator’s Manual for Peer Ops COVID
- TMH Peer Operator CheckList
- Crisis Clinical Staff
- Crisis SoC Protocols - Community Response Triage TMH
- Essential Workers Support Line Protocol and Procedure TMH

Peer Manager Report:

The report will share the key players, the steps taken and the lessons learned as Riverside University Health System-Behavioral Health (RUHS-BH) worked to rapidly deploy the test phase of the first, ever, live, one-on-one Peer Support web-based chat platform, in response to the COVID-19 pandemic.

Evaluation:

A multi-tiered approach to examine various level of functionality, user experience and impact. The testing phase evaluation will focus on the following goals: 1). Test product acceptance and usability with real chat participants; 2). Gather information on Chat participant experience; 3). Gather information on Peer and CT Operator’s Experience and Training

- Chat Statistics
- Total chats,
- Peer Operators Performance
- Chat duration
- Chat rating
- Chat availability
- Chat engagement
- Chat response time
- Missed chats
- Tags usage
- Chat abandonment time
- Chat Surveys: pre and post chat surveys (English, Spanish, 1st time visitors, & crisis)
- Peer Operators interviews

A multi-tiered approach to examine various levels of functionality, user experience and impact. The testing phase evaluation focused on the following goals: 1). Test product acceptance and usability with real chat participants; 2). Gather information on Chat participant experience; 3). Gather information on Peer and CT Operator’s Experience and Training

- Chat Statistics: Total chats; Peer Operators Performance; Chat duration; Chat rating; Chat availability; Chat engagement; Chat response time; Missed chats; Tags usage; Chat waiting time; Chat abandonment time; Chat Surveys: Region of County, zip code, acceptance of Terms of Service, post chat satisfaction survey, and demographics collection from first time visitors.
- Testing phase report also included qualitative data from UCI focused interviews with peer chat operators
- Dear and Hard of Hearing (DHH) Needs Assessment began including a focus group and survey with community advocates. A broader DHH community survey is under development in collaboration with a lead DHH community advocate, UCI and County Evaluation staff.
- Recruitment began for stakeholders to participate in focus groups to assist with app selection for piloting
- Draft materials for app selection focus groups were developed including participation agreement, demographics, and tech use survey and focus group questions.

Focus Groups Materials

- A4I vs. FOCUS
- PowerPoint presentation under development to use in focus group presentations to stakeholders
- Demographics and tech use survey developed for focus group participants, focus questions for A4I and FOCUS app developed

- A4I vs FOCUS Power Point Presentation
- Facilitate Focus Group
- Design of Focus Group Registration Google Form
- Tracking of final list of Focus Group Participants
- Configure 4 iPad Devices to loan to focus group participants
- Focus Groups gift baskets for participants - completed
- Help@Hand Learning Brief_Riverside County APP Exploration Report (A4I and FOCUS) - Focus Groups (FSP, TAY, Adult, Older Adult)
- Data Analysis on Education Level for current FSP TAY Consumers

Digital Mental Health Literacy Training

- Completed Section 1 of DMHL Self-Guided Online Platform version
- Started -Section 1 of DMHL facilitator-guided online platform

Reduce stigma associated with mental illness by promoting mental wellness Educate/Outreach/Reduce Stigma/Partnership/ Resources

- Operation Uplift - Medical Center - offering the Take my Hand Peer Chat Resource
- LGBT Medical Center -offering the Take my Hand Peer Chat Resource
- Suicide Prevention Coalition
- Cultural Competency Reducing Disparities Committee
- FSP Committee
- Behavioral Health Commission
- Eating Disorder Collaborative
- Tested & Explored free Apps
- Riverside Free app guide - English
- Riverside Free app guide -Spanish
- Rural Communities (Facebook live panel to learn about approaches to reach rural communities in California)
- Map -Unincorporated Riverside Communities
- Attempted contact and build rapport in order to incorporate Model Deaf Community Committee’s perspective in DHOH survey for a fuller community view.
- Collecting app information (Android & iOS) from the team to maintain information on free-freemium apps to keep Free App guide up-to-date.
- Exploring free to freemium apps (during downtime)

Lessons Learned

- **Focus Groups**
- **How did you recruit participants for your focus groups, and what were your strategies to communicate with them?** You Voice Counts Fliers, and A4I/Focus PowerPoint Presentations during managers and Quality Improvement Committee meetings, emails to the executive team, department Peer Workforce, Managers and Clinic Supervisors were sent to announce and get help with stakeholders' recruitment.
- **What worked well in terms of communicating?** Meetings and A4I and Focus Video presentations.
- **What did not work well?** Short timeline in recruiting stakeholders' participants, an extended timeline can allow for verbal promotion via telephone with clinic supervisors and clinic staff meetings.
- **What would you do differently next time?** Extend the recruitment timeline and better preparation for the logistics in general (presentation, devices, support staff, incentives, etc.)
- **What were your goals and were they clearly defined going into these focus groups?** The goal was for stakeholders to share their thoughts about the two app features (A4I and FOCUS). Main theme was around "Do they find the app feature helpful" and "Does it not interest you at all?"
- **Did the focus group achieve those?** Yes. Findings are in the Help@Hand Learning Brief_Riverside County APP Exploration.v5 (UCI Report).
- **If they did, what worked well?** Our Peer team participated in providing feedback on the content of the presentation as to ensure recovery language is in use throughout the presentation, survey and one-on-one communication. Peer team was very proactive in working with the focus participant one-on-one to assist with the completion of the pre-focus group survey and in explaining the participation consent. Email and text reminders were sent to participants a day prior and on the day of the focus group. This was key to ensure participants remember their focus group event. In addition, we had a good number of TAY participants that were well informed about existing wellness apps and they were already using some of these apps.
- **TakemyHand Live Peer Chat**
- Identified need to create fuller Peer/CT Operator Training for TMH.
- Identified need to train Peer Team regarding emotional response and effective communication in text.
- Coping skills Resource Binder per Topic.
- Closing the gap of available mental health Peers for the DHOH population - "Building Peer Leaders" Peer Support Training to a few Gloria-identified CODIE members. Coordinate with CODIE (Gloria) to develop a Peer Training Plan.
- **Deaf and Hard of Hearing**
- Findings from the first stakeholders meeting were very useful and are a baseline to start drafting user case stories.
- To be able to gather more stakeholder representation data, there is the need to implement a DHOH Community needs assessment survey distributed along with an ASL video adaptation featured with Deaf talent that is representative of the Riverside demographic breakdown.

Recommendations

- **Next steps:**
- **Target Area:** Improve Service Access to Underserved Communities
- **Population:** Deaf and Hard of Hearing"
- Work with Sorenson for the adaptation of the DHOH Community Needs Assessment Survey
- Deaf & Hard of Hearing App (custom or existing app) - Continue with identifying needs
- "Building Peer Leaders" Peer Support Training to a few Gloria-identified CODIE members. Coordinate with CODIE (Gloria) to develop a Peer Training Plan.
- Facilitator's Guide and Student Workbook in preparation to meet with Gloria to discuss the materials, and how we augment them for the DMHL learning.
- Coordinate with CODIE (Gloria) to TakemyHand Peer Operators Training Plan -after hired/contracted.
- Global transformational advocacy
- **Technology**
- Deliver devices
- Kiosks distribution/install process
- Draft policy and procedures for sanitizing the kiosk
- Draft policy and procedures for addressing vandalism on kiosks
- Research Text to Speech Apps for our Blind Community
- **Take my Hand Peer Chat**
- **Target Area:** Improve Service Access to Underserved Communities
- **Population:** Deaf and Hard of Hearing, Mid-County & Desert Regions, Ethnic Cultural and LGBT"
- Take my Hand Peer Chat Terms of Service VIDEO (English/Spanish)
- Take my Hand Peer Chat Terms of Service VIDEO (Deaf and Hard of Hearing) -Sorenson
- LGBT Take my Hand Riverside Spotlight Report
- Peer Staff Development (Ongoing)
- Addition of Family Advocate services on TakemyHand Website
- Take my Hand Chat Language Translator
- Take my Hand Video functionality (DHOH)
- TakemyHand Grievance/End-User Experience feedback form available independently from automated survey after chat close.
- Chatbot Functionality for visitors in the queue - (HIPPA compliance)

Recommendations

- TakemyHand Mobile app version
 - Contract RIA/Metrolink - Take my Hand - marketing skin for buses -digital advertising
 - Service Mark
 - URL link to California Consumer Privacy Act
 - IIS Server set up - to store chats data - get approval
 - Word cloud chat analysis
 - Dashboard reports configuration
 - Video stories webpage - marketing/
 - Link to Help@Hand website
 - Automate chat data exports for evaluation
 - TMH changes/improvements based on stakeholder feedback
 - Create TakemyHand Product Profile - for Pilot Proposal?
 - TakemyHand vetting process from other counties - San Francisco
 - Secure timeline for pilot phase (Riverside Only) - do we need to have a Pilot?
 - Secure timeline for pilot phase (additional Counties – added in after initial Riverside pilot)- San Francisco
 - TakemyHand Landing Page- Other Counties - San Francisco county
 - Coping skills Resource Binder per Topic (WIP)
 - Articulate tool training to create presentations (ongoing)
 - Searchable spreadsheet for our resource list (WIP)
 - Identified need to create fuller Peer/CT Operator Training for TMH. (WIP)
 - Identified need to train Peer Team regarding emotional response and effective communication in text (WIP)
 - Press Release - marketing
- **A4I**
 - **Target Area:** Improve Outcomes for High Risk Populations
 - **Population:** FSP Consumers'
 - Aim to start A4I App Pilot during this Quarter
 - Pilot Proposal (see CalMHSA Template)
 - User Agreement - Consumer - review by county counsel -compliance officer
 - Informed Consent -Consumer - review by county counsel -compliance officer
 - Evaluation Planning
 - App customizations
 - Trainings
- **Marketing**
 - Digital Mental Health Literacy Training
 - Start DMHL training with peers who are going in to the hospitals to engage consumers.
 - Start normalizing DMHL and telehealth services, as well as introduce free wellness applications as a tool for self-support as they transition services.
 - Started -Section 1 of DMHL facilitator-guided online platform
 - Painted Brain contract to assist with DMHL training throughout the Department
- **Reduce stigma associated with mental illness by promoting mental wellness**
 - **Educate/Outreach/Reduce Stigma/Partnership/Resources**
 - Riverside free app guide 123 Approval Process
 - Work with the Peer Support Specialists doing Navigation to get them primed for the opportunity to do that kind of introduction of apps. FSP Peers/consumers.
 - Model Deaf Community Committee (MDCC)-- (promote community survey, DMHL videos, etc.)
 - Establish our consulting cultural outreach workforce to reach out to targeted populations about Help@Hand, education, resources and reduction of Mental Health Stigma. (SOW)
 - Riverside Help@Hand Story Map - prioritize and support Activities in Rural Areas
- **Quarter 2 (Apr-May-Jun)**
 - myStrength
 - Target Area: LGBT, FSP, Older Adults, TAY,
 - Population:
 - Select Apps for other Pilots
 - Focus Groups: SageSurfer, ManTherapy, FEEL Wearable
- **Quarter 3 (Jul-Aug-Sep)**
 - Distribution of devices acquired through government program.

Santa Barbara County	Quarter 1 (Jan – Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	<ul style="list-style-type: none"> Lindsay Walter, JD- MHSA Maria Arteaga, JD- Peer & Ethnic Services Vanessa Ramos- Help@Hand Project Manager 	<ul style="list-style-type: none"> Lindsay Walter, JD- MHSA Maria Arteaga, JD- Peer & Ethnic Services Vanessa Ramos- Help@Hand Project Manager 	<ul style="list-style-type: none"> Lindsay Walter, JD- MHSA Maria Arteaga, JD- Peer & Ethnic Services Vanessa Ramos- Help@Hand Project Manager 	<ul style="list-style-type: none"> Lindsay Walter, JD- MHSA Maria Arteaga, JD- Peer & Ethnic Services Vanessa Ramos- Help@Hand Project Manager
Implementation Site	<ul style="list-style-type: none"> TBD 	<ul style="list-style-type: none"> On-line for Q2 	<ul style="list-style-type: none"> TBD 	<ul style="list-style-type: none"> TBD
Team Composition	<ul style="list-style-type: none"> MHSA Chief, Department Peer and Equity Services Manager, Assistant Director, County IT staff, Project Manager, Division Chief of IT, MHSA Coordinator, Regional Tech Ambassadors, Tech- Testers 	<ul style="list-style-type: none"> Assistant Director: Ethnic Services and Peer Manager; MHSA Chief; Health Care Coordinator- Tech/Peer lead; IT; Help@ Hand peer team; Project Contractor 	<ul style="list-style-type: none"> Assistant Director: Peer and Ethnic Services Manager; MHSA Chief; Health Care Coordinator- Tech/Peer lead; Help@ Hand peer team; Project Contractor- Painted Brain 	<ul style="list-style-type: none"> Assistant Director: Peer and Ethnic Services Manager; MHSA Chief; Health Care Coordinator- Tech/Peer lead; Help@ Hand peer team; Project Contractor- Painted Brain
Target Audience	<ul style="list-style-type: none"> Individuals age 16 and over living in geographically isolated communities of diverse backgrounds Transitional aged youth who are students at colleges and universities Adults discharged from psychiatric hospitals and/or recipients of crisis services 	<ul style="list-style-type: none"> Individuals age 16 and over living in geographically isolated communities of diverse backgrounds Transitional aged youth who are students at colleges and universities Adults discharged from psychiatric hospitals and/or recipients of crisis services 	<ul style="list-style-type: none"> Individuals age 18 and over living in geographically isolated communities of diverse backgrounds Transitional aged youth who are students at colleges and universities- 18 and older Adults discharged from psychiatric hospitals and/or recipients of crisis services 	<ul style="list-style-type: none"> Individuals age 18 and over living in geographically isolated communities of diverse backgrounds Transitional aged youth who are students at colleges and universities- 18 and older Adults discharged from psychiatric hospitals and/or recipients of crisis services
Products in Use/Planned	<ul style="list-style-type: none"> Headspace (planned) Digital Literacy - Needs and Responses from Stakeholder Sessions (planned) Digital Mental Health Literacy Course from CalMHSA (planned) 	<ul style="list-style-type: none"> Digital Wellness Ambassadors curriculum- combined digital literacy (Help@Hand/Painted Brain/ CalMHSA) Zoom platform App guide-mobile application in the brochure 	<ul style="list-style-type: none"> Digital Wellness Ambassadors curriculum- combined digital literacy (Help@Hand/Painted Brain/ CalMHSA) Zoom platform Outreach materials created by local Help@Hand team Mindfulness sessions with Dr. Brock Travis 	<ul style="list-style-type: none"> Zoom platform App guides Appy Hour Templates Peer Support Group PPTs Headspace
Implementation Approach	<ul style="list-style-type: none"> Headspace with up to 45 people which will include Dept. Clinical Staff/IT Staff/Peer Staff/Tech Testers within each target population/CBO that work with target populations/ MHSA Chief/Peer and Equity Manager/Help@Hand Project Manager/If hired by then Help@Hand Project Outreach Coordinator 	<ul style="list-style-type: none"> Combine digital literacy to create Digital Wellness Ambassadors materials Disseminate by providing literacy curriculum throughout clinics; community centers; community-based organizations; adult housing; recovery learning centers; on-line; tbd Share and provide linkage to low cost laptops/ phone and WIFI 	<ul style="list-style-type: none"> Combine digital literacy to create Digital Wellness Ambassadors materials Disseminate by providing literacy curriculum throughout clinics; community centers; community-based organizations; adult housing; recovery learning centers; on-line; TBD Share and provide linkage to low-cost laptops/ phone and WIFI 	<ul style="list-style-type: none"> Increase access to technology devices through sharing acquisition resources Increase digital literacy through hosting Appy Hours throughout the county through collaboration with community partners Create normalcy in using wellness apps to support mental wellness such as Headspace through peer led support groups
Other Unique Qualities (of target audience, implementation, or other program aspect)	<ul style="list-style-type: none"> Foster diversity within target populations including Spanish/Mixteco speakers and individuals from communities marginalized including LGBTQ+ Goals for the pilot include adoption of digital wellness tools within the target populations, reduce isolation and loneliness within target populations, reduce negative life events among members of each target population, implementation of digital literacy and mental health literacy facilitated through peer employment opportunities and measuring the success of wellness through employment 	<ul style="list-style-type: none"> Peer driven curriculum is created to meet specific needs of peer community within SB target populations COVID highlighted the need for technology access within target populations; project will begin to explore low cost laptop within target populations; The group coordinated a digital Mental Health COVID-19 Campaign to compliment the May Mental Health Awareness including daily motivations and resources for all MH Staff, daily peer groups for community and disclosed peers, and targeted age groups by postcard mailings and chalk art. This was then extended by local peer support partners coordinating zoom daily peer groups whose monthly calendar is sent out digitally by our PIO. 	<ul style="list-style-type: none"> Digital Wellness Ambassador's will provide warm hand off through engaging BWELL Adult PHF in peer-led digital literacy groups at the PHF; connecting clients to Lifeline cell phone; providing warm hand offs after the client discharges while awaiting outpatient services Digital Wellness Ambassadors will work with Painted Brain to engage TAY enrolled in colleges/universities in hosting Appy Hours Sessions to build Digital Wellness and Digital Empowerment Toolboxes Digital Wellness Ambassadors will work with Promotoras community to enhance digital literacy for use with mental health education as created by the local promotoras 	<ul style="list-style-type: none"> Digital Wellness Ambassador engage BeWell Adult Recipients of Crisis Services/Discharged from PHF in peer-led digital literacy groups at the PHF; share resources to the Lifeline cell phone program; provide introduction to the clinic peers who may be working with clients after discharge from the PHF Digital Wellness Ambassadors will work with Painted Brain to engage TAY enrolled in colleges/universities in developing curriculum supporting using digital tools to support mental wellness Digital Wellness Ambassadors will work with community to enhance digital literacy of current county application available such as Octopus- the benefits platform created by Social Services
Milestones	<ul style="list-style-type: none"> Employment of peers 	<ul style="list-style-type: none"> Help@Hand peers are now hired through county 	<ul style="list-style-type: none"> Digital Wellness Ambassadors are working on the 	<ul style="list-style-type: none"> Help@Hand is facilitating peer-led groups at the

Santa Barbara County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
	<ul style="list-style-type: none"> Engagement with peer agencies Development of strategies for upcoming pilot Solidified the need for Digital Literacy and Digital Mental Health Literacy throughout the community Explored digital wellness tools within the Psychiatric Health Facility connecting to the ongoing Wellness and Recovery Peer-run groups Identified the need for target population of baseline data 	<p>extra-help vs temp agency</p> <ul style="list-style-type: none"> Contracted with Painted Brain Began on-line learning collaboratives with painted brain and Help@Hand peers 	<p>creation of the Digital Wellness Handbook where the Digital Wellness Ambassador role is defined and supported through the development of peer-run groups; agendas to be led at the PHF and throughout the target populations including MHSA Housing and Senior Facilities</p> <ul style="list-style-type: none"> A guide to Zoom basics is being formulated to ensure that clients at the PHF understand the basics to connecting to tele-health via Zoom platform Project Manager/Healthcare Coordinator is working through OCM Plan with implementation team Monthly Action Items are being documented to ensure project's continued progress- see attached 	<p>in-patient Psychiatric Health Facility</p> <ul style="list-style-type: none"> More than 50 community members have received digital literacy training Help@Hand project is highlighted quarterly in the Consumer and Family Member Newsletter Community stakeholders are given updates monthly at different department hosting action team meetings Help@Hand is working with local research and evaluation team on a Process Improvement Project approved by EQRO that measures the success of clients discharged from the PHF and client's first appointment Help@Hand has gained community feedback through presentations given at BeWell Action Team meetings and with community-based organizations
Lessons Learned	<ul style="list-style-type: none"> Lessons learned- The realization regarding the digital divide that exist within the community. Basic technology needs must be addressed prior to the adaptation of digital tools intended to support mental health needs. The three basic needs we learned about are: 1. Lack of access to digital technology tools 2. Lack of access to WiFi; internet; data plans 3. Lack of digital literacy such as how to download an app, how to update an app for best practices surrounding security An additional lesson learned we discovered is the resiliency of mental health consumers in Santa Barbara County. For example, Help@Hand project hosted over 100 support groups on ZOOM and several Appy Hours with contracted vendor Painted Brain. The community rallied together and worked amongst each other to help one another learn how to use the call-in feature on ZOOM. Little by little the comfortability of using the ZOOM platform lessened. Help@Hand collaborated with a local Lifeline vendor to provide smartphones to local community members that qualified. Once the qualifying consumers received phones, consumers then worked with local community-based organization to learn about digital basics. 			
Recommendations	<ul style="list-style-type: none"> Recommendations are: 1) a robust stakeholder feedback at the beginning of project implementation to continue to better understand and meet the basic needs of the community 2) to respect and honor the learnings found. For example, CallMHSA's Peer Manager visited several counties and met with community stakeholders to better learn about the community needs. The information that was gathered was that the community needed phones, WiFi and to increase digital literacy. Unfortunately, the project was already moving ahead with selection of mobile apps which left a fragmented system of who had access to digital technology, understanding of digital tools and who did not. If the project would have visited counties before beginning the process of the application selection there may have been better programming or focus in connecting consumers with technology devices, WiFi and increasing digital literacy. 3) to utilize peer staff from different counties to support the development and vet the language of materials being created for the larger project such as the website, stakeholder reports etc. This may help the project ensure that the project is peer-led as it was intended. 			

