San Mateo County Health System

Behavioral Health and Recovery Services

Mental Health Services Act (MHSA)

Annual Update for MHSA Programs and Expenditures Fiscal Year 2015-2016

WELLNESS • RECOVERY • RESILIENCE

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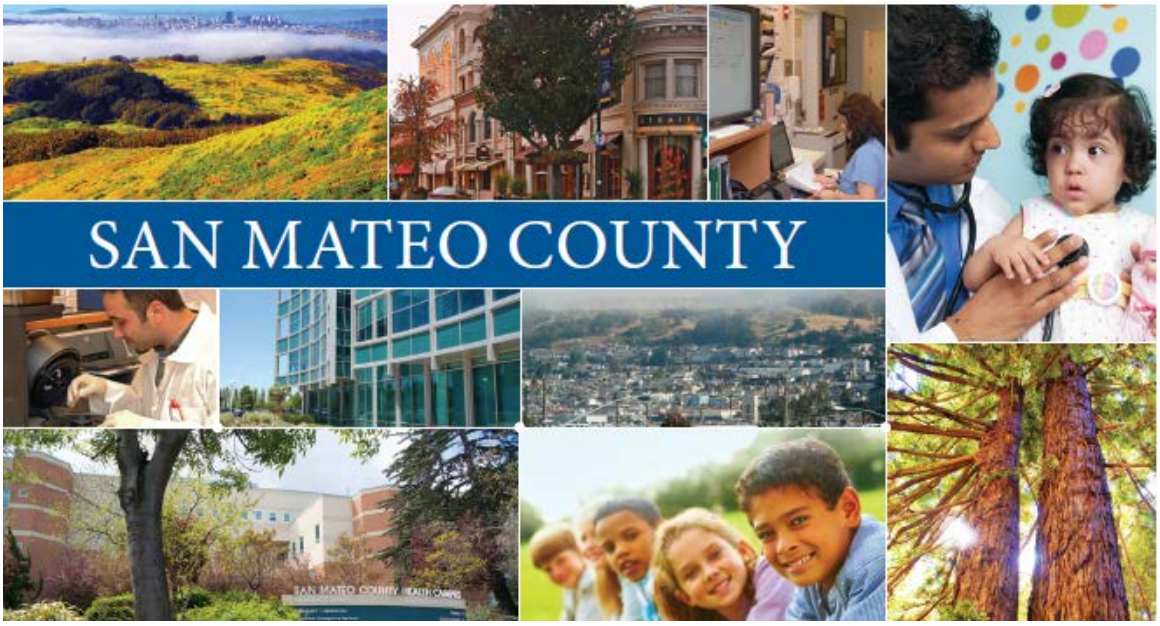
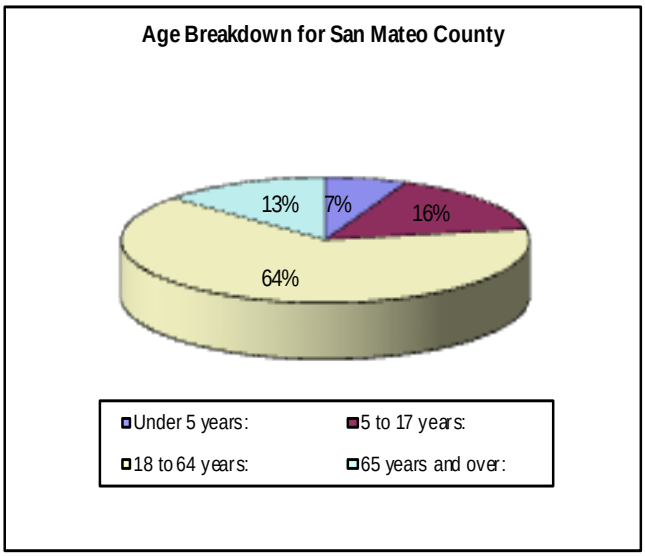
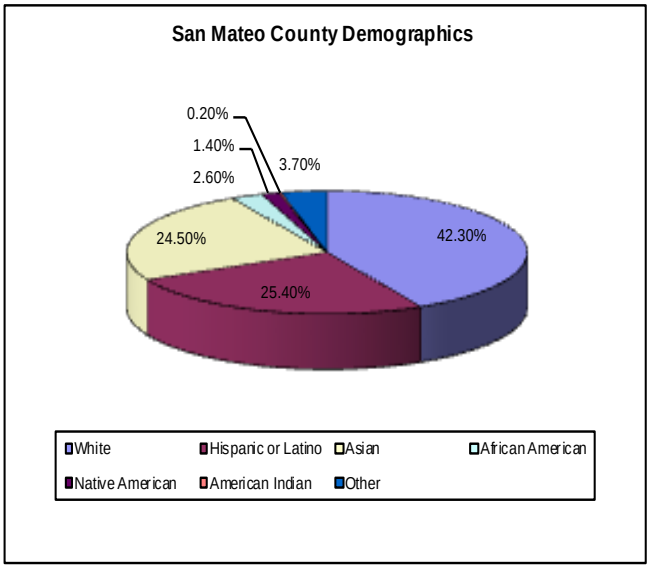