San Francisco County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	<ul style="list-style-type: none"> Teresa Yu, LMFT 	<ul style="list-style-type: none"> Teresa Yu, LMFT 	<ul style="list-style-type: none"> Teresa Yu, LMFT Meaghan O'Brien, MA 	<ul style="list-style-type: none"> Teresa Yu, LMFT Meaghan O'Brien, MA
Implementation Site	<ul style="list-style-type: none"> TBD 	<ul style="list-style-type: none"> TBD 	<ul style="list-style-type: none"> TBD- currently narrowed down 9 apps (using Product Matrix developed by Help@Hand). Plan to have 10 apps to review and narrow down if Riverside's Peer Chat becomes available for the collaborative to use 	<ul style="list-style-type: none"> Headspace SOW approved for 10,000 licenses for Jan 1- Dec 1. Have identified Take my Hand as the app of preference for TAY and Trans-identified Adults.
Team Composition	<ul style="list-style-type: none"> MHSA Director, Peer, MHSA Coordinator, Tech Lead, 2 Finance 	<ul style="list-style-type: none"> MHSA Interim Director (Tech Lead), Peer/MHSA Peer Services Manager, Finance, BHS Consultant, Staff and Director from MHASF 	<ul style="list-style-type: none"> MHSA Interim Director (Tech Lead), Peer/MHSA Peer Services Manager, Finance, BHS Consultant, Staff and Director from MHASF 	<ul style="list-style-type: none"> MHSA Interim Director (Tech Lead), Peer/MHSA Peer Services Manager, Finance, BHS Consultant, Staff and Director from MHASF: MHSA Director, SOCs, MHSA Peer Services Manager.
Target Audience	<ul style="list-style-type: none"> TBD 	<ul style="list-style-type: none"> TBD 	<ul style="list-style-type: none"> App being researched: Community and Mental Health Consumers/family members with a specific focus on TAY and Trans-identified individuals Headspace: MHA SF clients, mental health system clients including SRO residents 	<ul style="list-style-type: none"> App being researched: Community and Mental Health Consumers/family members with a specific focus on TAY and Trans-identified individuals Headspace: MHA SF clients, mental health system clients including SRO residents and Children, Youth and Families Department.
Products in Use/Planned	<ul style="list-style-type: none"> TBD (waiting on approved apps by the Collaborative) Headspace (the City/County of SF is exploring to possibly pilot for staff. This would add to the populations included in this project) 	<ul style="list-style-type: none"> TBD (waiting on approved apps by the Collaborative and conducting app exploration) 	<ul style="list-style-type: none"> 9 apps have been narrowed down for continued app exploration Headspace: 10,000 licenses planned to be added to MHA SF contract for this fiscal year 	<ul style="list-style-type: none"> Take my Hand Headspace: 10,000 licenses planned to be added to MHA SF contract for this fiscal year
Implementation Approach	<ul style="list-style-type: none"> TBD 	<ul style="list-style-type: none"> TBD 	<ul style="list-style-type: none"> TBD 	
Other Unique Qualities (of target audience, implementation, or other program aspect)	<ul style="list-style-type: none"> Interested in Peer Chat apps available to all, but with a focus on the Transgender and Transitional Age Youth communities 	<ul style="list-style-type: none"> Interested in Peer Chat apps available to all, but with a focus on the Transgender and Transitional Age Youth communities 	<ul style="list-style-type: none"> Interested in Peer Chat apps available to all, but with a focus on the Transgender and Transitional Age Youth Communities (TAY) Peers are concerned with PHI/data consumption while using app 	<ul style="list-style-type: none"> Exploring Headspace use with CYF (Children, Youth and Families) who are wanting to integrate it with clinical services
Milestones	<ul style="list-style-type: none"> Started the City/County's collaboration with Mental Health Association of San Francisco 	<ul style="list-style-type: none"> Mental Health Association (MHA) has started to participate in Tech Lead and Implementation calls. They are conducting app exploration. 	<ul style="list-style-type: none"> Establishing a biweekly meeting between SF DPH and MHA SF MHA SF hiring a Programs Coordinator to heavily support project (10/1 start date) Developed a Product Matrix of apps that fit SF city/county needs, completed Needs Assessment Exploring Headspace for SF city/county consumers 	<ul style="list-style-type: none"> Working on a hiring plan to hire two Peer Navigators to support Programs Coordinator at MHASF Developing 12-part Digital Literacy Education training series for SF residents to begin 2/2021 Moving forward with Headspace implementation with SF city and county
Lessons Learned	<ul style="list-style-type: none"> Frequent and regular communication between County and CBO and adequate staffing devoted to the project has been key More involved County/CBO collaboration than other innovation projects due to complexity and changes with projects Getting all parties together and more communication: such as between City Attorney and CalMHSA helped ensure clarity with complex County BOS/contracting process 			
Recommendations	<ul style="list-style-type: none"> Communication and collaboration: see above and also meeting with other counties who are implementing similar projects is very helpful for planning and learning about best practices for implementation 			

San Mateo County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	<ul style="list-style-type: none"> Doris Estremera, MPH 	<ul style="list-style-type: none"> Doris Estremera, MPH 	<ul style="list-style-type: none"> Doris Estremera, MPH 	<ul style="list-style-type: none"> Doris Estremera, MPH
Implementation Site	<ul style="list-style-type: none"> Peninsula Family Service (PFS) Youth Leadership Institute (YLI) 	<ul style="list-style-type: none"> MHSA Coordinator, Peer Specialist/Peer Support, Contracted Agencies: 1) Youth Leadership Institute (TAY Contractor); Peer Lead/ Program Coordinator, Bilingual-bicultural TAY Peer Lead (Spanish), 2) Peninsula Family Services (PFS); Peer Lead/ Program Coordinator, bilingual-bicultural Peer (Spanish/Chinese) 	<ul style="list-style-type: none"> MHSA Coordinator Office of Consumer and Family Affairs: Peer Specialist/Peer Support Contracted Agencies: <ul style="list-style-type: none"> Youth Leadership Institute (TAY Contractor); Peer Lead/ Program Coordinator, Bilingual-bicultural TAY Peer Lead (Spanish) Peninsula Family Service (Older Adult Contractor); Peer Lead/ Program Coordinator, bilingual-bicultural Peer (Spanish/ Chinese) California Clubhouse and Heart and Soul: Help@Hand Peer Ambassadors 	<ul style="list-style-type: none"> Community-based agencies, BHRS clinics, online
Team Composition	<ul style="list-style-type: none"> MHSA Coordinator, Peer Specialist/Peer Support, Contracted Agencies: 1) Youth Leadership Institute (TAY Contractor); Peer Lead/ Program Coordinator, Bilingual-bicultural TAY Peer Lead (Spanish), 2) Peninsula Family Services (PFS); Peer Lead/ Program Coordinator, bilingual-bicultural Peer (Spanish/Chinese) 	<ul style="list-style-type: none"> MHSA Coordinator Office of Consumer and Family Affairs: Peer Specialist/Peer Support Contracted Agencies: <ul style="list-style-type: none"> Youth Leadership Institute (TAY Contractor); Peer Lead/ Program Coordinator, Bilingual-bicultural TAY Peer Lead (Spanish) Peninsula Family Service (Older Adult Contractor); Peer Lead/ Program Coordinator, bilingual-bicultural Peer (Spanish/ Chinese) California Clubhouse and Heart and Soul: Help@Hand Peer Ambassadors 	<ul style="list-style-type: none"> MHSA Coordinator Office of Consumer and Family Affairs: Peer Specialist/Peer Support Contracted Agencies: <ul style="list-style-type: none"> Youth Leadership Institute (TAY Contractor); Peer Lead/ Program Coordinator, Bilingual-bicultural TAY Peer Lead (Spanish) Peninsula Family Service (Older Adult Contractor); Peer Lead/ Program Coordinator, bilingual-bicultural Peer (Spanish/ Chinese) California Clubhouse and Heart and Soul: Help@Hand Peer Ambassadors 	<ul style="list-style-type: none"> MHSA Coordinator Office of Consumer and Family Affairs: Peer Specialist/Peer Support Contracted Agencies: <ul style="list-style-type: none"> Youth Leadership Institute (TAY Contractor); Peer Lead/ Program Coordinator, Bilingual-bicultural TAY Peer Lead (Spanish) Peninsula Family Service (Older Adult Contractor); Peer Lead/ Program Coordinator, .5FTE bilingual-bicultural Peer (Spanish) California Clubhouse and Heart and Soul: Help@Hand Peer Ambassadors Painted Brain: Peers providing digital mental health literacy train-the-trainer for peers and “tech hours” for community at large
Target Audience	<ul style="list-style-type: none"> Transitional age youth Older adults 	<ul style="list-style-type: none"> Transitional age youth Older adults 	<ul style="list-style-type: none"> Transitional age youth (TAY) Older adults 	<ul style="list-style-type: none"> Transitional age youth (TAY) Older adults
Products in Use/Planned	<ul style="list-style-type: none"> Happify with older adults (planned) Remente with transitional age youth (planned) 	<ul style="list-style-type: none"> Headspace for COVID rapid response, plan to release August/ September 2020 Selecting new products, considering: <ul style="list-style-type: none"> Unipercare, myStrength, Wysa for older adults Headspace, myStrength, Wysa for transitional age youth 	<ul style="list-style-type: none"> Headspace for COVID Rapid Response released September 2020 Selecting new products for pilot, considering: <ul style="list-style-type: none"> myStrength, Wysa for older adults Headspace, myStrength, Wysa for TAY Painted Brain digital mental health training for peers 	<ul style="list-style-type: none"> Headspace for COVID Rapid Response released September 2020 Older Adults and TAY selected Wysa for pilot to launch in February/March 2021
Implementation Approach	<ul style="list-style-type: none"> Remente for transitional age youth, YLI Peer Leads and youth ambassadors plan, promote and support the use of the app Happify for older adults, PFS Peer Leads and older adult ambassadors plan, promote and support use of the app 	<ul style="list-style-type: none"> Phase 1 – Help@Hand Peer Ambassadors from YLI, PFS and Advisory Committee to promote and support use of all apps (HeadSpace and additional selections), Peer ambassadors supporting outreach and engagement efforts through appy hours, direct community outreach and additional strategies to be developed. Phase 2 – California Clubhouse and Heart and Soul (peer-led organizations) Peer Ambassadors to support integration of apps into Behavioral Health and Recovery Services. Strategies to be developed. 	<ul style="list-style-type: none"> Help@Hand Advisory Committee of local stakeholders continues to meet monthly and provides feedback on appropriate technology to meet the needs of older adults and transition-age youth, consults on the strategies for outreach and engagement, informs project evaluation, supports recruitment of older adults and youth to participate in the exploration and pilot phase of app selection, and serve as ambassadors of Help@Hand Phase 1 – Help@Hand Peer Ambassadors from YLI, PFS and Advisory Committee promote and support use of all apps (HeadSpace and additional selections), Peer Ambassadors support outreach and engagement efforts through ‘Appy Hours,’ recruitment of participants in selection of apps and digital mental health literacy Phase 2 – California Clubhouse and Heart and Soul (peer-led organizations) and BHRS Peer Ambassadors will support integration of apps into Behavioral Health and Recovery Services including 	<ul style="list-style-type: none"> Help@Hand Advisory Committee of local stakeholders continues to meet monthly and provides feedback on appropriate technology to meet the needs of older adults and transition-age youth, consults on the strategies for outreach and engagement, informs project evaluation, supports recruitment of older adults and youth to participate in the exploration and pilot phase of app selection, and serve as ambassadors of Help@Hand Phase 1 – Help@Hand Peer Ambassadors from YLI, PFS and Advisory Committee promote and support use of all apps (HeadSpace and additional selections), Peer Ambassadors support outreach and engagement efforts through ‘Get Appy’ workshops, recruitment of participants in selection of apps and digital mental health literacy <ul style="list-style-type: none"> Further marketing and outreach plans for HeadSpace response under development Phase 2 –BHRS Peer Ambassadors will support integration of apps into Behavioral Health and

San Mateo County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Other Unique Qualities (of target audience, implementation, or other program aspect)	<ul style="list-style-type: none"> Help@Hand Advisory Committee of local stakeholders meet monthly since inception (provides feedback on technology features, enhancements and customization to meet the needs of older adults and transition age youth, consults on the strategies for outreach and engagement, informs project evaluation questions and outcomes) 	<ul style="list-style-type: none"> Using T-Mobile Gov L1 Plan to procure devices for clients. Using Headspace as a broader response to the San Mateo County community at-large to support for one-year due to COVID 	<p>digital mental health training of clients by peers</p> <ul style="list-style-type: none"> Painted Brain is supporting a train-the-trainer for peers and clients will receive devices (cell phone/tablets) along with digital mental health supports. Further marketing and outreach plans for Headspace response under development 	<p>Recovery Services including digital mental health training of clients by peers</p> <ul style="list-style-type: none"> Painted Brain is supporting a train-the-trainer for peers and clients will receive devices (cell phone/tablets) along with digital mental health supports.
Milestones	<ul style="list-style-type: none"> Conducted focus groups with older adults and youth to learn needs and select the most appropriate apps Focus groups to support development of digital mental health literacy curriculum Hosted NorCal Peer Summit PFS hosting AppyHours, engaging older adults in using technology YLI developed a Help@Hand specific Youth Advisory Group Advisory Committee received training on app exploration process to provide more in-depth input on selected apps Ambassadors and peers participated in Digital Mental Health Literacy Train-the-Trainer 	<ul style="list-style-type: none"> Using T-Mobile Gov L1 Plan to procure devices for clients. Using Headspace as a broader response to the San Mateo County community at-large to support for one-year due to COVID 	<ul style="list-style-type: none"> Leveraged \$408,000 of MHSA and CARES Act funding to procure additional federally subsidized broader telehealth and recovery-oriented services for clients Using Headspace as a broader response to the San Mateo County community at-large to support for one year due to COVID 	<ul style="list-style-type: none"> Contracted with Painted Brain to support additional “tech hours” for both Help@Hand implementation and broader racial equity actions due to COVID shelter-in-place Leveraged \$408,000 of MHSA and CARES Act funding to procure additional federally subsidized devices for clients to use for both Help@Hand and broader telehealth and recovery-oriented services for clients Using Headspace as a broader response to the San Mateo County community at-large to support for one year due to COVID
Lessons Learned	<ul style="list-style-type: none"> Addressing the digital divide by providing digital literacy supports are needed prior to engagement in any behavioral health technology solution and at various levels including: peer support workers, behavioral health staff across the network of providers, community and clients. Having explicit communication with stakeholders of “non-negotiables” should be part of the selection of an app. 	<ul style="list-style-type: none"> PFS shifted to over-the-phone and online AppyHours to continue engaging older adults in using technology. YLI kicked off online Youth Advisory Group Successfully procured and distributed 40 free phones to clients and tablets for peer workers to support during COVID In negotiations with Headspace to provide access to the app for one-year to San Mateo County residents as a response to COVID Re-started app selection process due to Happify unavailability during COVID and youth needs shifting now that interactions are primarily online. Worked with UCI to tailor the app selection survey and make it available online 	<ul style="list-style-type: none"> Engaged 20+ BHRS and community-based agencies’ Peer Partners and Family Partners in the distribution of phones to clients, which will include digital mental health literacy training for the clients Contracted with Painted Brain to provide digital mental health literacy train-the-trainer for Peer/Family Partners Launched Headspace access for one-year to San Mateo County residents as a response to COVID 	<ul style="list-style-type: none"> Selected apps Expanded “tech hours” to community at large and partnering community-based agency staff Partnering with other counties on Headspace license sharing, evaluation and marketing
Recommendations	<ul style="list-style-type: none"> Implement an advisory committee of stakeholders early in the process to vet, consult with, create buy-in and provide direction Include evaluation lens as part of project planning and process development for all aspects of the project including procurement, selection, piloting and implementation Include devices and digital literacy as part of the overall solution; including train-the-trainer for peer support workers, and various opportunities for ongoing digital literacy support for clients (“tech hours”) and providers (intermediate tech training, e.g. equitable facilitation of groups, telehealth, etc.) Include opportunities for collaboration with other Help@Hand Counties while honoring local diversity and needs 			

Tehama County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	<ul style="list-style-type: none"> Michelle Brousseau Avery Vliche 	<ul style="list-style-type: none"> Travis Lyon Avery Vliche 	<ul style="list-style-type: none"> Travis Lyon Avery Vliche 	<ul style="list-style-type: none"> Travis Lyon Avery Vliche
Implementation Site	<ul style="list-style-type: none"> TBD 	<ul style="list-style-type: none"> Tehama County 	<ul style="list-style-type: none"> Tehama County 	<ul style="list-style-type: none"> Tehama County
Team Composition	<ul style="list-style-type: none"> MHSA Coordinator, Tech Leads, Peer, Behavioral Health Director, Staff 	<ul style="list-style-type: none"> Behavioral Health Director, MHSA Coordinator, Tech Leads, Peer Supervisor, Staff, Peer Advocates 	<ul style="list-style-type: none"> Behavioral Health Director, MHSA Coordinator, Clinician, Case Manager, 2 Health Educators, Peer Supervisor, 2 Peer Advocates, Health Services Analyst 	<ul style="list-style-type: none"> Behavioral Health Director, MHSA Coordinator, Clinician, Case Manager, 2 Health Educators, Peer Supervisor, 2 Peer Advocates, Health Services Analyst
Target Audience	<ul style="list-style-type: none"> TBD 	<ul style="list-style-type: none"> Persons who are Homeless or at risk of Homelessness, Geographically Isolated Adults, and TCHSA-BH Consumers 	<ul style="list-style-type: none"> Persons who are Homeless or at risk of Homelessness Isolated Individuals Tehama County Health Services Agency – Behavioral Health (TCHSA-BH) Consumers 	<ul style="list-style-type: none"> Persons who are Homeless or at risk of Homelessness Isolated Individuals Tehama County Health Services Agency – Behavioral Health (TCHSA-BH) Consumers
Products in Use/Planned	<ul style="list-style-type: none"> TBD 	<ul style="list-style-type: none"> myStrength 	<ul style="list-style-type: none"> myStrength 	<ul style="list-style-type: none"> myStrength
Implementation Approach	<ul style="list-style-type: none"> TBD 	<ul style="list-style-type: none"> Pilot with 30 people (10 from each Target Audience), Track Progress 	<ul style="list-style-type: none"> Pilot with 30 people (10 from each Target Audience), Track Progress 	<ul style="list-style-type: none"> Pilot with 30 people (10 from each Target Audience), Track Progress
Other Unique Qualities (of target audience, implementation, or other program aspect)	<ul style="list-style-type: none"> TBD 	<ul style="list-style-type: none"> TBD 	<ul style="list-style-type: none"> Using a one-on-one individualized approach with participants linked to Peer Staff and Wellness Advocates 	<ul style="list-style-type: none"> Using a one-on-one individualized approach with participants linked to Peer Staff and Wellness Advocates
Milestones	<ul style="list-style-type: none"> Not applicable 	<ul style="list-style-type: none"> Not applicable 	<ul style="list-style-type: none"> Pilot Proposal received budget approval from Collaborative Leadership Organizational change management (OCM) Plan completed and initiated Evaluation Plan completed Vendor Engagement Plan completed 	<ul style="list-style-type: none"> Evaluation instruments completed Statement of Work drafted
Lessons Learned	<ul style="list-style-type: none"> Time required for processes and approvals Project requires dedicated resources OCM is as important as the technology Strong ad hoc communication between implementation meetings facilitates progress 			
Recommendations				

Tri-City	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	<ul style="list-style-type: none"> Toni Robinson Dana Barford 	<ul style="list-style-type: none"> Toni Robinson Dana Barford 	<ul style="list-style-type: none"> Dana Barford 	<ul style="list-style-type: none"> Amanda Coit Dana Barford
Implementation Site	<ul style="list-style-type: none"> Transitional Age Youth Wellness Center 	<ul style="list-style-type: none"> Tri-City Wellness Center 	<ul style="list-style-type: none"> Tri-City Wellness Center 	<ul style="list-style-type: none"> Virtual due to COVID-19
Team Composition	<ul style="list-style-type: none"> MHSA Coordinator, MHSA Manager, Peer Lead, MHSA Director 	<ul style="list-style-type: none"> MHSA Manager, MHSA Coordinator, Wellness Advocate Supervisor, Wellness Advocates, Wellness Center Supervisor, Clinicians, MHSA Director, Clinical Director 	<ul style="list-style-type: none"> MHSA Manager, MHSA Coordinator, Wellness Advocate Supervisor, Wellness Advocates, Wellness Center Supervisor, Clinicians, MHSA Director, Clinical Director 	<ul style="list-style-type: none"> MHSA Manager, MHSA-Inn Program Coordinator, MHSA Director, Cambria Consultant, Painted Brain Peer Consultant
Target Audience	<ul style="list-style-type: none"> Transitional age youth Older adults Monolingual Spanish speakers 	<ul style="list-style-type: none"> For the potential pilot, our target audience has been updated to include: TAY: Older adults; Wellness advocates (peers); FSP clients being monitored by their clinicians 	<ul style="list-style-type: none"> For the potential pilot, our target audience has been updated to include: TAY: Older adults; Wellness advocates (peers); FSP clients being monitored by their clinicians 	<ul style="list-style-type: none"> For implementation, our target populations will be TAY, Older adults, and Monolingual Spanish Speakers
Products in Use/Planned	<ul style="list-style-type: none"> Wysa with transitional age youth 	<ul style="list-style-type: none"> Wysa 	<ul style="list-style-type: none"> Wysa 	<ul style="list-style-type: none"> Mindstrong collaboration with Orange County HeadSpace or myStrength with CalMHSA
Implementation Approach	<ul style="list-style-type: none"> Have a small focus group for pilot to obtain valuable feedback on a biweekly basis 	<ul style="list-style-type: none"> Twenty users will be recruited to use Wysa for 3 months and will participate in 7 focus groups held biweekly to evaluate Wysa's usability and effectiveness. 	<ul style="list-style-type: none"> Due to the loss of key staff, the pilot project and related focus groups were placed on temporary hold. However, Tri-City continues to actively participate in all other aspects and activities of this project and the Collaborative 	<ul style="list-style-type: none"> Due to COVID-19 and turnover of Program Coordinators we have continued to participate in all activities of the collaborative, but implementation of project has been delayed Currently in discussion with Orange County to join them in the implementation of Mindstrong Working with CalMHSA to implement either HeadSpace or myStrength with our target populations
Other Unique Qualities (of target audience, implementation, or other program aspect)	<ul style="list-style-type: none"> Having input from a focus group of peers to select the app to be piloted 	<ul style="list-style-type: none"> A group of 4 clinicians will also be recruited to determine the feasibility and appropriateness of using Wysa in support of the services they provide. 	<ul style="list-style-type: none"> Due to COVID-19, the 4 clinicians originally anticipated to determine the feasibility and appropriateness of using Wysa were not available to support this project due to the increased need for client services. The goal is to reevaluate this component in January 2021 	<ul style="list-style-type: none"> We will be holding a workgroup in January to present to them our ideas for moving forward with Mindstrong and either HeadSpace or myStrength
Milestones	<ul style="list-style-type: none"> Focus group selected the app for pilot 	<p>April</p> <ul style="list-style-type: none"> A focus group comprised of Wellness Advocates, MHSA staff, and the IT consultant, participated in a product testing of the Wysa application Product testing resulted in Tri-City moving forward with the app, with adjustments to the emergency contact function <p>May</p> <ul style="list-style-type: none"> Wysa agreed to making adjustments to the emergency contact function of the app CalMHSA began contract negotiations with Wysa Tri-City started drafting the pilot proposal Through the collaboration, various wellness apps have made accessing their apps free for participating counties/agencies and Tri-City has been taking advantage of the opportunity by providing the resources to staff and clients 	<p>August</p> <ul style="list-style-type: none"> Innovation Coordinator/Tech Lead left Tri-City in August. As a result, the Wysa pilot project was placed on temporary hold until a replacement is hired Tri-City continues to actively participate in all other aspects and activities of this project and the Collaborative 	<p>December</p> <ul style="list-style-type: none"> Hired new Innovation Program Coordinator Speaking with Orange County to possibly collaborate with them in order to implement Mindstrong in Tri-City In discussion with CalMHSA about implementing either HeadSpace or myStrength with our Target Populations

Tri-City	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
		<ul style="list-style-type: none"> • CalMHSA created Digital Mental Health Literacy training videos and Tri-City will be utilizing the videos for clients and community members • Tri-City met with UCI to develop an evaluation plan for the pilot process <p>June</p> <ul style="list-style-type: none"> • CalMHSA and Wysa reached an agreement in contract negotiations and Tri-City was given the green light to move forward with the pilot proposal and pilot evaluation plan • Tri-City continued to send useful wellness app information to our staff for self-care (and some client resources) • Tri-City Wellness Advocates started planning for a Community Connections webinar to teach our clients and community members how to be safe online. They will be using the skills and information they acquired during the train-the-trainer session of the February Help@Hand Peer Summit • Tri-City was trained to use Smartsheet for project management 		
Lessons Learned	<ul style="list-style-type: none"> • We learned that we did not have the adequate internal staff to support implementation of project. We are reaching out to Painted Brain and Cambria to assist with support during implementation of future projects in order to ensure we can have a successful launch. 			
Recommendations	<ul style="list-style-type: none"> • Collaborate with Orange County to take over some of their licenses for Mindstrong in order to roll out Mindstrong to our Target Populations. Work with CalMHSA to implement either Headspace or myStrength. 			

Mobile Application Rating Scale (MARS)

App Quality Ratings

The Rating scale assesses app quality on four dimensions. All items are rated on a 5-point scale from “1.Inadequate” to “5.Excellent”. Circle the number that most accurately represents the quality of the app component you are rating. Please use the descriptors provided for each response category.

SECTION A

Engagement – fun, interesting, customisable, interactive (e.g. sends alerts, messages, reminders, feedback, enables sharing), well-targeted to audience

1. **Entertainment: Is the app fun/entertaining to use? Does it use any strategies to increase engagement through entertainment (e.g. through gamification)?**
 - 1 Dull, not fun or entertaining at all
 - 2 Mostly boring
 - 3 OK, fun enough to entertain user for a brief time (< 5 minutes)
 - 4 Moderately fun and entertaining, would entertain user for some time (5-10 minutes total)
 - 5 Highly entertaining and fun, would stimulate repeat use

2. **Interest: Is the app interesting to use? Does it use any strategies to increase engagement by presenting its content in an interesting way?**
 - 1 Not interesting at all
 - 2 Mostly uninteresting
 - 3 OK, neither interesting nor uninteresting; would engage user for a brief time (< 5 minutes)
 - 4 Moderately interesting; would engage user for some time (5-10 minutes total)
 - 5 Very interesting, would engage user in repeat use

3. **Customisation: Does it provide/retain all necessary settings/preferences for apps features (e.g. sound, content, notifications, etc.)?**
 - 1 Does not allow any customisation or requires setting to be input every time
 - 2 Allows insufficient customisation limiting functions
 - 3 Allows basic customisation to function adequately
 - 4 Allows numerous options for customisation
 - 5 Allows complete tailoring to the individual’s characteristics/preferences, retains all settings

4. **Interactivity: Does it allow user input, provide feedback, contain prompts (reminders, sharing options, notifications, etc.)? Note: these functions need to be customisable and not overwhelming in order to be perfect.**
 - 1 No interactive features and/or no response to user interaction
 - 2 Insufficient interactivity, or feedback, or user input options, limiting functions
 - 3 Basic interactive features to function adequately
 - 4 Offers a variety of interactive features/feedback/user input options
 - 5 Very high level of responsiveness through interactive features/feedback/user input options

5. **Target group: Is the app content (visual information, language, design) appropriate for your target audience?**
 - 1 Completely inappropriate/unclear/confusing
 - 2 Mostly inappropriate/unclear/confusing
 - 3 Acceptable but not targeted. May be inappropriate/unclear/confusing
 - 4 Well-targeted, with negligible issues
 - 5 Perfectly targeted, no issues found

A. Engagement mean score = _____

SECTION B

Functionality – app functioning, easy to learn, navigation, flow logic, and gestural design of app

6. **Performance: How accurately/fast do the app features (functions) and components (buttons/menus) work?**
 - 1 App is broken; no/insufficient/inaccurate response (e.g. crashes/bugs/broken features, etc.)
 - 2 Some functions work, but lagging or contains major technical problems
 - 3 App works overall. Some technical problems need fixing/Slow at times
 - 4 Mostly functional with minor/negligible problems
 - 5 Perfect/timely response; no technical bugs found/contains a 'loading time left' indicator

7. **Ease of use: How easy is it to learn how to use the app; how clear are the menu labels/icons and instructions?**
 - 1 No/limited instructions; menu labels/icons are confusing; complicated
 - 2 Useable after a lot of time/effort
 - 3 Useable after some time/effort
 - 4 Easy to learn how to use the app (or has clear instructions)
 - 5 Able to use app immediately; intuitive; simple

8. **Navigation: Is moving between screens logical/accurate/appropriate/ uninterrupted; are all necessary screen links present?**
 - 1 Different sections within the app seem logically disconnected and random/confusing/navigation is difficult
 - 2 Usable after a lot of time/effort
 - 3 Usable after some time/effort
 - 4 Easy to use or missing a negligible link
 - 5 Perfectly logical, easy, clear and intuitive screen flow throughout, or offers shortcuts

9. **Gestural design: Are interactions (taps/swipes/pinches/scrolls) consistent and intuitive across all components/screens?**
 - 1 Completely inconsistent/confusing
 - 2 Often inconsistent/confusing
 - 3 OK with some inconsistencies/confusing elements
 - 4 Mostly consistent/intuitive with negligible problems
 - 5 Perfectly consistent and intuitive

B. Functionality mean score = _____

SECTION C

Aesthetics – graphic design, overall visual appeal, colour scheme, and stylistic consistency

10. **Layout: Is arrangement and size of buttons/icons/menus/content on the screen appropriate or zoomable if needed?**
 - 1 Very bad design, cluttered, some options impossible to select/locate/see/read device display not optimised
 - 2 Bad design, random, unclear, some options difficult to select/locate/see/read
 - 3 Satisfactory, few problems with selecting/locating/seeing/reading items or with minor screen-size problems
 - 4 Mostly clear, able to select/locate/see/read items
 - 5 Professional, simple, clear, orderly, logically organised, device display optimised. Every design component has a purpose

11. Graphics: How high is the quality/resolution of graphics used for buttons/icons/menus/content?

- 1 Graphics appear amateur, very poor visual design - disproportionate, completely stylistically inconsistent
- 2 Low quality/low resolution graphics; low quality visual design – disproportionate, stylistically inconsistent
- 3 Moderate quality graphics and visual design (generally consistent in style)
- 4 High quality/resolution graphics and visual design – mostly proportionate, stylistically consistent
- 5 Very high quality/resolution graphics and visual design - proportionate, stylistically consistent throughout

12. Visual appeal: How good does the app look?

- 1 No visual appeal, unpleasant to look at, poorly designed, clashing/mismatched colours
- 2 Little visual appeal – poorly designed, bad use of colour, visually boring
- 3 Some visual appeal – average, neither pleasant, nor unpleasant
- 4 High level of visual appeal – seamless graphics – consistent and professionally designed
- 5 As above + very attractive, memorable, stands out; use of colour enhances app features/menus

C. Aesthetics mean score = _____

SECTION D

Information – Contains high quality information (e.g. text, feedback, measures, references) from a credible source. Select N/A if the app component is irrelevant.

13. Accuracy of app description (in app store): Does app contain what is described?

- 1 Misleading. App does not contain the described components/functions. Or has no description
- 2 Inaccurate. App contains very few of the described components/functions
- 3 OK. App contains some of the described components/functions
- 4 Accurate. App contains most of the described components/functions
- 5 Highly accurate description of the app components/functions

14. Goals: Does app have specific, measurable and achievable goals (specified in app store description or within the app itself)?

- N/A Description does not list goals, or app goals are irrelevant to research goal (e.g. using a game for educational purposes)
- 1 App has no chance of achieving its stated goals
 - 2 Description lists some goals, but app has very little chance of achieving them
 - 3 OK. App has clear goals, which may be achievable.
 - 4 App has clearly specified goals, which are measurable and achievable
 - 5 App has specific and measurable goals, which are highly likely to be achieved

15. Quality of information: Is app content correct, well written, and relevant to the goal/topic of the app?

- N/A There is no information within the app
- 1 Irrelevant/inappropriate/incoherent/incorrect
 - 2 Poor. Barely relevant/appropriate/coherent/may be incorrect
 - 3 Moderately relevant/appropriate/coherent/and appears correct
 - 4 Relevant/appropriate/coherent/correct
 - 5 Highly relevant, appropriate, coherent, and correct

16. Quantity of information: Is the extent coverage within the scope of the app; and comprehensive but concise?

- N/A There is no information within the app
- 1 Minimal or overwhelming
- 2 Insufficient or possibly overwhelming
- 3 OK but not comprehensive or concise
- 4 Offers a broad range of information, has some gaps or unnecessary detail; or has no links to more information and resources
- 5 Comprehensive and concise; contains links to more information and resources

17. Visual information: Is visual explanation of concepts – through charts/graphs/images/videos, etc. – clear, logical, correct?

- N/A There is no visual information within the app (e.g. it only contains audio, or text)
- 1 Completely unclear/confusing/wrong or necessary but missing
- 2 Mostly unclear/confusing/wrong
- 3 OK but often unclear/confusing/wrong
- 4 Mostly clear/logical/correct with negligible issues
- 5 Perfectly clear/logical/correct

18. Credibility: Does the app come from a legitimate source (specified in app store description or within the app itself)?

- 1 Source identified but legitimacy/trustworthiness of source is questionable (e.g. commercial business with vested interest)
- 2 Appears to come from a legitimate source, but it cannot be verified (e.g. has no webpage)
- 3 Developed by small NGO/institution (hospital/centre, etc.) /specialised commercial business, funding body
- 4 Developed by government, university or as above but larger in scale
- 5 Developed using nationally competitive government or research funding (e.g. Australian Research Council, NHMRC)

19. Evidence base: Has the app been trialled/tested; must be verified by evidence (in published scientific literature)?

- N/A The app has not been trialled/tested
- 1 The evidence suggests the app does not work
- 2 App has been trialled (e.g., acceptability, usability, satisfaction ratings) and has partially positive outcomes in studies that are not randomised controlled trials (RCTs), or there is little or no contradictory evidence.
- 3 App has been trialled (e.g., acceptability, usability, satisfaction ratings) and has positive outcomes in studies that are not RCTs, and there is no contradictory evidence.
- 4 App has been trialled and outcome tested in 1-2 RCTs indicating positive results
- 5 App has been trialled and outcome tested in ≥ 3 high quality RCTs indicating positive results

D. Information mean score = _____ *

* Exclude questions rated as "N/A" from the mean score calculation.

App subjective quality

SECTION E

20. Would you recommend this app to people who might benefit from it?

- | | | |
|---|-------------------|---|
| 1 | Not at all | I would not recommend this app to anyone |
| 2 | | There are very few people I would recommend this app to |
| 3 | Maybe | There are several people whom I would recommend it to |
| 4 | | There are many people I would recommend this app to |
| 5 | Definitely | I would recommend this app to everyone |

21. How many times do you think you would use this app in the next 12 months if it was relevant to you?

- | | |
|---|-------------|
| 1 | None |
| 2 | 1-2 |
| 3 | 3-10 |
| 4 | 10-50 |
| 5 | >50 |

22. Would you pay for this app?

- | | |
|---|-------|
| 1 | No |
| 3 | Maybe |
| 5 | Yes |

23. What is your overall star rating of the app?

- | | | |
|---|-------|---------------------------------|
| 1 | ★ | One of the worst apps I've used |
| 2 | ★★ | |
| 3 | ★★★ | Average |
| 4 | ★★★★ | |
| 5 | ★★★★★ | One of the best apps I've used |

Scoring

App quality scores for

SECTION

A: Engagement Mean Score = _____

B: Functionality Mean Score = _____

C: Aesthetics Mean Score = _____

D: Information Mean Score = _____

App quality mean Score = _____

App subjective quality Score = _____

App-specific

These added items can be adjusted and used to assess the perceived impact of the app on the user's knowledge, attitudes, intentions to change as well as the likelihood of actual change in the target health behaviour.