Home to 739,311 people (2012 estimate, US Census); San Mateo is a diverse county, both in terms of population and geography.





Starting January 1, 2015, San Mateo County's threshold languages will be English, Chinese, Spanish, and Tagolog. The Health System identified Russian and Tongan as priority languages based on clients served. Data indicate that 45.6% of individuals age five and older served speak a language other than English at home (U.S. Census data, July 2014).

Geography: Located on the San Francisco Peninsula, stretching from the Pacific Ocean to the San Francisco Bay, the County is known for a mild climate and scenic vistas.

Nearly three quarters of the County's 455 square miles is open space.

The County has a diverse geography—including abundant farmland on a geographically isolated, rural coast, redwood forests, wetlands, creeks, and rolling hills, and includes suburban/urban features.

CRYSTAL SPRINGS RESERVOIR

San Mateo County is made up of 20 cities, as well as unincorporated areas. The County is home to numerous park and recreation areas, and much of the shoreline along the San Francisco Bay is part of the San Francisco Bay Trail. This trail provides residents and visitors alike with miles of biking and walking trails.

Cultural and Economic Diversity: The County's cultural diversity is in part due to it being home to the San Francisco International Airport and being positioned between San Francisco, a popular tourist destination, and the Silicon Valley. San Mateo County is also home to the Port of Redwood City, which is the only deep water port in the Southern part of the San Francisco Bay. The County also houses two smaller airports—San Carlos and Half Moon Bay Airports, which serve important business and emergency services functions. The transportation hubs located here contribute to the County's cultural and economic vitality.

SAN FRANCISCO INTERNATIONAL AIRPORT (ABOVE)

PORT OF REDWOOD CITY (RIGHT)

STAKEHOLDER INPUT

Background

Since the inception of the Mental Health Services Act (MHSA), San Mateo County Behavioral Health and Recovery Services (BHRS) made a conscious decision to promote a vision of collaboration and integration by embedding MHSA programs and services within existing programmatic and administrative structures. 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.

One of these system-wide planning and transformation activities is the Community Service Area (CSA) model development that was undertaken in 2012, by BHRS. CSAs provided a perfect opportunity to explore what integration could look like for San Mateo County by bringing together local resources from different fields—education, health care, nonprofits, faith-based organizations, law enforcement and others—together to connect people to mental health or substance use prevention, treatment, and recovery supports in designated areas in the county. The following regional CSA's were established; officially shifting the entire County and MHSA activities to this new service delivery approach:

- South CSA (San Carlos, Redwood City, Woodside, Atherton, West Menlo Park, Portola Valley)
- Central CSA (Burlingame, Hillsborough, San Mateo, Foster City, Belmont)
- Coastside CSA (Half Moon Bay, La Honda, Pescadero)
- East Palo Alto CSA (East Menlo Park, East Palo Alto)
- Northwest CSA (Daly City, Pacifica, Colma)
- Northeast CSA (Brisbane, South San Francisco, San Bruno, Milbrae)

Since the last MHSA Annual Update, stakeholder convenings were completed and the Community Advisory Committees (CAC) in each CSA launched. Each CSA has hosted at least one community event and CAC's are meeting regularly to implement their action plans.