SECTION F

- 1. Awareness: This app is likely to increase awareness of the importance of addressing [insert target health behaviour]**

Strongly disagree Strongly Agree
1 2 3 4 5

- 2. Knowledge: This app is likely to increase knowledge/understanding of [insert target health behaviour]**

Strongly disagree Strongly Agree
1 2 3 4 5

- 3. Attitudes: This app is likely to change attitudes toward improving [insert target health behaviour]**

Strongly disagree Strongly Agree
1 2 3 4 5

- 4. Intention to change: This app is likely to increase intentions/motivation to address [insert target health behaviour]**

Strongly disagree Strongly Agree
1 2 3 4 5

- 5. Help seeking: Use of this app is likely to encourage further help seeking for [insert target health behaviour] (if it's required)**

Strongly disagree Strongly Agree
1 2 3 4 5






- 6. Behaviour change: Use of this app is likely increase/decrease [insert target health behaviour]**

Strongly disagree Strongly Agree
1 2 3 4 5













































APPENDIX C: REVIEWS OF MEDITATION AND PEER SUPPORT APPS

Selected Feature and User Experience Reviews of Meditation Apps

App name	Screen Reader Capabilities	Customizable Display Features	Offline Availability	Number of Languages Available in App	Content for Selected Target Groups	Peer connection in-app	User Experience Score (Max: 5)	
	<p>+++ All buttons spoken</p> <p>++ Most buttons or features spoken, some exceptions</p> <p>+ Some buttons or features spoken, many exceptions</p>	<p>A+ Text size</p> <p>T High contrast text</p> <p>○ Color inversion</p> <p>▶ Animation reduction</p>	<p> Internet needed</p> <p> Offline Access</p> <p> Offline access, paid version only</p> <p> Downloadable content</p> <p> Downloadable content, paid version only</p>				Expert	Consumer
10% Happier	+	A+ T ○		1	None	No	4.57	4.39
Aura	+	A+ T ○		1	None	Yes	4.52	4.65
Black Lotus	++	A+ T ○		2	None	Yes	4.19	3.82
Breathe	+	A+ T ○ ▶		1	"Dealing with injustice" content in paid version	No	4.76	4.00
Buddhify	+	T ○		1	None	Yes	4.25	2.99
Calm	+++	A+ T ○ ▶		6	None	No	4.69	4.11
Headspace	++	A+ T ○ ▶		5	None	Yes	4.95	5.00
HelloMind	+	A+ T ○ ▶		1	None	No	3.67	4.09
Humm.ly	+	A+ ○		1	None	No	4.11	3.80
Insight Timer	+	A+ T ○		35+	None	Yes	4.38	4.39
Liberate Meditation	++	A+ ○		1	Black, Indigenous, and POC community	No	3.23	3.21
21-Day Meditation Experience	++	A+ T ○		1	None	No	3.61	3.83
Meditopia	++	T ○		9	None	No	4.77	3.98
Mind the Bump	++	A+ T ○		1	LGBTQ+ community, single parents (app designed for expectant parents)	No	3.81	3.58
Omvana	++	A+ T ○		3	None	No	3.39	3.95
Preksha Meditation	+++	A+ T ○		2	None	No	1.99	2.67
Relax Melodies	+	A+ T ○ ▶		2	None	No	4.65	3.73
Simple Habit	+	A+ T ○ ▶		1	None	No	3.45	4.02

Simply Being	++	A+ T ○		1	None	No	2.32	3.22
Smiling Mind	++	A+ T ○		4	None	No	4.88	4.79
Take a Break	++	A+ T ○		1	None	No	1.84	3.17
The Mindfulness App	++	A+ T ○		13	None	No	3.94	3.96
Waking Up	+	○		1	None	Yes	4.04	3.98

Selected Feature and User Experience Reviews of Peer Support Apps

App Name	Screen Reader Capabilities	Customizable Display Features		Offline Access	Number of Languages Available in App	Content for Selected Target Groups	In-App Peer Support						User Experience Scores (MARS)			
		Is app content available offline?					Moderated chatroom	Unmoderated chatroom	Moderated forum	Unmoderated forum	1-on-1 peer messaging	Connect in-app with therapist	Referral available	Expert	User	
Screen Reader Capabilities +++ All buttons spoken ++ Most buttons or features spoken, some exceptions + Some buttons or features spoken, some exceptions Customizable Display Features A- Text size T High contrast text Color inversion		Is app content available offline?  Internet needed, no content available online  Internet needed for chats, other content available offline														
365 Gratitude Journal	+	A-				1	None			•					4.36	3.95
7 Cups	++					34	LGBTQ+	•		•	•	•			3.44	2.75
DBT Coach	++	A-	T			1	None		•	•					3.85	4.09
Habitica	++	A-				19	None	•		•	•				3.88	3.65
iPrevail	++	A-	T			1	None			•	•				4.16	3.56
iRel8	++		T			1	None				•	•	•		2.88	3.47
LGBT+ Amino	+	A-	T			1*	LGBTQ+	•		•	•				3.51	3.7
OOTify	++	A-	T			1	None			•		•	•		3.79	4.09
Pocket Rehab	++	A-	T			1	None			•		•	•		4.07	3.28
rTribe	++	A-	T			1	None	•				•	•		4.05	4.24
Sanvello	+++		T			1	None			•		•			4.8	4.79
Sober Grid	++					1	None			•		•			3.51	3.4
SoberTool	++	A-	T			1	None			•					2.71	3.41
Solace	++	A-	T			1	None	•		•					1.28	2.53
TalkLife	+	A-	T			1	None			•		•			n/a	n/a
Therapeer	++		T			1	None	•							4.23	3.9
Trill Project	+	A-	T			1	LGBTQ+			•		•	•		3.44	3.64
Unmasked Mental Health	++	A-	T			1	None					•			2.74	3.15
Wakie	++	A-	T			1*	None	•		•		•			3.08	3.45
We Are More	++	A-				1	People living with chronic disease			•		•	•		3.15	3.79
What's Up						1	None			•					2.67	3.83
Wisdo	+++	A-	T			1	None			•		•			3.38	4.25

*More languages available in iOS (see Appendix C)

APPENDIX D: MARKETPLACE REVIEWS OF HELP@HAND RFSQ APPROVED APPS











All numbers shown are medians since averages were not available for these metrics on the third-party analytics platform used. Top performing apps are apps with the highest number of downloads. Some apps were included in more than one OAC RFSQ component, which is why some top performing apps are repeated (e.g. Headspace & Ouchie).

OAC RFSQ Component	# apps in this RFSQ category	Data type	# apps with this data available	Metric	Top performing app	Jan 10 - Feb 10	Feb 11 - Mar 10	Mar 11 - Apr 10	Apr 11 - May 10	May 11 - Jun 10	Jun 11 - Jul 10	Jul 11 - Aug 10	Aug 11 - Sep 10	Sep 11 - Oct 10	Oct 11 - Nov 10	Nov 11 - Dec 10
Peer Chat/Digital Therapeutic	23	iOS & Android	DAU	6022	6353	5100	2619	1286	6513	5505	5608	8792	7010	6746		
			MAU	16165	16828	15838	3981	6193	19525	19646	25830	25519	27647	37102		
	4	iOS only	Downloads	237	263	228	186	198	349	357	415	419	423	428		
			DAU	--	256	1281	1340	1053	2219	2195	2043	1453	1506	1220		
	3	Android only	MAU	20715	23753	31562	33978	35959	38640	40659	42031	41948	42005	45984		
			Downloads	--	98	81	32	99	100	92	73	60	55	38		
	Therapy AVATAR	3	Android only	DAU	--	--	--	278	662	--	--	--	--	--	--	
				MAU	110	110	109	813	8315	15080	18438	21066	28449	31247	29882	
		5	iOS & Android	Downloads	--	--	--	92	126	--	--	--	--	--	--	
				DAU	6308	6081	5013	4440	6693	5321	4410	3738	3559	3211	2941	
4		iOS only	MAU	39803	38245	34987	33137	35732	33582	30092	26994	25115	22267	17844		
			Downloads	263	260	204	198	285	158	172	151	159	110	103		
3		Android only	DAU	--	225	1240	1340	1037	2215	2195	2043	1453	1506	1220		
			MAU	--	352	2418	3894	4150	7075	8653	9202	8624	8306	7937		
Passive Data		2	iOS only	Downloads	--	98	80	32	92	100	92	73	60	55	38	
				DAU	--	--	--	278	662	--	--	--	--	--	--	
	8	iOS & Android	MAU	--	--	--	745	3809	--	--	--	--	--	--		
			Downloads	--	--	--	92	126	--	--	--	--	--	--		
	41	Android only	DAU	883	799	169	386	780	131	373	486	359	429	5873		
			MAU	11557	10850	979	1728	4494	2182	1225	3610	3890	4035	30883		
	2	Android only	Downloads	83	83	84	87	151	11	60	85	83	99	371		
			DAU	--	--	--	--	--	--	--	--	--	--	--		
	2	Android only	MAU	--	--	--	--	--	--	--	--	--	--	--		
			Downloads	--	--	--	--	--	--	--	--	--	--	--		
2	Android only	Downloads	--	--	9	--	--	7	--	--	--	--	--			
		DAU	--	--	--	--	14	--	--	--	--	--	--			
2	Android only	MAU	--	--	--	--	115	--	--	--	--	--	--			
		Downloads	--	--	--	4	4	--	--	--	--	--	--			

APPENDIX E: MARKET SURVEILLANCE LEARNING BRIEFS

FREE APPS TO HELP PEOPLE COPE WITH COVID-19 June 2020

This review highlights well-established and popular free apps to help people cope with COVID-19. These apps have either made existing content available for free during the pandemic, or added new content to address issues arising from COVID-19.

App Name Developer	Platform	Cost		Intervention Components						Available Languages	Population-Specific Tailored Content	Available COVID-19 Specific Content	Year Launched	# of Downloads (in past 90 days)		Published Research Evidence	Vetted in Help@Hand RFSQ?
		Free, with additional features available in paid version	Completely Free	Psychoeducation	Symptom Tracking	Chatbot/AI	Mindfulness	Positive Psychology	CBT					iOS	Android		
 Calm Calm, Inc.	Web Android iOS	• • •	• • •	• • •	• • •	• • •	• • •	• • •	English, German, Spanish, French, Korean, Portuguese	Children	Free resource hub online: https://www.calm.com/blog/take-a-deep-breath	2013	2,279,000	2,272,000	Yes	No	
 COVID Coach National Center for PTSD	Web Android iOS	• • •	• • •	• • •	• • •	• • •	• • •	English	Some resources for military personnel & parents/caregivers	App created for COVID-19 & draws from another app by same developers	2020	16,920	9,412	No	No		
 Happify Happify, Inc.	Web Android iOS	• • •	• • •	• • •	• • •	• • •	• • •	English, Chinese, French, German, Japanese, Portuguese, Spanish, Traditional Chinese	None	Has content such as "Managing Stress in Uncertain Times"	2013	30,290	9,125	Yes	Yes		
 Headspace* Headspace Inc.	Web Android iOS	• • •	• • •	• • •	• • •	• • •	• • •	English, French, German, Portuguese, Spanish	Children	COVID-19 "Weathering the storm" content pack free for everyone. Premium access is free to the unemployed, health professionals, & educators during pandemic	2012	860,200	851,200	Yes	Yes		
 NOD Grit Digital Health	Web Android iOS	• • •	• • •	• • •	• • •	• • •	• • •	English	College students & young people	App redesigned for COVID-19 & has activities for social distancing	2019	1,108	738	No**	Yes		
 Sanvello* Sanvello Health Inc.	Web Android iOS	• • •	• • •	• • •	• • •	• • •	• • •	English, text translations in Spanish & French	None	Has community discussion groups specific to the pandemic. Premium access is free during pandemic	2012	63,020	254,800	Yes	No		
 SuperBetter SuperBetter, LLC	Web Android iOS	• • •	• • •	• • •	• • •	• • •	• • •	English	None	Two new COVID-19 specific content ("Stay Strong in a Pandemic" & "Stay-at-Home Scavenger Hunt")	2012	10,030	3514	Yes	No		
 This Way Up St Vincent's Hospital Sydney	Web Android iOS	• • •	• • •	• • •	• • •	• • •	• • •	English	Teenagers, young adults, & adults	Guided downloadable workbooks & resources ("Staying on Track During the Pandemic")	2012	N/A – Web app	N/A – Web app	Yes	No		
 Woebot Woebot Labs, Inc.	Web Android iOS	• • •	• • •	• • •	• • •	• • •	• • •	English	Young adults	Additional COVID-19 lesson ("Perspective")	2018	23,760	115,800	Yes	No		
 Wysa* Wysa Ltd.	Web Android iOS	• • •	• • •	• • •	• • •	• • •	• • •	English	None	Has health anxiety & isolation content free to anyone during pandemic	2016	30,450	45,770	Yes	Yes		

* Apps included in Catalyst toolkit located at: https://georgehills.SharePoint.com/sites/helpandhand/_layouts/15/Doc.aspx?sourceidoc=%7B0CC8FF8F-DF56-46D2-8718-4D0A452F9AAA%7D&file=COVID%2019%20Resources.docx&action=default&mobileredirect=true

** Randomized control trial completed, but not yet published

Multiple sources have reported increases in mental health needs since the outbreak of COVID-19, as shown by increasing rates of anxiety, depression, stress, sleep disturbance, and substance use.^[1,2,3,4] Increased rates of mental health symptoms are especially prevalent among those most directly impacted, such as frontline medical workers^[5] and children.^[6] Given unique barriers to care that currently exist (e.g. physical distancing measures that may limit contact with providers), people are looking to digital tools to help them manage these stressors. This may potentially lead to an important opportunity for digital mental health.^[7,8] Indeed, many digital mental health companies have reported that they have received record numbers of users during the pandemic.^[9,10,11]

As such, Tri-City expressed interest in learning about the traffic and use of the following apps since the onset of COVID-19 in March 2020:

- Calm
- Headspace
- iChill
- myStrength
- Sanvello
- Wysa

This learning update presents marketplace performance data on the number of downloads and daily active users (DAU) to examine traffic and use. The data reflects users in the United States during the time period of March – September 2020. The data is combined across iOS and Android apps stores. Data separated for iOS and Android is available on request.

METRIC	DEFINITION
Number of Downloads	Number of new users downloading the app for the first time over a defined time period. ^a
Daily Active Users (DAU)	Number of unique devices that created at least one session (e.g., opened the app) in a 24-hour period. ^b
Average Daily Active Users (DAU)	The average DAU over a period of time. ^c

Overall Number of Downloads and Daily Active Users by Month

Below are the number of downloads and daily active users over two-month periods for each app.

Number of Downloads							
	Jan-Feb	Mar-Apr	% change	May-Jun	% change	Jul-Aug	% change
Calm	2,469,074	2,767,405	+12%	3,128,669	+13%	2,796,824	-11%
Headspace	1,282,453	1,279,537	-0.2%	1,100,017	-14%	741,374	-33%
iChill	80	72	-10%	961	+1,235% ^d	327	-66%
myStrength	7,859	15,157	+93%	34,662	+129%	26,941	-22%
Sanvello	48,824	175,191	+259%	234,537	+34%	264,983	+13%
Wysa	68,533	47,883	-30%	58,350	+22%	66,051	+13%

*NOTE: Percent change represents change from previous two-month period

^a This metric only captures overall new users. Re-downloads do not count toward this metric (i.e., if you break your phone, get a new phone, re-download the same app again – the re-download will not count). App updates also do not count toward this metric.

^b This means that a user who opened the app once and a user who opened the app 10 times in the last 24-hours are both only counted as one DAU.

^c Any time that you are looking at DAU over an aggregated period of time (e.g., a week, month, quarter, year, etc.) you are looking at the Average DAU. For example, if you look at the DAU for April 2018, then you are looking at the average of the 30 daily DAU values in that month.

^d Please note this app had small number of total downloads and DAUs.

Average DAU

	Jan-Feb	Mar-Apr	% change	May-Jun	% change	Jul-Aug	% change
Calm	1,954,907	1,975,848	+1%	2,234,581	+13%	2,246,286	+1%
Headspace	939,467	1,055,420	+12%	960,340	-9%	847,818	-12%
iChill	17	15	-15%	78	+423%	40	-49%
myStrength	984	2,184	+122%	5,800	+166%	5,271	-9%
Sanvello	24,684	60,908	+147%	117,792	+93%	156,249	+33%
Wysa	37,471	26,538	-29%	29,023	+9%	29,442	+1%

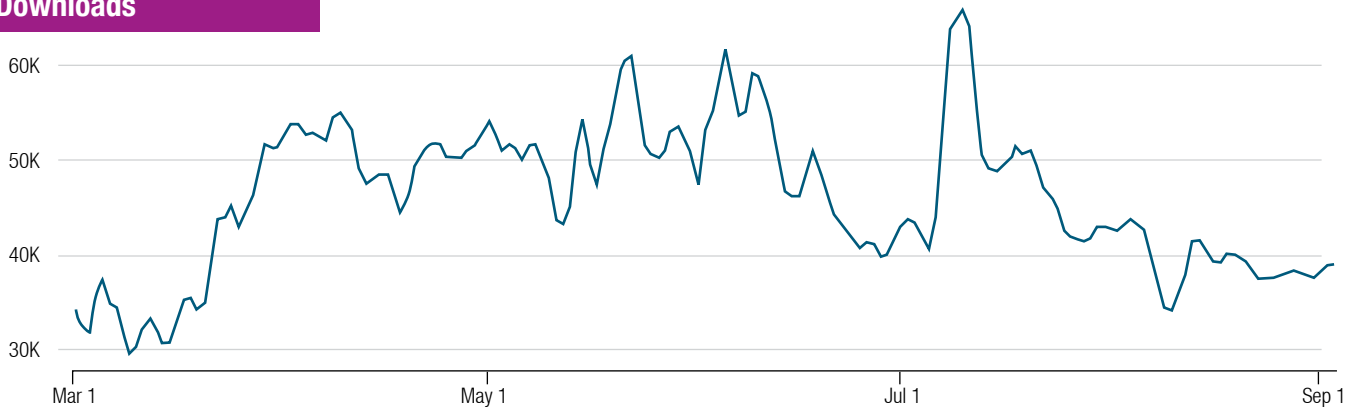
*NOTE: Percent change represents change from previous two-month period

Detailed Number of Downloads and Daily Active Users by App

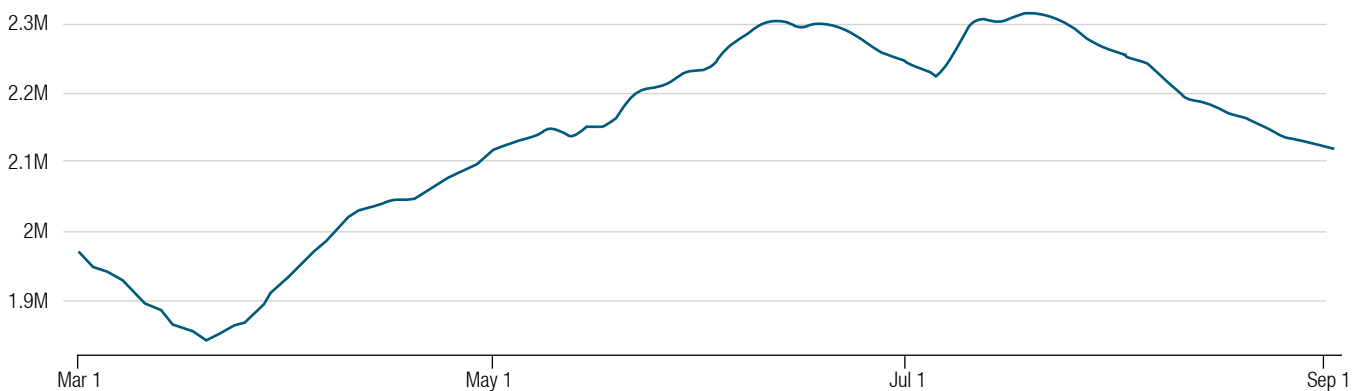
Below are the number of downloads and daily active users for each app between March 1-September 3, 2020.