The community-driven stakeholder convenings focused on tailoring the CSA model to the needs of specific geographical areas and developing action plans to guide the work moving forward. Each CSA is guided by a Community Advisory Committee, along with a CSA Manager. The committees are comprised of 51% clients and family members and are the heart and soul of the stakeholder process. These permanent committees will have an important role in the local system transformation, its values, activities and directions. And they will also have an important role in MHSA planning. These are permanent ongoing committees that build consumer feedback into the planning process in a foundational way.

For more on the CSA model please visit www.smchealth.org/BHRSGoodModern.

Community Input Process

In 2005, BHRS devised a local planning process and structure to seek input from the broad San Mateo County stakeholder community for the implementation of the initial component of the MHSA, Community Services and Supports. This planning and input structure has remained in place and has since framed all the planning activities related to MHSA.

The Mental Health and Substance Abuse Recovery Commission (MHSARC), formerly the Mental Health Board, as a whole and through its committee structure, is involved in all MHSA planning activities providing input and receiving regular updates. The meetings of the MHSARC are open to the public, and attendance is encouraged through various means: notice of meetings (flyers, emails) are sent to a broad, increasing network of contacts including community partners and County agencies, as well as consumer and advocacy organizations, and the general public. There is an MHSA update as a standing item on the MHSARC monthly meeting agenda.

The MHSA Steering Committee was also created in 2005 and makes recommendations to the planning and services development process. As a group, the Steering Committee 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 is co-chaired by a member of the San Mateo County Board of Supervisors and by the Chair of the MHSARC. Comprised of over 40 community leaders representing the diverse San Mateo community including behavioral health constituencies (clients, advocates, family members, community partners, County and CBO staff), and non-behavioral health constituencies (County leadership, Education, Healthcare, Criminal Justice, Probation, Courts, among others). Additionally, all members of the MHSARC are members of the MHSA Steering Committee.

MHSA implementation is very much a part of BHRS' day-to-day business. Information is shared and input collected with a diverse group of stakeholders on an ongoing basis. All the MHSA information is made available to stakeholders on the San Mateo County Behavioral Health and Recovery Services MHSA webpage, www.smchealth.org/bhrs/mhsa. The site includes a subscription feature to receive an email notification when the website is updated with MHSA developments, meetings and opportunities for input. This is currently at over 800 subscribers, increased 300+ in the last year. Hard copies of materials are made available upon request.

The BHRS's e-journal, Wellness Matters is published the first Wednesday of every other month and distributed electronically and serves as an information dissemination and educational tool, with a standing column written by the County's MHSA Manager. In addition, presentations and ongoing progress reports are provided by BHRS, and input is sought on an ongoing basis at the monthly MHSARC meeting at the MHSA Steering Committee meeting; at meetings with community partners and advocates; and internally with staff.

Mental Health Services Act Steering Committee Members *(new members are highlighted yellow)*

Stakeholder Group	Name(s)	Title (if applicable)	Organization (if applicable)
Consumer/Client and Veterans	Edmund Bridges*	Chair, MHSARC	
SMC District 1	David Pine*	Supervisor, District 1	Board of Supervisors *Co-chairs, MHSARC
African American Community	Sheri Broussard	African American Community Health Initiative	HIP Housing
Aging & Adult Service Provider	Michelle Makino	Community Program Supervisor	SMC Health System, Aging & Adult Services
AOD Service Provider	Clarise Blanchard	Director of Substance Abuse & Co-occurring Disorders	Star Vista and BHRS Contractors Association
AOD Service Provider	Ray Mills	Executive Director	Voices of Recovery
Chinese Community	Michael Lim		Chinese Health Initiative
Client Advocate	Randall Fox	Health Policy Advocate	
Consumer/Client	Patrick Field		
Consumer/Client - Adult	Cardum Harmon	Executive Director	Heart & Soul, Inc.
Consumer/Client – Older Adult	Carmen Lee	Program Director	Stamp Out Stigma
Consumer/Client Liaison	Jairo Wilches	Liaison and BHRS Wellness Champion	BHRS, Office of Family and Consumer Affairs
Courts	Rodina Catalano	Deputy Crt Exec Officer	Superior Court
Disabilities Community	David DeNola		Center for Independence
Disabilities Community	Maisoon Sahouria		Center for Independence
Disabilities Community	Vincent Merola		Center for Independence
East Palo Alto Community	Reverend William Chester McCall		Multicultural Counseling and Education Services of the Bay Area (MCESBA)
East Palo Alto Community	Shanna ‘Uhila		East Palo Alto Behavioral Health Advisory Group
East Palo Alto Community	Tiffany Hautau		East Palo Alto Behavioral Health Advisory Group
Education	Joan Rosas	Superintendent	San Mateo-Foster City Elementary School District
Family Member	Patricia Urbina		
Filipino Community	Athila Lambino		Filipino Mental Health Initiative
Health Care Organization	Dan Becker	Medical Director	Mills Peninsula Health Svcs
Health Care Organization	Gina Wilson	Financial Svcs Mngr	San Mateo County Health System
Health Care Organization	Louise Rogers	Deputy Chief	San Mateo County Health System
Health Care Organization	Maya Altman	Executive Director	Health Plan of San Mateo
Latino Community	Hector Moncada		Latino Collaborative
Law Enforcement	Eric Wollman	Chief	Burlingame Police
LGBTQQI Community	Lauren Szyper		PRIDE Initiative

LGBTQQI Community	Susan Takalo		PRIDE Initiative
Native American Community	Gloria Gutierrez	MH Counselor	BHRS
North County Community	Mary Bier		North County Outreach Collaborative
Pacific Islander Community	Agnes Tuipulotu		Pacific Islander Initiative
Pacific Islander Community	Juliet Vimahi		Pacific Islander Initiative
Service Provider	Cori Manthorne		Community Overcoming Relationship Abuse - CORA
Service Provider	Lynn Schuette		Community Overcoming Relationship Abuse- CORA
Service Provider - Adult	Juliana Fuerbringer		NAMI, The Clubhouse
Social Service Provider	Melissa Platte	Executive Director	Mental Health Association
South Coastside Community	Joann Watkins	Clinical Director	Puente de la Costa Sur
Spirituality Community	Vacant		Spirituality Initiative

Mental Health and Substance Abuse Recovery Commission (MHSARC). MHSARC commissioners are members of the Steering Committee. *(new members are highlighted yellow)*

Stakeholder Group	Name(s)	Title (if applicable)	Organization (if applicable)
Consumer/Client and Veterans	Edmund Bridges	Chair, MHSARC	
SMC District 1	David Pine	Supervisor, District 1	Board of Supervisors
SMC District 1	Randy Torrijos	Staff to David Pine	Board of Supervisors
Consumer/Client	Patrisha Ragins		
Consumer/Client	Rocio Cornejo		
Consumer/Client	Rodney Roddewig		
Consumer/Client	Wanda Thompson		
Consumer/Client - SA	Carol Marble		
Consumer/Client - SA	Kathleen Bernard		
Family Member	Cameron Johnson		
Family Member	Judith Schutzman		
Family Member	Patricia Way		
Family Member	Sharon Roth		
Law Enforcement	Dan DeSmidt		
Public	Valerie Gibbs		
Public	Josephine Thompson		
Public	Betty Savin		
	Debbra Yamaguchi		
	Michael Horgan		

Public Comment and Public Hearing

This Annual Update was presented to a combined MHSARC and MHSA Steering Committee meeting on November 4, 2015. At this meeting the MHSARC released the full document, Annual Update for MHSA Programs and Expenditures Fiscal Year 2015-2016 (covering program highlights and data from FY 2013-2014 programs), for a 30-day public comment. The MHSARC held a public hearing on December 2, 2015 to close the public comment period on December 4, 2015.

[To be added: Please see Appendix 1 for all public comments received during the planning phase and the 30 day public comment period.]