Downloads



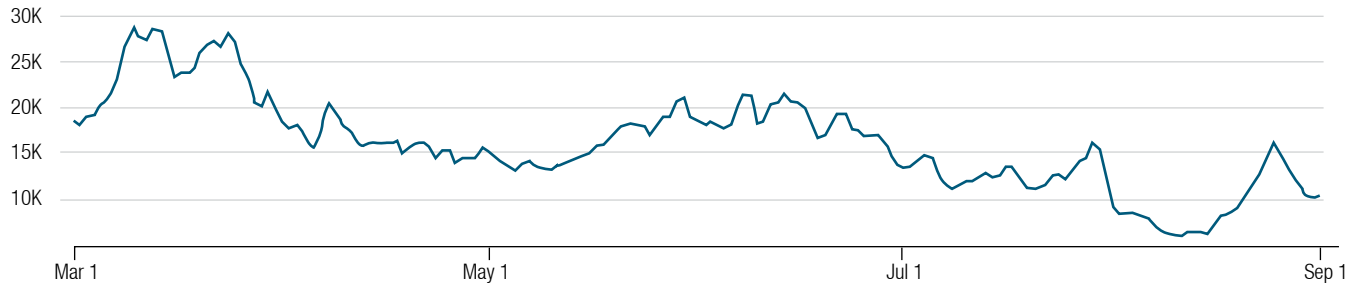
Daily Active Users



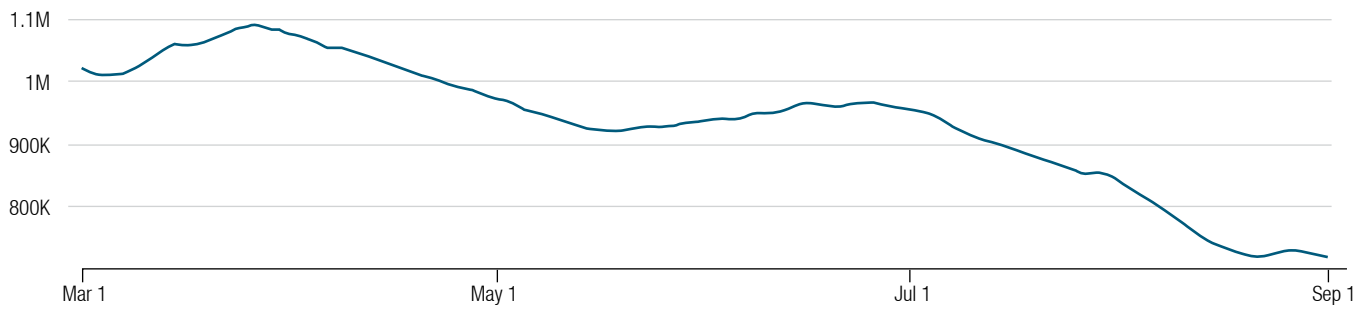


HeadSpace

Downloads

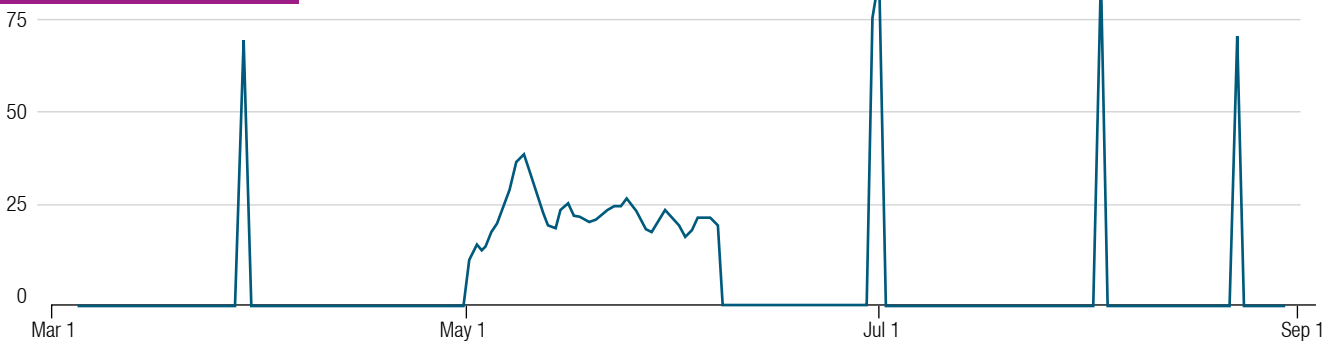


Daily Active Users

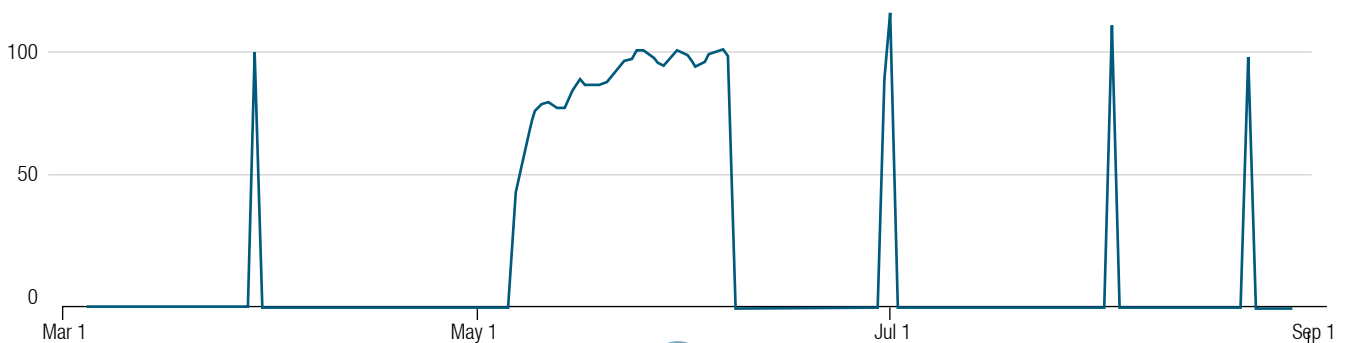


iChill

Downloads



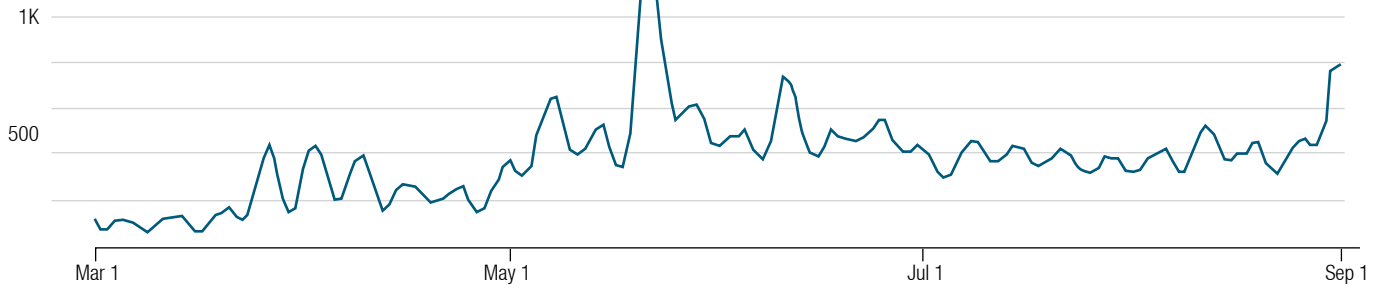
Daily Active Users



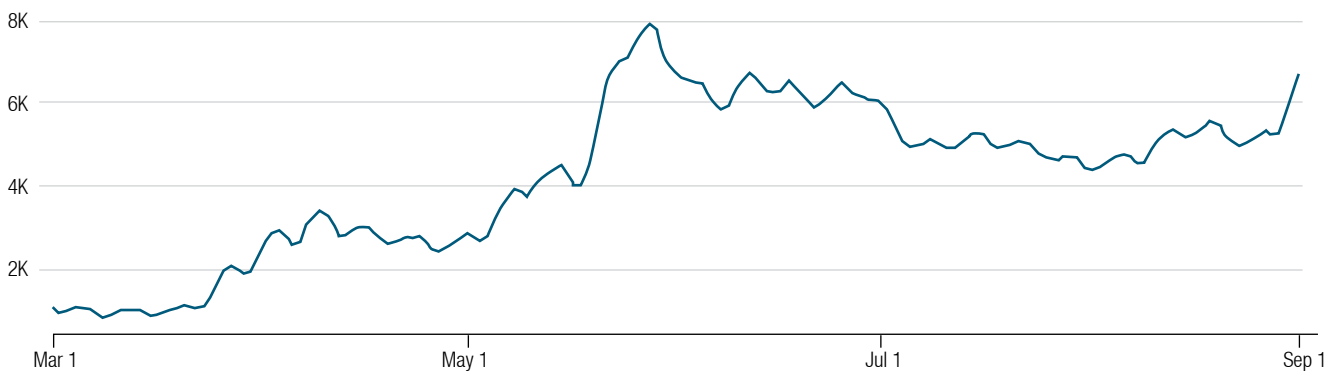


myStrength

Downloads

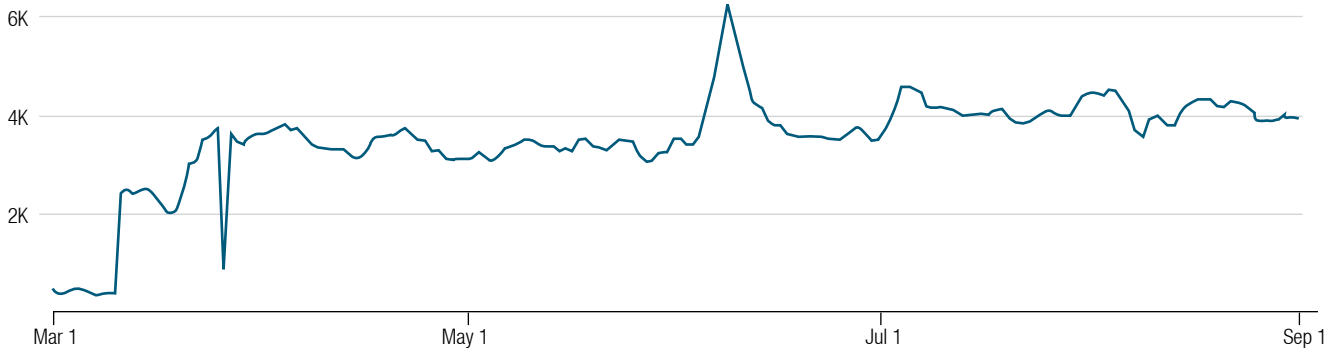


Daily Active Users

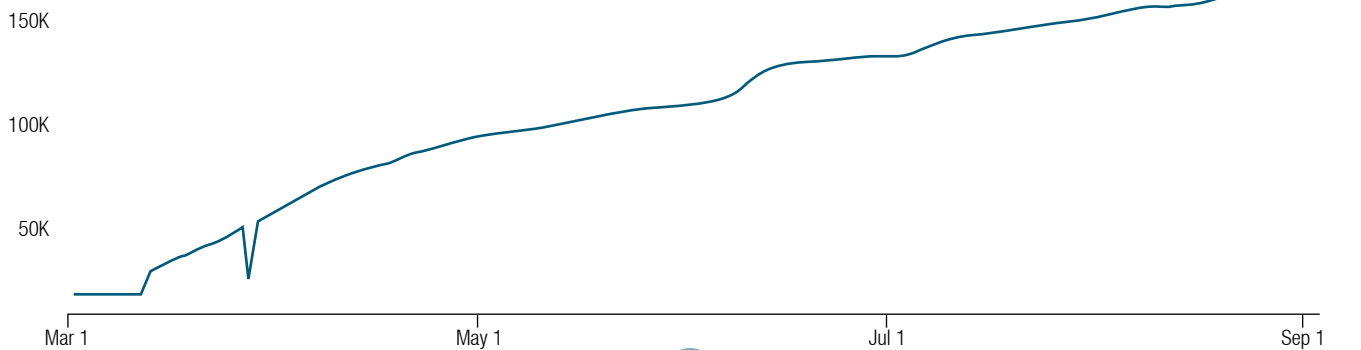


Sanvello

Downloads



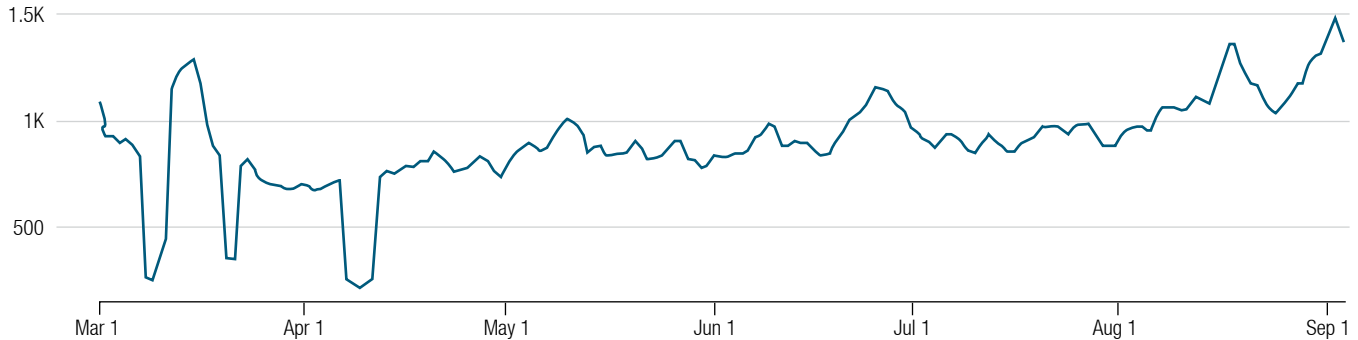
Daily Active Users



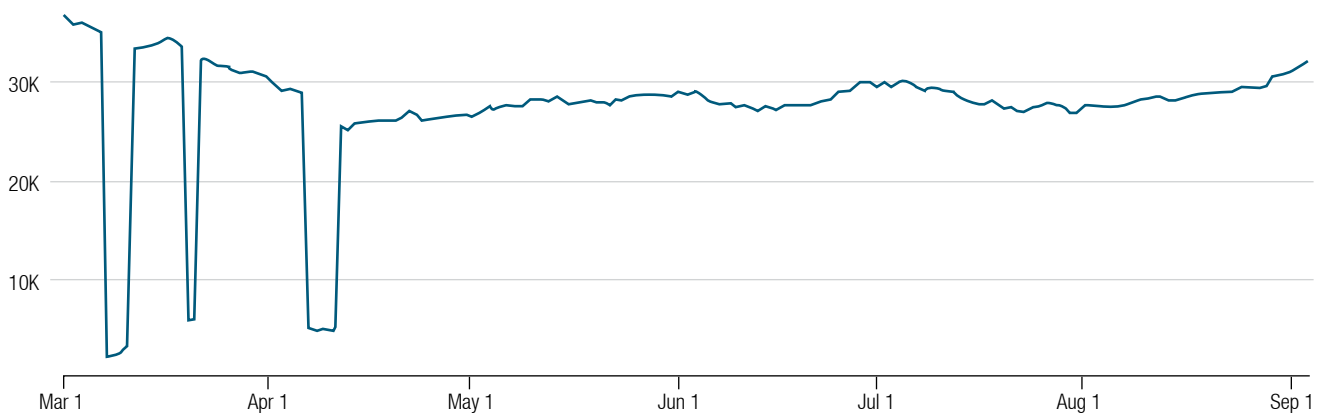


Wysa

Downloads



Daily Active Users



Notable Partnerships

Below are links to articles describing notable partnerships for each app that may have affected market performance.

[Calm membership included on American Express cards \[May 18, 2020\]](#)

[Calm available to Kaiser Permanente members \[May 19, 2020\]](#)

[Headspace free for healthcare professionals \[March 16, 2020\]](#)

[Headspace available to NY state residents \[Apr 6, 2020\]](#)

[Headspace available to all LA County Residents \[Apr 28, 2020\]](#)

[Headspace made available for free for people who are unemployed \[May 14, 2020\]](#)

[myStrength available to Kaiser Permanente members \[April 2, 2020\]](#)

[Sanvello announced free premium access for anyone \[March 20, 2020\]](#)

[Sanvello releases free clinician dashboard to mental health professionals \[Apr 16, 2020\]](#)

[Aetna International announces partnership with Wysa \[May 18, 2020\]](#)

[Wysa being offered for free at Cincinnati Children's Hospital \[Aug 8, 2020\]](#)

References

- ¹ *A third of Americans now show signs of clinical anxiety or depression - The Washington Post.* (n.d.). Retrieved September 10, 2020, from <https://www.washingtonpost.com/health/2020/05/26/americans-with-depression-anxiety-pandemic/?arc404=true>
- ² Panchal, N., Kamal, R., Muñana, C., Aug 21, P. C. P., & 2020. (2020, August 21). The Implications of COVID-19 for Mental Health and Substance Use. *KFF*. <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>
- ³ *“Staggering” Increase in COVID-Linked Depression, Anxiety.* (n.d.). Medscape. Retrieved September 10, 2020, from <http://www.medscape.com/viewarticle/934882>
- ⁴ Twenge, J. M., & Joiner, T. E. (2020). US Census Bureau-assessed prevalence of anxiety and depressive symptoms in 2019 and during the 2020 COVID-19 pandemic. *Depression and anxiety*.
- ⁵ Pappa, S., Ntella, V., Giannakas, T., Giannakoulis, V. G., Papoutsis, E., & Katsaounou, P. (2020). Prevalence of depression, anxiety, and insomnia among healthcare workers during the COVID-19 pandemic: A systematic review and meta-analysis. *Brain, behavior, and immunity*.
- ⁶ Courtney, D., Watson, P., Battaglia, M., Mulsant, B. H., & Szatmari, P. (2020). COVID-19 impacts on child and youth anxiety and depression: challenges and opportunities. *The Canadian Journal of Psychiatry*, 0706743720935646.
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- ⁸ Ben-Zeev, D. (2020). The digital mental health genie is out of the bottle. *Psychiatric Services*, appi-ps.
- ⁹ As Headspace booms, the app's popularity outpaces its evidence. (2020, August 7). *STAT*. <https://www.statnews.com/2020/08/07/headspace-mindfulness-covid19-employers/>
- ¹⁰ *Healthcare Apps: A Boon, Today And Tomorrow.* (n.d.). Retrieved September 10, 2020, from <https://www.forbes.com/sites/eladnatanson/2020/07/21/healthcare-apps-a-boon-today-and-tomorrow/#5700a6101bb9>
- ¹¹ *Telemedicine, Once a Hard Sell, Can't Keep Up With Demand - WSJ.* (n.d.). Retrieved September 10, 2020, from <https://www.wsj.com/articles/telemedicine-once-a-hard-sell-cant-keep-up-with-demand-11585734425>

Learning Brief: Mental Health Apps Provided and Recommended By California Insurance Plans

September 2020

The table below summarizes a selection of mental health apps that are provided or recommended by insurance plans across California. The information provided was gathered in Summer 2020.

App	Description	Provided by ¹	Recommended By ²
	Calm is a mindfulness apps with content for music, meditation, and sleep.	Oscar Kaiser Permanente	Blue of California Anthem Blue Cross
	Headspace is a mindfulness meditation app, which includes content to help users focus, sleep, meditate, and be more physically active.	--	Blue of California
	MyLife Meditation (formerly Stop, Breathe & Think) allows users to check in with how they are feeling, and recommends short guided meditations and mindfulness activities based on current mood.	--	Anthem Blue Cross
	myStrength allows users to track their mood over time, join supportive online communities, and access other educational and coping resources to help with the management of depression, anxiety, stress, etc.	Kaiser Permanente	--
	Recovery Record is designed to aid recovery from eating disorders using techniques rooted in cognitive behavioral therapy (CBT).	--	Cigna
	Sanvello uses principles of CBT to help users with symptoms of anxiety, depression, or stress.	United Healthcare	--
	Teladoc connects users with medical and behavioral health professional through phone or video.	Tufts Health Plan Molina	--
	Virtual Hope Box contains simple tools to help users with coping, relaxation, distraction, and positive thinking. It also allows users to upload photos and other files to create a "hope box."	--	Anthem Blue Cross
	Wysa is an artificially intelligent (AI) chatbot who can coach users to cope with issues like stress, depression, anxiety, sleep, etc.	Aetna	--

¹ App is included in membership with free or discounted access for insurance plan members.





² App is listed on insurance plan's website as a recommended resource, but no free or discounted access benefits for insurance plan members.

MYSTRENGTH AND SIMILAR APPS

September 2020

PRODUCT MATRIX SUMMARY

Below is a summary of information from the Help@Hand product matrix for myStrength and apps similar to myStrength. It also identifies those apps with published research evidence. Please note that the Help@Hand product matrix did not have information related to “Specialized Target Populations,” “Improving Communication with Isolated Individuals,” and “Utilization of Peers” for these apps.

App Name	OAC Component	Additional Product Features	Physical or Behavioral Health	Referral	Monolingual Support	Wearable/ Additional Tech	Published Research Evidence
 myStrength	Digital Therapeutics	Addiction Recovery + Goal Setting Mood Tracker + Meditation + Journal + Assessments	Behavioral	Needs Referral	Spanish	None listed on product matrix	No
 Happyfy	Digital Therapeutics	Community / Group Involvement + Goal Setting + Mood Tracker + Meditation + Journal + Assess- ments + Games	Behavioral	No Referral Necessary	Chinese, French, German, Japanese, Portuguese, Spanish, Traditional Chinese	None listed on product matrix	Yes
 Meru	Chat (Therapist or Non-Peer) + Digital Therapeutics	Care Coordination + Virtual Appointments / Telehealth + Meditation + Assessments	Physical & Behavioral	Needs Referral	None listed on product matrix	Wearable/ Additional Tech	Yes
 SilverCloud	Chat (Therapist or Non-Peer) + Digital Therapeutics	Addiction Recovery + Virtual Appointments / Telehealth + WRAP or Action Planning + Goal Setting + Mood Tracker + Journal + Assessments	None listed on product matrix	No Referral Necessary	None listed on product matrix	None listed on product matrix	Yes

SELECTIONS FROM PUBLISHED RESEARCH EVIDENCE

Below is a selection of the published literature of Happify, Meru, and SilverCloud. Studies related to the feasibility and acceptability of these apps among users and/or studies that had strong research design are shown since they may help inform decisions of Help@Hand Counties/Cities.



Happify

Article Name: “Seeing the ‘Big’ Picture: Big Data Methods for Exploring Relationships Between Usage, Language, and Outcome in Internet Intervention Data.”

Publication year: 2016

What did the study look at? Does greater usage of Happify predict higher well-being?

How did they collect the data? 152,747 users within the app were sampled. The research team used a proprietary measure called the Happify Scale to measure positive emotion and satisfaction with life.

What did they learn? It is challenging to infer data without a control group. The goal of the study was more to understand how to leverage big datasets to understand the effects of using Happify without inferring its effectiveness. Analyzing data within each user led the team to conclude that those who used the app saw greater well-being during periods of time when they used Happify more frequently.

Citation: Carpenter, J., Crutchley, P., Zilca, R. D., Schwartz, H. A., Smith, L. K., Cobb, A. M., & Parks, A. C. (2016). Seeing the “Big” Picture: Big Data Methods for Exploring Relationships Between Usage, Language, and Outcome in Internet Intervention Data. *Journal of Medical Internet Research*, 18(8), e241. <https://doi.org/10.2196/jmir.5725>

Article Name: Effect of Brief Biofeedback via a Smartphone App on Stress Recovery: Randomized Experimental Study

Publication year: 2019

What did the study look at? Does using Happify lead to physiological and psychological effects that indicate stress reduction?

How did they collect the data? They sampled 140 participants who were randomized to recover from a stressful situation in one of three ways: with no phone; with a phone (no Happify); and with Happify. The research team measured stress through a self-report measure and by measuring two salivary biomarkers (Salivary cortisol and sAA [salivary alpha amylase]).

What did they learn? The study found significantly lower levels of sAA for those in the Happify group, with no significant differences for the conditions of levels of salivary cortisol and self-reported stress.

Citation: Hunter, J. F., Olah, M. S., Williams, A. L., Parks, A. C., & Pressman, S. D. (2019). Effect of Brief Biofeedback via a Smartphone App on Stress Recovery: Randomized Experimental Study. *JMIR Serious Games*, 7(4), e15974. <https://doi.org/10.2196/15974>

Article Name: Testing a scalable web and smartphone based intervention to improve depression, anxiety, and resilience: A randomized controlled trial

Publication year: 2018

What did the study look at? Does use of Happify reduce depression and anxiety symptoms and increase resilience?

How did they collect the data? Final data was taken from 1,051 total users who were randomized into conditions of using Happify or receiving psychoeducation—only. Users were further split into subgroups of recommended usage or low usage of both conditions. The researchers used the PHQ–9, GAD–7, and a proprietary scale to measure depression, anxiety, and resilience, respectively.

What did they learn? Participants who used Happify at recommended levels reported fewer depressive and anxiety symptoms and greater resilience.

Citation: Parks, A. C., Williams, A. L., Tugade, M. M., Hokes, K. E., Honomichi, R. D., & Zlica, R. D. (2018). Testing a scalable web and smartphone based intervention to improve depression, anxiety, and resilience: A randomized controlled trial. *International Journal of Wellbeing*, 8(2), 22–67. <https://doi.org/10.5502/ijw.v8i2.745>



Meru

Article Name: Feasibility and Efficacy of the Addition of Heart Rate Variability Biofeedback to a Remote Digital Health Intervention for Depression

Publication year: 2020

What did the study look at? How feasible is it to use Meru with Heart Rate Variability Biofeedback and did this treatment show changes in symptoms of depression?

How did they collect the data? An enhanced group (N = 48) where patients received heart rate variability—biofeedback (HRV–B) along with using Meru, was compared to a standard group (N = 48) which only used Meru (no HRV–B). The study took historical outcome data from a group of patients. Researchers used the PHQ–9 to measure changes in symptoms and also used the number of completed exercises and other usage statistics such as hours spent in practice and the number of messages sent between therapist and client to measure engagement.

What did they learn? Patients in the enhanced group were more likely to report a clinically significant improvement in depressive symptom score post–intervention.

Citation: Economides, M., Lehrer, P., Ranta, K., Nazander, A., Hilgert, O., Raevuori, A., ... Forman–Hoffman, V. L. (2020). Feasibility and Efficacy of the Addition of Heart Rate Variability Biofeedback to a Remote Digital Health Intervention for Depression. *Applied Psychophysiology and Biofeedback*, 45(2), 75–86. <https://doi.org/10.1007/s10484-020-09458-z>

Article Name: Feasibility of a Therapist–Supported, Mobile Phone–Delivered Online Intervention for Depression: Longitudinal Observational Study

Publication year: 2019

What did the study look at? How feasible is it to integrate the Ascend intervention from Meru Health?

How did they collect the data? Researchers conducted 2 pilot studies with a total of 117 Finnish adults with elevated depression symptoms were prescribed a specific intervention within Meru. Researchers examined dropout rates and daily practice with Meru. They also looked at weekly group chat use and changes in depression symptoms using the BDI–II for study 1 and the PHQ–9 for study 2.

What did they learn? Dropout rates were 27% for study 1 and 15% for study 2. Daily practice and group chat use decreased from the beginning of the intervention to 4–weeks after the intervention. Depression rates decreased as well during the period. More daily practice and chat group use predicted occurrence of fewer depressive symptoms at 4–weeks after the intervention.

Citation: Goldin, P. R., Lindholm, R., Ranta, K., Hilgert, O., Helteenvuori, T., & Raevuori, A. (2019). Feasibility of a Therapist–Supported, Mobile Phone–Delivered Online Intervention for Depression: Longitudinal Observational Study. *JMIR Formative Research*, 3(1), e11509. <https://doi.org/10.2196/11509>

Article Name: Long-Term Outcomes of a Therapist-Supported, Smartphone-Based Intervention for Elevated Symptoms of Depression and Anxiety: Quasiexperimental, Pre-Postintervention Study

Publication year: 2019

What did the study look at? Does the Ascend intervention in Meru maintain a reduction in symptoms of anxiety and depression up to 12-months post-treatment?

How did they collect the data? The study involved 102 adult participants who were a part of a previous study and who showed a reduction in symptoms of anxiety and depression. Researchers measured change with the GAD-7 and PHQ-9.

What did they learn? The intervention was associated with reductions in symptoms of depression maintained 12-months after the program and symptoms of anxiety maintained 6-months after the program.

Citation: Economides, M., Ranta, K., Nazander, A., Hilgert, O., Goldin, P. R., Raevuori, A., & Forman-Hoffman, V. (2019). Long-Term Outcomes of a Therapist-Supported, Smartphone-Based Intervention for Elevated Symptoms of Depression and Anxiety: Quasiexperimental, Pre-Postintervention Study. *JMIR MHealth and UHealth*, 7(8), e14284. <https://doi.org/10.2196/14284>

Article Name: Smartphone-Delivered, Therapist-Supported Digital Health Intervention for Physicians with Burnout

Publication year: 2020

What did the study look at? Is it feasible to use Meru to support physicians experiencing burnout?

How did they collect the data? 36 physicians who were showing elevated signs of work-related stress based on a burnout measure were administered the Meru Health app. Data was available for 33 of the physicians. Researchers used a single-item burnout measure and the PHQ-9. Intervention engagement was measured by user interaction with Meru via the smartphone app (e.g., total number of seconds of completed mindfulness meditation practices).

What did they learn? There was significant decrease in burnout and depressive symptoms. Engagement metrics were not significantly associated with the outcomes.

Citation: Raevuori, A., Forman-Hoffman, V., Goldin, P., Gillung, E., Connolly, S., Dillon, E., ... & Huang, F. Smartphone-Delivered, Therapist-Supported Digital Health Intervention for Physicians with Burnout. https://static1.squarespace.com/static/5cc948f6348cd94004675d2a/t/5f3a2e6362c23339b595ce66/1597648525041/PAMF_PhysicianBurnout_MeruHealth.pdf



SilverCloud Health

Article Name: Supported Internet-Delivered Cognitive Behavioral Therapy Programs for Depression, Anxiety, and Stress in University Students: Open, Non-Randomised Trial of Acceptability, Effectiveness, and Satisfaction

Publication date: 2018

What did the study look at? How feasible is the use of SilverCloud developed platforms?

How did they collect the data? 102 participants were recruited from counseling centers at a U.S. University. The PHQ-9, GAD-7, and DASS-21 were used to assess changes in symptoms. A Satisfaction with Treatment questionnaire was also used to understand acceptability of SilverCloud.

What did they learn? There was a significant decrease in symptoms of depression, anxiety, and stress. Most participants found the programs helpful or very helpful and liked the convenience and flexibility of the intervention.

Citation: Palacios, J. E., Richards, D., Palmer, R., Coudray, C., Hofmann, S. G., Palmieri, P. A., & Frazier, P. (2018). Supported Internet–Delivered Cognitive Behavioral Therapy Programs for Depression, Anxiety, and Stress in University Students: Open, Non–Randomised Trial of Acceptability, Effectiveness, and Satisfaction. *JMIR Mental Health*, 5(4), e11467. <https://doi.org/10.2196/11467>

Article Name: An internetdelivered selfmanagement programme for bipolar disorder in mental health services in Ireland: Results and learnings from a feasibility trial

Publication date: 2020

What did the study look at? How feasible is it to use SilverCloud in a treatment facility?

How did they collect the data? 15 patients in a mental health treatment facility in Ireland used SilverCloud for 10–weeks. Feasibility was assessed from the perspective of patients and clinicians, with patient feasibility being measured through engagement with the intervention, and clinician feasibility being measured through metrics like number of patients supported and if the clinicians were active supporters of the product. Researchers also used the Satisfaction with Treatment questionnaire, Bipolar Recovery Questionnaire (BRQ), Quality of Life in Bipolar Scale (QOL-BD), Brief Illness Perception Questionnaire (BIPQ), Internal State Scale (ISS), as well as semi–structured interviews.

What did they learn? There was a high frequency of tool usage. Patients found the intervention acceptable and easy–to–use, but it was noted that there were several barriers to implementation, such as patient access to technology and low numbers of clinicians who became active supporters of the intervention.

Citation: Enrique, A., Duffy, D., Lawler, K., Richards, D., & Jones, S. (2020). An internetdelivered selfmanagement programme for bipolar disorder in mental health services in Ireland: Results and learnings from a feasibility trial. *Clinical Psychology & Psychotherapy*. <https://doi.org/10.1002/cpp.2480>

Article Name: A pragmatic randomized waitlist–controlled effectiveness and cost–effectiveness trial of digital interventions for depression and anxiety

Publication date: 2020

What did the study look at? How cost–effective is it to use SilverCloud in stepped–care settings and is it effective in reducing symptoms?

How did they collect the data? The study looked at PHQ–9, GAD–7, and WSAS to measure effectiveness among participants in a stepped–care setting. Calculated quality–adjusted life year (QALY) and a modified–Client Service Receipt Inventory (care resource–use) was also used.

What did they learn? SilverCloud users showed improvements in symptoms of depression and anxiety. The probability of cost–effectiveness was 46.6% over a 6–month period, which increased to 91.2% over a 12–month period.

Citation: Richards, D., Enrique, A., Eilert, N., Franklin, M., Palacios, J., Duffy, D., ... Timulak, L. (2020). A pragmatic randomized waitlist–controlled effectiveness and cost–effectiveness trial of digital interventions for depression and anxiety. *Npj Digital Medicine*, 3(1). <https://doi.org/10.1038/s41746-020-0293-8>

Article Name: Adapting an internet–delivered intervention for depression for a Colombian college student population: An illustration of an integrative empirical approach

Publication date: 2019

What did the study look at? How can SilverCloud be adapted for different cultures?

How did they collect the data? Researchers used qualitative and quantitative methods to adapt the Space from Depression program from SilverCloud. Researchers adapted the Space from Depression program by including Colombian actors in the videos they used, common phrases used in Colombia, and relevant scenarios. Researchers developed their own measure, the Cultural Relevance Questionnaire (CRQ), which they administered to reviewers of the adapted product to help rate cultural validity.

What did they learn? Researchers found that the changes made to the adapted product was positive, and feedback was used to further improve the product.

Citation: Salamanca–Sanabria, A., Richards, D., & Timulak, L. (2019). Adapting an internet–delivered intervention for depression for a Colombian college student population: An illustration of an integrative empirical approach. *Internet Interventions*, 15, 76–86. <https://doi.org/10.1016/j.invent.2018.11.005>



Peer Evaluation Learnings

September 2020

EXECUTIVE SUMMARY

Between April and June 2020, the Help@Hand Evaluation Team conducted one-on-one telephone interviews with Peer Leads (N = 11) and Tech Leads (from Counties/Cities without Peer Leads; N = 2) from the following regions participating in the Help@Hand Collaborative: City of Berkeley; Kern County; Los Angeles County; Marin County; Modoc County; Monterey County; Orange County; Riverside County; San Mateo County; Santa Barbara County; Tehama County; and Tri-City. Interview transcripts were analyzed using Atlas.ti. Results are summarized in **Table 1**. More detailed results will be reported in the Y2Q3 Evaluation Report.

Major Learnings

- **Peer involvement in the Help@Hand Collaborative is overwhelmingly seen as a value-added component**, with Peers offering a unique and critical perspective on product selection, development, and delivery.
- The size and employment models of the Peer workforce are both quite variable across Help@Hand counties/cities, and a number of counties/cities have engaged subcontractors to access Peers and facilitate program management.
- In Year 2 Quarter 1, **Peers were involved in a variety of activities**, including creating materials, outreach, product testing, and being trained in digital literacy.
- In Year 2 Quarter 3, **Counties/Cities plan to involve Peers in virtual outreach, digital literacy training, and reviewing apps**.
- **Integrating Peer input into Help@Hand continues to be an essential element of the project's mission and vision**. A number of counties/cities reported very positive experiences with Peers providing input locally. Perceptions of Peer input at the Collaborative-level was mixed, with some respondents noting room for improvement.
- **Leveraging the power of the Collaborative to enhance the effectiveness of Help@Hand also continues to be critical for project success**. Although a couple of respondents gave very positive and specific examples of assistance they received from other counties/cities in the Collaborative, a majority of respondents expressed an interest in clarifying the decision-making process across the Collaborative.
- Respondents reported a range of challenges to integrating Peers into the Help@Hand Collaborative. **Client-level challenges** included: lack of digital literacy among clients; lack of access to the internet or cell phones among clients; need for bilingual staff and materials; and restrictions on face-to-face contact related to the COVID-19 pandemic. **County/City-level challenges** related to: the COVID-19 pandemic (i.e., re-allocation of county/city resources and work-from-home requirements); limited Peer staffing capacity since many Peers wear multiple hats within their agencies and do not have enough time to spend on Help@Hand; need for better internal communication within and among county/city staff; and difficulty recruiting, hiring and retaining Peers.

Major Recommendations

The learnings indicate that there are potential gains by facilitating greater flow of information across the Collaborative. The impact has been considerable when counties/cities have made personal contact with their counterparts at other counties/cities, particularly given that each county/city has pioneered unique strategies for overcoming challenges that might well be translatable to additional counties/cities. The current structure, in which Peers exchange information with one another in a Peer-only call, limits the potential degree to which counties/cities can learn from one another and rapidly adopt innovations. Recommendations based on this synthesis are:

1. The **Peer Engagement Manager** has a central role in providing strong leadership for the Help@Hand Peer component. Therefore, it is important for Help@Hand to immediately hire a strong Peer candidate for this position. This individual will be able to accelerate the flow of Peer-related information across the Collaborative.
2. The size and complexity of the Help@Hand Collaborative Peer component requires **administrative support for the Peer Engagement Manager** in order to fully support the development and implementation of Peer activities throughout the 14 counties/cities of the Collaborative. Additional personnel may also help facilitate dissemination of information from the Collaborative to the Peers.

Table 1. Themes identified from interviews.

 = theme present in 25-50% of interviews.

 = theme present in greater than 50% of interviews.

Selected quotes provided as examples.

Peer Contribution	
	Peers add value to Help@Hand <i>"You need the culturally-appropriate strategies for each community. You have Peer people who have lived experience who wear that badge and can be an example to people."</i>
Peer Workforce Models	
	Use of Subcontractors <i>"We are able to make this happen with the support of a peer-trusted and peer-run [subcontractor who has] an incredible wealth of knowledge when it comes to supporting peer employment and peer tech questions."</i>
	Variable Peer workforce size <i>"As of now, there are no Peers assigned to work on this project." "We have 8 total peers – 7 plus myself."</i>
Past Peer Activities	
	Creation of Help@Hand materials Outreach
	Product Testing Peers trained in digital mental health literacy
Planned Peer Activities	
	Outreach Peers to deliver digital mental health literacy training
	App reviewing and testing
Peer Input (County/City-level)	
	Positive assessment of Peer input <i>"Our leadership team really seems to support and appreciate the skills abilities and work of the peer workforce."</i>
	Room for improvement <i>"People are making decisions without having peers involved."</i>
Peer input (Collaborative-level)	
	Peers well integrated <i>"What I have seen I feel like we have a really strong voice. I feel like we have a lot of input."</i>
	Room for improvement <i>"I get the sense that the Peers feel like they are not heard."</i>
Horizontal Communication (County/City to County/City)	
	Productive collaborations
Vertical Communication (Collaborative to County/City)	
	Lack of clarity on roles and responsibilities, particularly related to decision making <i>"It is still unclear where decision making power lies in all of this. Is it the collaborative, or the county? Who from the county is part of the collaborative in terms of decision-making power?"</i>
Challenges (Client-level)	
	Limited digital literacy Lack of access to technology
	Language barriers COVID-19-related restrictions on face-to-face outreach
Challenges (County/City- level)	
	COVID-19-related work-from-home and physical distancing requirements COVID-19-related resource redirection Limited time on the project given that Peers and Peer Leads fulfill multiple roles within the county/city Miscommunication between and among county/city staff
	Difficulty finding, recruiting, and retaining qualified Peers <i>"That has been a challenge: to hire people specifically for Help@Hand and our program."</i>

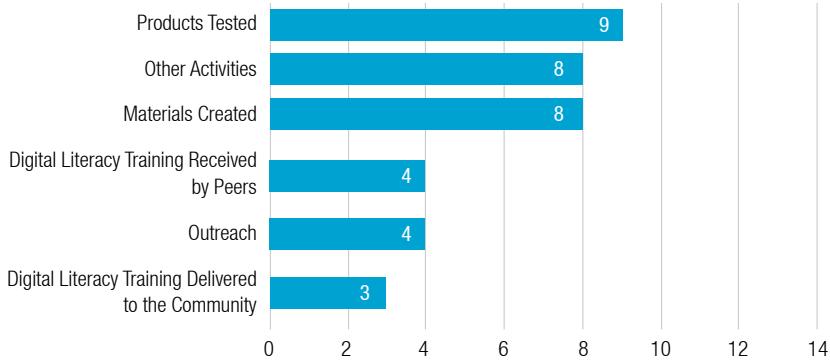
Peer Evaluation Learnings

Year 2, Quarter 3 (July - September 2020)

A brief survey was completed by 14 Peer Leads and 1 Tech Lead at the end of Q3.¹ Participating Counties/Cities included: City of Berkeley, Kern County, Los Angeles County, Marin County, Modoc County, Mono County, Monterey County, Orange County, Riverside County, San Francisco County, San Mateo County², Santa Barbara County, Tehama County, and Tri-City. The surveys were followed with an interview to collect additional details, and the interview findings will be summarized in the upcoming Year 2 Evaluation Report. This preliminary learning brief summarizes data from the survey in order to provide rapid feedback on the implementation of the Help@Hand Peer component.