The final steps include a presentation to the Board of Supervisor for adoption of the plan and to the Controller to certify expenditures.

OUTREACH STRATEGIES

Outreach strategies used to circulate information about the availability of the plan and request for public comment include:

- Flyers created and sent to/placed at County facilities, as well as other venues like family resource centers and community-based organizations;
- Numerous internal and external community meetings;
- Information through program activities (Parent Project, Health Ambassador Program, Lived Experience Academy, Mental Health First Aid trainings, etc.);
- E-mails disseminating information to over 1,800 electronic addresses;
- Notices published in local news outlets;
- Word of mouth on the part of committed staff and active stakeholders,
- MHSA webpage smchealth.org/bhrs/mhsa and the BHRS Blog smcbhrsblog.org/

Priority Expansions and Programs from Three-Year Plan

Priorities identified by stakeholders in previous planning years remained top priorities and were included in the updated priority expansions that were developed through the recent Three-Year Plan Community Program Planning process; the following projects/programs were prioritized for funding as revenue becomes available.

Component	Updated Priority Expansions FY 2014-17	Implemented
Community Services & Supports (CSS), Full Service Partnerships (FSP)	Support and assistance program to connect MI with vocational, social and other services	YES FY 14/15
	Drop-in Center (South)	Expected FY 15/16
	FSP slots for transition age youth with housing	Expected FY 15/16
	FSP slots for older adults	Expected FY 15/16
CSS, Non-FSP	Expansion of supports for transition age youth	Expected FY 15/16
	Expansion of supports for older adults	Expected FY 15/16
Prevention & Early	Culturally aligned and community-defined	Expected FY 15/16

Intervention (PEI)	outreach with a focus on emerging communities and outcome-based practices	
	Expansion of Stigma Free San Mateo, Suicide Prevention and Student Mental Health efforts	Expected FY 15/16

FUNDING SUMMARY

FY 2015/16 Mental Health Services Act Annual Update

Funding Summary

County: San Mateo Date: 12/3/15

	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 2015/16 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	5,603,396	3,501,776	4,298,992	1,207,228	0	
2. Estimated New FY 2015/16 Funding	19,147,840	5,106,091	1,276,523			
3. Transfer in FY 2015/16[a/]	0	0	0	0		0
4. Access Local Prudent Reserve in FY 2015/16	0	0	0			0
5. Estimated Available Funding for FY 2015/16	24,751,236	8,607,867	5,575,515	1,207,228	0	
B. Estimated FY 2015/16 MHSA Expenditures	16,984,504	5,735,963	1,800,000	442,435	0	
G. Estimated FY 2015/16 Unspent Fund Balance	7,766,732	2,871,904	3,775,515	764,793	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2015	600,000
2. Contributions to the Local Prudent Reserve in FY 2015/16	0
3. Distributions from the Local Prudent Reserve in FY 2015/16	0
4. Estimated Local Prudent Reserve Balance on June 30, 2016	600,000

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

FY 2015/16 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: San Mateo Date: 10/30/15

		Fiscal Year 2015/16					
		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.	Youth /TAY	6,783,459	3,372,793	989,548	54,688	791,638	1,781,445
2.	Adults and Older Adults	6,208,545	4,399,228	1,727,144	0	0	82,173
3.	PES and 3AB FSP Expansion	116,735	116,735	0	0	0	0
4.	Supports and assistance for SMI	300,000	300,000	0	0	0	0
5.	Drop-in Center (South)Expansion*	480,474	480,474	0	0	0	0
6.	10 FSP slots for TAY, housing Expansion*	230,000	230,000				
7.	5 FSP slots for older adults Expansion*	57,500	57,500				
8.	Wraparound services for C/Y*	90,000	90,000				
9.		0					
10.		0					
11.		0					
12.		0					
13.		0					
14.		0					
15.		0					
16.		0					
17.		0					
18.		0					
19.		0					
Non-FSP Programs							
1.	Community Outreach and Engagement	1,147,087	1,063,170	68,551	0	0	15,366
2.	Criminal Justice Initiative	504,772	504,772	0	0	0	0
3.	Older Adult System of Care	560,862	552,368	0	0	0	8,494
4.	System Transformation	6,636,182	5,396,937	851,754	55,601	222,404	109,486
5.	Supports for TAY Expansion*	70,000	70,000				
6.	Supports for Older Adults Expansion*	65,000	65,000				
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					
CSS Administration		707,182	285,527	128,783	86,462	97,308	109,103
CSS MHSA Housing Program Assigned Funds		0					
Total CSS Program Estimated Expenditures		23,957,798	16,984,504	3,765,780	196,751	1,111,350	2,106,067
FSP Programs as Percent of Total		84.0%					