Characteristics of Help@Hand Peer Programs		
Number of Peers Employed Across Counties/Cities		Use of Subcontracts
Number of Peers	Number of Cities/Counties	
0	1	6 Help@Hand Peer Leads are subcontractors 8 Counties/Cities employ Help@Hand Peer outreach workers using a subcontract
1	3	
2-4	4	
5-8	4	
9 or more	2	

Peer Activities Reported during Year 2 Quarter 3

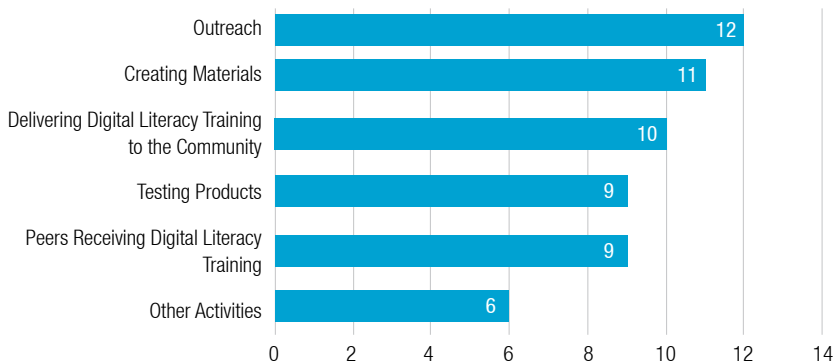


Question wording:

The following questions ask about the activities that Help@Hand Peers engaged in within your city/county during the third quarter of 2020 (July, August, September). Please choose the appropriate answer for each potential activity. (Response options: Peers did this during 3rd Quarter or Peers did not do this during 3rd Quarter).

* The figure to the left shows the number of interviewees who responded Peers did the activity in the 3rd quarter.

Peer Activities Planned for Year 2 Quarter 4



Question wording:

The following questions ask about PLANNED Peer activities for the fourth quarter of 2020 (October, November, December). Please indicate which of the following activities are currently planned for Peers to engage in in support of Help@Hand for the fourth quarter of 2020.

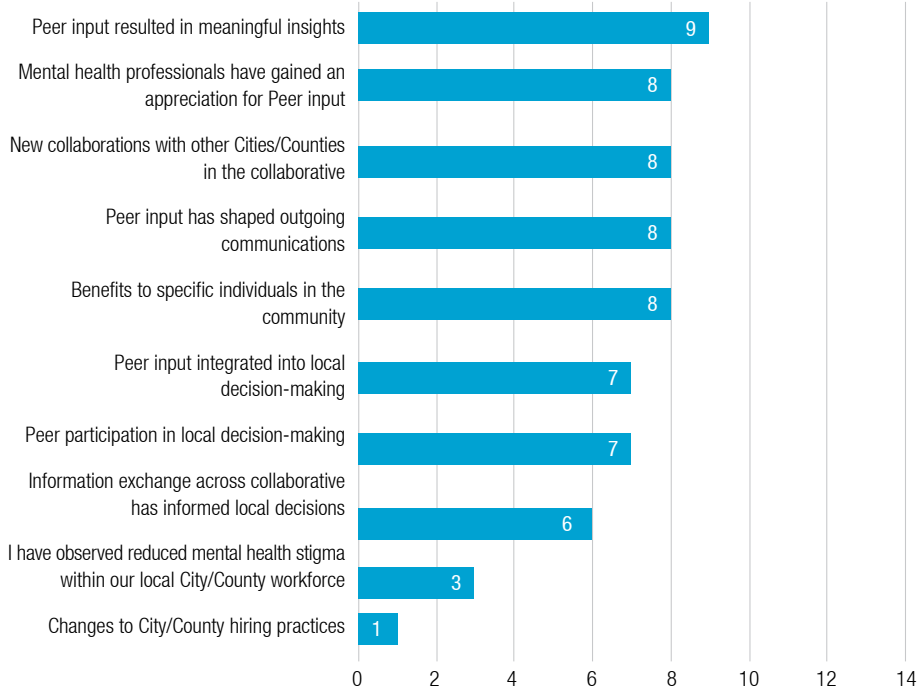
(Response options: We plan for Peers to do this in the 4th Quarter or We do not plan for Peers to do this in the 4th Quarter).

* The figure to the left shows the number of interviewees who responded Peers are planned to do the activity in the 4th quarter.

¹ The survey was developed based on themes emerging from interviews conducted with county/city Peer and Tech Leads in Year 2, Quarter 2. The survey conducted in Year 2, Quarter 3 had a response rate of 100%. One survey was omitted from the summary of challenges and successes owing to missing data.

² Two Peer Leads from San Mateo County were surveyed.

Year 2 Quarter 3 Successes

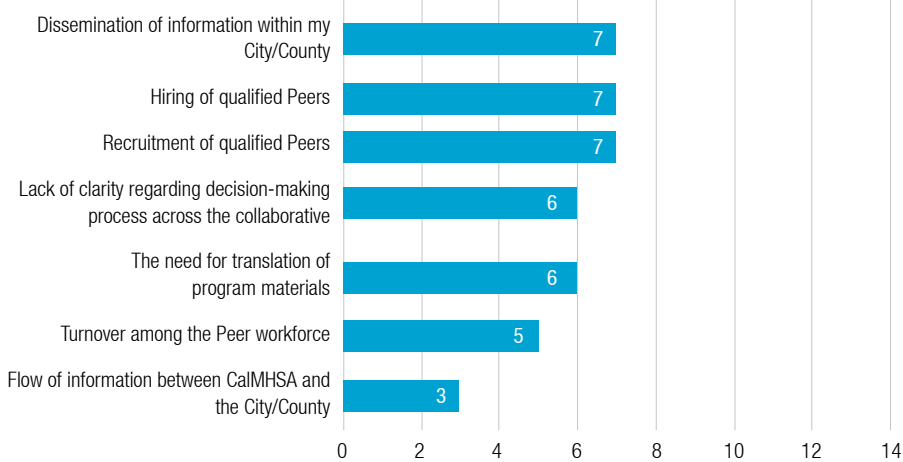


Question wording:

Successes: To help us estimate how widespread specific are across the Help@Hand collaborative, please indicate whether your City/County has experienced any of the following as a consequence of participation in Help@Hand. For this question, you can think about all experiences since the start of the project. Please choose yes or no for each option.

* The figure to the left shows the number of interviewees who identified the specific success.

Year 2 Quarter 3 Challenges



Question wording:

Challenges: To help us estimate how widespread the following challenges are, please indicate which of the following has hindered your progress as you implemented the Peer component of the Help@Hand project. For this question, you can think of all experiences since the start of the project. Please choose yes or no for each option.

* The figure to the left shows the number of interviewees who identified the specific challenge.

APPENDIX G: TAKE MY HAND



Summary

Lessons Learned

Lessons learned are organized within each EPIS phase. Within each phase, learnings are further characterized by the key people/process as follows:

- RUHS-BH Leadership
- Peers (Senior Peer Support Specialists and Peer Operators)
- Technology/Take my Hand Features
- Users
- Service Delivery

Recommendations

To facilitate generalizable knowledge across the Help@Hand Collaborative, recommendations are organized in the following categories: Implementation, Organizational Change Management, Technology, and Evaluation.

The Help@Hand evaluation team acknowledges that some of the recommended actions are currently underway. These recommendations are documented, nonetheless, for the benefit of the Collaborative.

Background

Information was synthesized from the rapid deployment of Take my Hand led by Riverside University Health System-Behavioral Health (RUHS-BH) and their Peer team for the purposes of the formative evaluation. This includes identifying lessons learned and providing recommendations from the Help@Hand evaluation team. Sources of data used for this synthesis included: 1) "RUHS-BH Take my Hand Live Peer Chat COVID-19 Rapid Deployment-Test Phase Report" developed by the Help@Hand Team in Riverside County; 2) "Take My Hand Test Phase Report" developed by Riverside County's local evaluators; and 3) Riverside County meeting notes from the Help@Hand evaluation team. This synthesis may provide generalizable insights as to how other counties/cities might successfully implement and sustain Take my Hand and/or apply learnings from Riverside's experience to their own implementations of other technologies.

Thank you to the entire TakemyHand project team for sharing your materials and learnings. Special thanks to Pamela, Shannon, Dakota, Maria Martha, Suzanna, and Christy.

Exploration, Preparation, Implementation, and Sustainment Framework

The Exploration, Preparation, Implementation, and Sustainment (EPIS) framework²⁷ was used to organize the lessons learned and recommendations for this synthesis. The EPIS framework highlights factors across the four phases that occur when implementing a new intervention or practice.

Exploration Phase

Identifying a Need and Exploring Possible Solutions

Riverside County experienced a high volume of COVID-19 cases early in the pandemic and anticipated an associated rise in mental health needs.

Lessons Learned

RUHS–BH Leadership:

1. Identified a public health need to find a safe alternative to alleviate the growing strain being placed on 911 and 211 crisis call centers at the onset of the COVID-19 pandemic.

Peers:

1. Determined that a Peer chat app would address the public and mental health needs in their community.

²⁷ See <https://episframework.com/> for more information on the EPIS Framework.

2. Recognized that it was important to leverage RUHS-BH's established Peer workforce, incorporating their skills and service delivery into the Take my Hand platform.

Technology:

1. Discovered through exploration that current digital mental health therapeutics (aka apps) were limited due to absence of a trained Peer Support Specialist. Specifically, someone who could address and respond to multiple needs of their community (e.g.; access to behavioral health resources, taking a non-medical approach that is recovery-oriented, multi-language capabilities, an interface that reduces mental health stigma and is multicultural, etc.).
2. Discovered through exploration that current apps did not identify core competencies of Peer support. These core competencies are defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as "the concepts and practices of 'Power Sharing', 'Recovery Coaching', 'Recovery Environment – High Expectation', 'Mutuality' and 'Role Modeling'".
3. Recognized that Take my Hand supplements already existing crisis services, and offers alternatives to these crisis services – by increasing access to Peer support, educating individuals about systems & services within Riverside County, and creating positive reputes for the RUHS-BH System.
4. Ventured that Take my Hand might offer cost savings to the County by: lessening the demand on clinical and crisis services through Peer support; reducing translation service costs with its chat function; and promoting efficient use of the behavioral health services that RUHS-BH offers.

Users:

No lessons learned were identified for users during the Exploration Phase.

Service Delivery:

1. Recognized the importance of supporting community members' ability to access support with a Peer Support Specialist at any time without an appointment.
2. Identified that shifting the service location to a live virtual platform might increase accessibility to individuals within and outside of Riverside County's behavioral health system.
3. Identified the importance of Take my Hand expanding the target audience to include new people not currently engaged by RUHS-BH, at any stage of wellness (including prevention and early intervention), with no triaging required.

Recommendations

Implementation

1. Identify current offerings, limitations, and opportunities of the existing service delivery system to support a virtual platform like Take my Hand.

Organizational Change Management

Peer Support Specialists: Training, Oversight, Experience

1. Define the roles and activities of a "Peer".
2. Define the need to be met (e.g., provide non-medical support).
3. Define the target audience.

Technology

1. Identify, develop answers for and integrate into the app Frequently Asked Questions (FAQs).

Evaluation (Local Evaluators and/or Help@Hand Evaluators)

1. Document a timeline of the various assessment time-points.
2. Attempt to systematically capture information obtained during exploration that informed subsequent decision-making.

Preparation Phase

Preparing for Implementation

To prepare for the Implementation of Take my Hand, RUHS-BH began gathering information and identifying factors that would be key to successful implementation, including but not limited to, the following: completing requirements for information technology and security, testing the technology's capacity to handle large volumes of users, mitigating potential risks or harm to users, developing strategic marketing, vetting materials for cultural appropriateness, projecting how the operation of Take my Hand might impact the prioritization of other duties at RUHS-BH, identifying key administrative stakeholders to successful deployment and implementation, identifying fiscal administrative barriers, and further developing the Peer Operator role.

Lessons Learned

RUHS–BH Leadership

1. Recognized that dedicated pre-implementation time is needed to vet and review terms of service by multiple key County employees (i.e., the Director, Information Security office, County Counsel etc.).

Peers

Senior Peer Support Specialist

1. Learned that the depth and nature of training varied across Peer Support Programs. Recognized need to identify core competencies required for Peer Operators.
2. Identified training gaps among Peer Operators (e.g. how Peer Operators could respond to emergent or unanticipated topics).

Peer Operator

3. Recognized that Peer Operators working remotely allowed for chat services to be provided 24/7
4. Identified the need for advanced training around the following topics: crisis transfers, how to use the Take my Hand platform, how to handle “trolls”²⁸ and controversial topics, and basic Peer support was necessary.

Technology

1. Recognized and corrected limitations of landing page.
2. Identified need to development ‘back-end’ of product for data collection.
3. Worked with Vendor to facilitate ease of use for consumer, Peer Operator, and Clinical Support²⁹

Users

1. Determined it was important to create scripted responses in preparation for frequently asked questions/topics.

Recommendations

Implementation

1. Develop an implementation plan grounded in the exploration and preparation activities completed. This plan can include:
 - a. Providing guidance on training Peer Operators (i.e., when the training will take place, who will be involved in the training, what content will be included in the training, defining timepoints of assessing the fidelity of the training, and determining a follow-up plan for assessing the adequacy of that training in terms of continued skill use or needs identified post-training).
 - i. Training is a good initial step, and it is important to identify training gaps to assess whether training is sufficient.
 - b. Defining the steps needed to obtain leadership approvals for implementation in the clinic.
 - c. Identifying when to collect specific website metrics and how those data will be used.
2. Disseminate the implementation plan to relevant clinic leadership, key stakeholders, and local evaluators.
3. Consider areas of potential adaptation to Take my Hand in the event that a nimble response is needed to respond to changes in delivery platforms or implementation processes. These areas of potential adaptation include training materials, training processes, tags and canned responses used, and Take my Hand's accessibility and functionality.

²⁸ Definition of Troll: “An Internet slang, a troll is a person who starts flame wars or intentionally upsets people on the Internet by posting inflammatory and digressive, extraneous, or off-topic messages in an online community (such as a newsgroup, forum, chat room, or blog) with the intent of provoking readers into displaying emotional responses. . . .” (see https://en.wikipedia.org/wiki/Internet_troll, accessed on 10/22/2020).

²⁹ There were many changes requested and made to the Vendor during this time to develop the website. Additional details are available upon request to the County or CalMHSA.

4. Develop an implementation plan prior to implementing practice change. Due to the goal of rapidly deploying Take my Hand in response to COVID, development of an implementation plan was not at the forefront of RUHS-BH's deployment efforts. However, an implementation plan may be developed based on the information gathered from the 10- week test phase as RUHS-BH moves forward with piloting Take my Hand in Riverside County.

Organizational Change Management

General

1. Regularly review and update Organizational Change Management plan to reflect changes in leadership, stakeholder engagement, readiness and sustainability.
2. Consider barriers and facilitators to sustainment even in early stages of planning. Create processes that support sustainment (e.g. creating opportunities for continual training, revisiting assigned responsibilities to updated changes).

Peer Support Specialists: Training, Oversight, and Experience

1. Create a structured Peer Operator training curriculum that can be adapted or modified if needed.
2. Review trainings and work collaboratively with Peers to identify any gaps in the curriculum. This might also be useful as an ongoing process as gaps might become more apparent overtime.
3. Review chats to determine how often to offer refresher courses or adapt the training curriculum.
4. Consider County limitations to hiring or contracting Peer Operators and develop a plan to address any challenges to onboarding the Peer Operators (e.g., hold a meeting with the Human Resources department and County leadership to develop a streamlined way to onboard Peers).
5. Define hours of operation for Take my Hand. If Take my Hand is operating 24/7, then a safe and secure place with stable internet connection should be identified (especially those for those individuals working the late night and early morning shifts).
6. Develop a plan to safely handle crisis events with step-by-step instructions on how to do a warm hand-off to a clinician.
7. Develop procedures to address submitted grievances by consumers.
8. Assign tasks and timing in the OCM plan to ensure Peers are allocated to specific tasks and review and training is conducted as regular times.

Technology

1. Identify the best way to integrate the approved terms of service into the Take my Hand platform.
2. Establish and define Take my Hand's cookie policy.
3. Identify the best way to convey the terms of service and cookie policy to consumers.
4. Establish a feature and procedure for consumers to submit grievances.

Evaluation

1. Define an evaluation plan that will guide how to determine whether the questions posed in the implementation effort will be answered. For example, if the question is about the optimal number of Peer Operators to support 10 unique chats per hour, then data about the user volume, length of chats, and perceived Peer Operator efficacy to respond to chats is needed.
2. Identify the most important website metrics (i.e., what RUHS-BH is trying to change or understand) and prioritize them when exporting data.
3. Develop procedures for prioritizing and exporting chat data files (i.e., total chats, Peer Operator performance measures, chat duration, chat rating, chat availability, chat engagement, chat response time, missed chats, tag usage, chat waiting time, chat abandonment etc.)
4. Identify how chat data files will be utilized within a specific County.

Implementation Phase

Pilot Implementation of Take my Hand

RUHS-BH launched Take my Hand on April 17, 2020. The testing phase lasted about 10-weeks and was completed on June 30, 2020. RUHS-BH gathered information from this testing phase and incorporated it into two COVID-19 rapid deployment reports: 1) one cataloging information developed by the RUHS-BH team, and 2) the other synthesizing data from user surveys and Peer Operator interviews. These reports were intended to help inform the Help@Hand Collaborative and document the processes that took place in the planning, development and implementation of Take my Hand. They identified key findings from the testing phase, including areas of growth, challenges experienced, and suggestions for moving forward with Take my Hand in Riverside County.

Lessons Learned

RUHS–BH Leadership

Peers

Senior Peer Support Specialists

Peer Operators

1. Identified that user volume was low and therefore manageable (chats ranged from 0-12 per day with an average number of chats being 1.85). Concerns were voiced that a higher volume of users might lead to consumers not receiving the necessary support or limit the peer support process.
2. Peer Operators recognized the value of being mindful of individual clients' needs. Standardized 'canned' responses were viewed as being less useful due to some clients reporting their responses were unhelpful.
3. Peer Operator's reported that reviewing past chats and observing chats helped to reduce their own anxiety around supporting users through a chat platform.

Technology

1. Learned that call volume fluctuates significantly. Early on in the testing phase, chat volume was its highest. Chats became less frequent as the testing phase went on over time.
2. Identified that accessing resources (on the Take my Hand platform) with Helpline information available and using "canned responses" (term used by RUHS-BH) around connecting the user with crisis-related resources was an effective alternative until a warm hand off with clinical staff could be made.
3. Recognized need to examine use and functionality of tags. Most tags fell under the "other" category due to the chat topic not fitting any of the pre-existing tags.
 - a. Other chat topics included: "depression", "COVID-19", "Already linked to RUHS-BH services", "anxiety", "positive feedback", "no response", "unemployment", "crisis intervention", "housing", "TAY" (Transitioned Aged Youth), "LGBT", "homeless", linked to SU Cares", "older adult", "resources", "food bank", "linked to Cares line", "repeat visitor", and "utilities help".

Users

1. Recognized need to continue to describe and address technical challenges. Most technical challenges reported were in regards to WiFi connectivity from both Peer Operators and clients.
2. Recognized need to continue to evaluate the visitor experience. It was noted that visitors to the Take my Hand website left the website when asked to answer questions at the start of a chat.
3. Concerns were expressed around the anonymity of users, especially if they reveal information that required mandated reporting.

Recommendations

Implementation

1. Keep a log of the various technical difficulties and how they were addressed.
2. Develop a short list of open-ended questions that Peer Operators can use at the start of chats to engage Users and retain them on the chatline (e.g., who is important in your life?).

3. Add new tags to capture life-stressors, such as relationship issues, stress, and parenting.
4. Identify strategies for supporting callers during crisis transfers.

Organizational Change Management

1. Designate payroll codes for Peer Operators to properly account for time spent working the chat.
2. Ensure clinical staff are trained on the purpose, development, and operations of Take my Hand.
3. Define what would constitute a crisis transfer from a Peer Operator to a clinician.
4. Develop a protocol for clinical staff and Peer Operators on how to engage in crisis related services over a chat or phone.
5. Train clinical staff and Peer Operators in engaging in crisis related services over a chat or phone.
6. Develop a streamlined way for Peer Operators, clinicians, and Senior Peer Support Specialists to communicate with one another.

Peer Support Specialists: Training, Oversight, and Experience

1. Train Peer Operators in exploring a user's expression of harm ideation to determine passive thoughts vs. active harm.
2. Develop and regularly review a safety protocol for assessing and managing crisis situations.
3. Develop a peer consultation and training protocol that includes reviewing and observing chats.

Technology

1. Create a feature that can be included in the website metrics data pull that captures technical difficulties on both the Peer Operator and User sides.
2. Define activities that constitute "trolling" (e.g., inappropriate use or behavior on platform) and create a protocol for how to address, de-escalate, and disengage with a "troll."
3. Post the Cookie Policy and Privacy Practices in both English and Spanish on the Take My Hand website.
4. Develop a Frequently Asked Questions page for the Take my Hand website.

Evaluation

1. Establish a technical difficulty monitoring protocol that determines the frequency of assessing and addressing technical difficulties.
2. Establish a fidelity monitoring protocol to assess the quality of support being provided through Take my Hand.
3. Monitor fidelity to the training protocol and determine the frequency of refresher training on the crisis transfer process, the ASIST model, and basics of Peer support.
4. Create a weekly or monthly Take my Hand Peer Operator consultation group to check in on issues that have come up during shifts, exploring solutions to challenges faced by users, and establish a support network for the Peer Operators.
5. Develop a safety protocol that is able to incorporate anonymous users if they disclose information that requires mandated reporting.
6. Identify relevant factors likely to influence call volume (e.g. marketing, PR, local and national events).

Sustainment Phase

Continued Delivery of Take my Hand at Scale

During the Sustainment Phase, it is recognized that the Outer Context (e.g., the OAC, CalMHSA, Statewide policies etc.) and Inner Context structures (e.g., RUHS-BH leadership, Peers, and Clients) and supports are ongoing so that Take my Hand continues to be delivered, with adaptation as necessary, to realize its public mental health impact. Take my Hand is currently preparing to expand within Riverside (to the Transition Aged Youth (TAY) population) and/or to other Counties. Because of this, there are yet no key findings, Lessons Learned, or Recommendations pertaining to the Sustainment Phase. However, the lessons learned and recommendations from the Exploration, Preparation and Implementation phases suggest the importance of returning to past phases to refine processes and apply recommendations in order to facilitate incremental growth and movement towards a sustained implementation system for Take my Hand.

APPENDIX H: HELP@HAND QUESTIONS ADDED TO CHIS

Web Version:

"Mental Health and Technology" [Mental Health and Technology] -

"AG44" [AG44] -

The next questions are about your use of technology.

People may use the internet for streaming video/music, playing games, checking social media, using apps, browsing the web, etc, on a computer or on a phone or mobile device.

On a typical day, how often do you use the internet?

- 01 Almost constantly
- 02 Many times a day
- 03 A few times a day
- 04 Less than a few times a day

"AG45" [AG45] - On a typical day, how often do you use a computer or mobile device for social media?

Social media may include Facebook, Instagram, Twitter, Snapchat, YouTube, etc

- 01 Almost constantly
- 02 Many times a day
- 03 A few times a day
- 04 Less than a few times a day

"AG46" [AG46] - In the past 12 months, have you tried to get help from an on-line tool, including mobile apps or texting services for problems with your mental health, emotions, nerves, or your use of alcohol or drugs?

- 01 Yes
- 02 No

If = 2, -3 go to AG48

"AG47" [AG47] - How useful was this?

- 01 Very
- 02 Somewhat
- 03 Not at all

"PN_AG48" [PN_AG48] -

**PROGRAMMING NOTE AG48: IF AG46 =2 AND AF81 = 1 THEN CONTINUE WITH AG48
ELSE SKIP TOAG49**

"AG48" [AG48] - What is the MAIN REASON you did not try to get help from an on-line tool, including mobile apps, or texting services?

- 1 Got better/ no longer needed
- 2 Wanted to handle problem myself
- 3 Don't own a smartphone or computer or don't have enough space to download new apps
- 4 Didn't know about these apps
- 5 Don't trust mobile apps
- 6 Concerns about privacy and security of data
- 7 Don't think it would be helpful or work
- 8 Cost
- 9 Don't have time
- 10 Received traditional/ face-to-face services
- 11 Don't think I needed it
- 12 Don't have enough space to download new apps
- 91 Other (Specify: _____)

"AG49" [AG49] - In the past 12 months, have you connected online with people that have mental health or alcohol/drug concerns similar to yours through methods such as social media, blogs, and online forums?

Include online forums or closed social media groups on specific issues, doing hashtag searches on social media, or following people with similar health conditions

- 01 Yes
- 02 No

"AG50" [AG50] - In the past 12-months, have you used online tools to find, be referred to, contact, or connect with a mental health professional?

For example, by texting, on-line messaging, video chat, or a mental health or health-related mobile app

- 01 Yes
- 02 No

CATI Version:

"Mental Health and Technology" [Mental Health and Technology] -

"AG44" [AG44] - The next questions are about your use of technology.

People may use the internet for streaming video/music, playing games, checking social media, using apps, browsing the web, etc, on a computer or on a phone or mobile device.

On a typical day, how often do you use the internet?

Would you say...

- 01 Almost constantly,
- 02 Many times a day,
- 03 A few times a day, or
- 04 Less than daily?
- 7 REFUSED
- 8 DON'T KNOW

"AG45" [AG45] - On a typical day, how often do you use a computer or mobile device for social media?
Would you say...

[IF NEEDED: "Social media may include Facebook, Instagram, Twitter, Snapchat, YouTube, etc.]

- 01 Almost constantly,
- 02 Many times a day,
- 03 A few times a day, or
- 04 Less than a few times a day?
- 7 REFUSED
- 8 DON'T KNOW

"AG46" [AG46] - In the past 12 months, have you tried to get help from an on-line tool, including mobile apps or texting services for problems with your mental health, emotions, nerves, or your use of alcohol or drugs?

- 01 YES
- 02 NO
- 7 REFUSED
- 8 DON'T KNOW

If = 2,-7,-8 goto AG48

"AG47" [AG47] - How useful was this?

- 01 VERY
- 02 SOMEHWAT
- 03 NOT AT ALL
- 7 REFUSED
- 8 DON'T KNOW

"PN_AG48" [PN_AG48] -

PROGRAMMING NOTE AG48: IF AG46 =2 AND AF81 = 1, THEN CONTINUE WITH AG48 ELSE SKIP TOAG49

"AG48" [AG48] - What is the main reason you did not try to get help from an on-line tool, including mobile apps, or texting services?

- 1 GOT BETTER/NO LONGER NEEDED
- 2 WANTED TO HANDLE PROBLEM ON OWN
- 3 DON'T OWN A SMARTPHONE OR COMPUTER OR DON'T HAVE ENOUGH SPACE TO DOWNLOAD NEW APPS
- 4 DIDN'T KNOW ABOUT THESE APPS
- 5 DON'T TRUST MOBILE APPS
- 6 CONCERNS ABOUT PRIVACY AND SECURITY OF THE DATA

- 7 DON'T THINK IT WOULD BE HELPFUL OR WORK
- 8 COST
- 9 DON'T HAVE TIME
- 10 RECEIVED TRADITIONAL/FACE-TO-FACE SERVICES
- 91 DON'T THINK I NEEDED IT
- 12 DON'T HAVE ENOUGH SPACE TO DOWNLOAD NEW APPS
- 13 Other (Specify: _____)
- 7 REFUSED
- 8 DON'T KNOW

"AG49" [AG49] - In the past 12 months, have you connected online with people online that have mental health or alcohol/drug concerns similar to yours through methods such as social media, blogs, and online forums?

[IF NEEDED: "Examples include online forums or closed social media groups on specific issues, doing hashtag searches on social media, or following people with similar health conditions."]

- 01 YES
- 02 NO
- 7 REFUSED
- 8 DON'T KNOW

"AG50" [AG50] - In the past 12-months, have you used online tools to find, be referred to, contact, or connect with a mental health professional?

[IF NEEDED: "Examples of online tools include texting, on-line messaging, video chat, or a mental health or health-related mobile app."]

- 01 YES
- 02 NO
- 7 REFUSED
- 8 DON'T KNOW

APPENDIX I: CHIS DATA BY COUNTY

MENTAL HEALTH TECHNOLOGY QUESTIONS	AGE	COUNTIES												
		LOS ANGELES	SAN DIEGO	ORANGE	RIVERSIDE	ALAMEDA	SAN FRANCISCO	SAN MATEO	KERN	SANTA BARBARA	MARIN	MONTEREY	TEHAMA, ETC.	DEL NORTE, ETC.
On a typical day, how often do you use the internet? (The numbers correspond to the percentage of participants who selected "Almost constantly" or "Many times a day")	12-17 y. o.	79.9 [72.0 ; 87.8]	75.2 [60.1 ; 90.3]	87.5 [77.8 ; 97.3]	81.3 [68.4 ; 94.3]	90.5 [76.1 ; 100]	88.5 [68.2 ; 100]	82.9 [56.4 ; 100]	68.0 [35.8 ; 100]	*	*	92.9 [79.2 ; 100]	75.8 [32.6 ; 100]	
	18-25 y. o.	90.7 [86.8 ; 94.6]	92.0 [86.5 ; 97.6]	93.1 [86.3 ; 99.9]	95.1 [87.5 ; 100]	*	93.6 [84.4 ; 100]	*	64.0 [67.3 ; 100]	95.8 [87.5 ; 100]	*	96.1 [87.9 ; 100]	81.2 [52.5 ; 100]	
	26-59 y. o.	68.7 [66.0 ; 71.5]	75.4 [71.0 ; 79.8]	70.4 [64.9 ; 75.9]	72.7 [67.6 ; 77.8]	76.2 [68.4 ; 84.0]	87.7 [81.9 ; 93.5]	85.3 [76.8 ; 93.8]	55.7 [44.4 ; 67.1]	71.3 [54.5 ; 88.0]	82.4 [74.9 ; 90.0]	76.1 [62.7 ; 89.4]	61.6 [46.7 ; 76.6]	67.8 [56.2 ; 79.3]
	60+ y. o.	36.1 [32.8 ; 39.4]	43.7 [37.0 ; 46.4]	39.6 [33.5 ; 45.6]	39.7 [33.5 ; 45.8]	40.9 [31.6 ; 50.1]	34.9 [23.3 ; 46.5]	60.4 [47.1 ; 73.7]	30.9 [19.7 ; 42.0]	38.9 [27.9 ; 49.9]	52.7 [42.7 ; 62.8]	50.1 [37.3 ; 62.9]	28.0 [20.6 ; 35.3]	34.8 [25.2 ; 44.4]
On a typical day, how often do you use a computer or mobile device for social media? (The numbers correspond to the percentage of participants who selected "Almost constantly" or "Many times a day")	12-17 y. o.	51.0 [42.0 ; 59.9]	66.9 [50.9 ; 82.9]	60.3 [45.8 ; 74.8]	77.8 [64.3 ; 91.3]	*	63.0 [32.6 ; 93.4]	82.0 [55.1 ; 100]	90.1 [75.8 ; 100]	*	77.5 [59.8 ; 100]	89.7 [74.0 ; 100]	*	
	18-25 y. o.	70.9 [65.2 ; 76.7]	69.7 [60.4 ; 79.1]	64.0 [50.7 ; 77.4]	73.1 [60.5 ; 85.8]	94.1 [85.9 ; 100]	49.2 [26.8 ; 71.7]	*	75.7 [59.4 ; 92.0]	91.5 [80.5 ; 100]	94.8 [82.5 ; 100]	*	73.2 [38.3 ; 100]	*
	26-59 y. o.	43.9 [41.3 ; 46.5]	44.6 [40.4 ; 48.8]	41.2 [35.6 ; 46.8]	46.9 [39.6 ; 54.2]	42.8 [35.3 ; 50.3]	50.5 [43.5 ; 57.5]	29.9 [20.6 ; 39.2]	31.7 [21.5 ; 41.8]	51.9 [35.3 ; 68.5]	28.5 [15.0 ; 42.0]	53.7 [36.4 ; 71.0]	34.6 [22.4 ; 46.7]	35.4 [12.4 ; 46.5]
	60+ y. o.	17.4 [14.6 ; 20.2]	15.6 [12.6 ; 18.5]	13.9 [10.5 ; 17.2]	20.4 [15.4 ; 25.4]	17.9 [10.0 ; 25.9]	16.2 [7.6 ; 24.8]	19.7 [10.9 ; 28.4]	14.8 [6.6 ; 23.0]	14.8 [6.6 ; 23.0]	20.3 [8.4 ; 32.2]	14.4 [7.4 ; 21.4]	15.3 [10.1 ; 20.4]	13.9 [7.5 ; 20.3]
DISTRESS LEVEL		COUNTIES												
On a typical day, how often do you use the internet? (The numbers correspond to the percentage of participants who selected "Almost constantly" or "Many times a day")	None to low	37.8 [35.2 ; 60.4]	65.9 [62.7 ; 69.2]	60.8 [56.7 ; 64.8]	38.5 [32.6 ; 64.4]	65.1 [58.6 ; 71.6]	77.3 [70.5 ; 84.1]	77.1 [67.8 ; 86.3]	54.9 [45.5 ; 64.4]	58.1 [46.1 ; 70.0]	73.9 [64.8 ; 82.9]	68.6 [57.0 ; 80.2]	55.0 [43.6 ; 66.4]	49.3 [36.7 ; 59.9]
	Medium	77.3 [72.3 ; 82.4]	73.5 [64.9 ; 82.1]	81.1 [73.2 ; 88.9]	83.2 [75.2 ; 93.1]	82.2 [75.0 ; 91.4]	95.7 [90.7 ; 100]	88.8 [76.0 ; 100]	58.7 [35.6 ; 89.9]	84.4 [68.6 ; 100]	37.3 [25.3 ; 89.3]	85.4 [61.8 ; 100]	58.2 [32.0 ; 84.4]	37.5 [34.4 ; 80.5]
	High	82.5 [77.5 ; 87.5]	88.3 [81.6 ; 95.1]	85.1 [75.0 ; 95.2]	87.6 [81.1 ; 94.2]	77.9 [61.3 ; 94.5]	68.6 [48.0 ; 88.1]	93.2 [84.8 ; 100]	47.6 [24.1 ; 71.0]	95.3 [89.7 ; 100]	93.7 [85.6 ; 100]	95.3 [87.3 ; 100]	47.6 [19.7 ; 75.4]	69.6 [45.7 ; 93.6]
	None to low	35.0 [32.7 ; 37.4]	38.0 [34.7 ; 41.3]	32.2 [27.5 ; 36.9]	34.2 [28.3 ; 40.0]	36.9 [30.6 ; 43.1]	42.6 [35.8 ; 49.4]	24.3 [15.6 ; 33.0]	31.2 [23.5 ; 38.9]	47.2 [35.1 ; 59.3]	36.0 [19.5 ; 52.5]	45.7 [32.2 ; 59.1]	34.7 [22.2 ; 47.2]	22.9 [15.5 ; 30.3]
On a typical day, how often do you use a computer or mobile device for social media? (The numbers correspond to the percentage of participants who selected "Almost constantly" or "Many times a day")	None to low	37.1 [35.3 ; 62.8]	43.4 [35.0 ; 53.8]	38.5 [45.4 ; 71.5]	66.7 [53.6 ; 79.9]	59.2 [48.7 ; 69.8]	46.3 [24.2 ; 68.4]	35.8 [31.8 ; 79.9]	45.6 [25.6 ; 67.6]	*	*	68.4 [32.5 ; 100]	*	
	Medium	59.6 [53.8 ; 65.4]	59.8 [49.8 ; 69.7]	52.9 [38.3 ; 67.6]	60.4 [46.2 ; 72.6]	54.2 [35.0 ; 73.5]	45.2 [24.5 ; 65.6]	*	46.4 [23.9 ; 68.9]	81.0 [62.0 ; 100]	*	68.4 [32.5 ; 100]	*	
	High													
	DISTRESS LEVEL		COUNTIES											
On a typical day, how often do you use the internet? (The numbers correspond to the percentage of participants who selected "Almost constantly" or "Many times a day")	None to low	76.8 [65.2 ; 88.3]	62.9 [36.5 ; 89.2]	87.2 [74.6 ; 99.9]	80.6 [60.4 ; 100]	78.3 [36.1 ; 100]	*	94.4 [81.8 ; 100]	*	*	*	82.8 [46.2 ; 100]	91.5 [73.3 ; 100]	
	Medium	77.6 [44.7 ; 100]	76.4 [37.3 ; 100]	80.7 [42.3 ; 100]	72.8 [34.0 ; 100]	95.1 [86.2 ; 100]	*	*	*	*	*	*	*	
	High	84.9 [72.3 ; 97.6]	*	94.1 [85.3 ; 100]	90.5 [78.0 ; 100]	*	81.5 [49.8 ; 100]	*	*	*	*	*	*	
	None to low	42.5 [30.2 ; 54.9]	57.8 [31.7 ; 83.8]	60.9 [41.5 ; 80.4]	72.3 [48.2 ; 96.5]	*	*	91.1 [74.9 ; 100]	86.2 [62.7 ; 100]	*	*	81.8 [36.4 ; 100]	74.9 [34.1 ; 100]	
On a typical day, how often do you use a computer or mobile device for social media? (The numbers correspond to the percentage of participants who selected "Almost constantly" or "Many times a day")	None to low	78.0 [56.9 ; 99.2]	79.0 [50.5 ; 100]	72.1 [33.9 ; 100]	81.6 [49.4 ; 100]	*	*	*	*	*	*	*	*	
	Medium													
	High	53.2 [37.0 ; 69.5]	71.6 [44.6 ; 98.7]	*	83.0 [64.2 ; 100]	*	81.5 [49.8 ; 100]	*	*	*	*	*	*	
	DISTRESS LEVEL		COUNTIES											

The numbers indicated within brackets represent the 95% confidence interval of these estimates.

The "*" are used for the cross-tabs for which the sample was too small, no respondents were in that category, or the estimates were unstable.

help @ hand™ Evaluation

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