*2 Quarters

FY 2015/16 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: San Mateo Date: 12/3/15

		Fiscal Year 2015/16					
		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	378,043	367,032	0	0	0	11,011
2.	Community Outreach and Engagement and Capacity Building	3,580,654	3,205,302	298,551	0	0	76,801
3.	Total Wellness for Adults and Older Adults	366,367	363,367	0	0	0	3,000
4.	Community Interventions for School Age and	511,518	506,814	0	0	0	4,704
5.	Expansion of outreach to emerging communities	75,000	75,000				
6.	Expansion of SMSMC, Suicide Prevention and Student Mental Health	25,000	25,000				
7.	CalHMSA Sustainability	90,508	90,508				
8.		0					
9.		0					
10.		0					
PEI Programs - Early Intervention							
11.	Youth/TAY Identification and Early Referral	85,189	18,128	0	0	0	67,061
12.	Primary Care/Behavioral Health Integration for Adults	20,211	8,551	0	0	0	11,660
13.	Early Onset of Psychotic Disorders	800,000	800,000				
14.		0					
15.		0					
16.		0					
17.		0					
18.		0					
19.		0					
20.		0					
PEI Administration		285,077	276,261	0	0	0	8,816
PEI Assigned Funds		0					
Total PEI Program Estimated Expenditures		6,217,567	5,735,963	298,551	0	0	183,053

FY 2015/16 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: San Mateo Date: 10/30/15

		Fiscal Year 2015/16					
		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.	New Innovation Programs	1,800,000	1,800,000				
2.		0					
3.		0					
4.		0					
5.		0					
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		1,800,000	1,800,000	0	0	0	0

FY 2015/16 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: San Mateo Date: 12/2/15

	Fiscal Year 2015/16					
	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. Workforce Staffing Support	244,043	236,077				7,966
2. Training and Technical Assistance	124,550	123,503				1,047
3. Behavioral Health Career Pathways	37,000	35,455				1,545
4. Internship Program	100,000	47,400				52,600
5.	0					
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					
WET Administration	0					
Total WET Program Estimated Expenditures	505,593	442,435	0	0	0	63,158

FY 2015/16 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: San Mateo Date: 10/30/15

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

FUNDING CONSIDERATIONS

Due to the shift at the State level prompted by AB 100, commencing on July 1, 2012, the County began receiving monthly MHSA allocations based on actual accrual of tax revenue. Since the State no longer provides an estimate of funding available to counties, it is impossible to know the exact allocation. We base the planning on various projections that take into account information produced by the State Department of Finance, analyses provided by the California Behavioral Health Director's Association, and ongoing internal analyses of the State's fiscal situation.

When the new modality for the disbursement of MHSA revenue to counties was first implemented, there were funds in the Mental Health Services Funds (State level) waiting to be disbursed. These funds became a "one time" allocation that was sent in September of 2012 along with receipts from July, August and September.

Changes in the tax law that took effect on January 1, 2013, led to many taxpayers filing in December 2012 in order to avoid paying higher taxes. This resulted in an additional "one time" increase in funding in FY 2013-14. A similar one-time distribution was received at the beginning of FY 2014-15.

During the Three-Year Plan and FY 2014-15 Annual Update, significant decrease in PEI revenue was projected and BHRS anticipated having overall spending in the Three-Year Plan to decrease as well to make up for this deficit. For this FY 2015-16, revenue is still projected to decrease, by 10%. Nonetheless, current projections anticipate a subsequent 20% increase FY 2016-17. These fiscal updates along with estimated unspent funds from previous years and some savings from the Total Wellness (now funded by the Health Plan of San Mateo) program components that were covered under PEI, will allow for implementation of the MHSA priority expansions identified in the Three-Year Plan.

The prudent reserve remains at $600,000. The County has been reluctant to build up the reserve because the process for accessing was initially unclear. The prudent reserve concept was included in the MHSA as a provision to ensure that unforeseen decreases in the revenue would not cause program to cease. We believe in this concept, and have actually managed significant fluctuations in MHSA funding with this same philosophy. However, we have preferred to leave unspent funds in an MHSA Trust Fund instead of constituting a reserve we weren't sure we would be able to access if/when funds would be needed.

INNOVATION PROJECT PLANS

(New Plans being submitting for approval)

Innovation Project ideas were presented by community stakeholders and partner agencies as part of the comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan FY 2014-2017. The Innovation ideas were brought to the San Mateo County MHSA Steering Committee in March 2015 by stakeholders, MHSA Steering Committee members and BHRS staff and stakeholders in the form of potential projects. The Steering Committee made recommendations on which projects to move forward for further exploration and prioritized 5 Innovation Projects for possible funding:

Category*	Project / Next Step	Estimated cost per year
Alternative Healing Practices	NMT expansion to adults (Expansion)	$100,000
Client Advocacy	Youth Health Ambassador Program (RFP Release 12/15/15)	$250,000
LGBTQQI	Coordinated LGBTQQI services (RFP Release 1/15/16)	$700,000
Housing	TBD (no LOI's received)	TBD
Technology Innovations	Social media and texting for youth in crisis (Expansion**)	$100,000
	Client lifestyle data tracking app (Pilot followed by RFP)	$200,000

*listed in order of Steering Committee prioritization
**StarVista currently runs the youth crisis line for San Mateo County

A Letter of Interest process further identified capacity, interest and allowed us to hone in on the project innovation. A Request for Proposal (RFP) process is currently in selection phase for the Health Ambassador Program - Youth (HAP-Y), released December 15, 2015 and the LGBTQ Coordinated Services, released January 15, 2016. These two projects along with the Neurosequential Model of Therapeutics (NMT) expansion to adults are being included for approval with this Annual Update, see Appendix 2 for the full Innovation Project Plans. The additional two technology-related projects are still in development.

(covering highlights and data from FY 2013-2014 services)

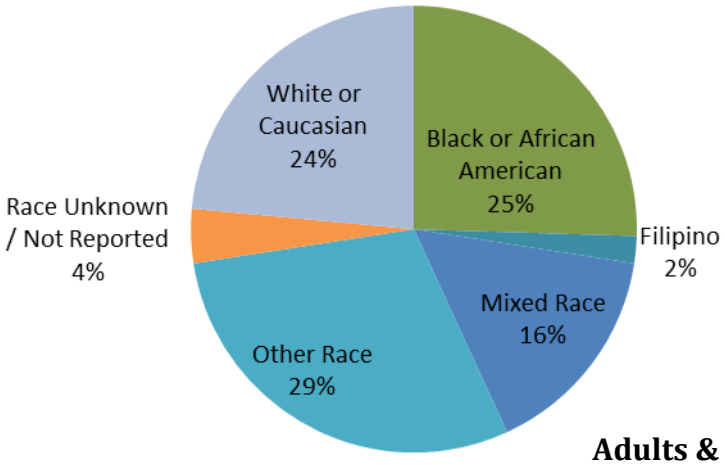
Community Services and Supports (CSS) – Full Service Partnership (FSP)

In FY 2013-14, 482 clients of all age groups were served by FSPs in San Mateo County. There are currently four comprehensive FSP providers, Edgewood Center and Fred Finch Youth Center serve children, youth and transition age youth (C/Y/TAY) and Caminar and Telecare serve adults and older adults. Edgewood, Fred Finch, and Telecare FSPs have been fully operational since 2006. Caminar's Adult FSP, was added in 2009.

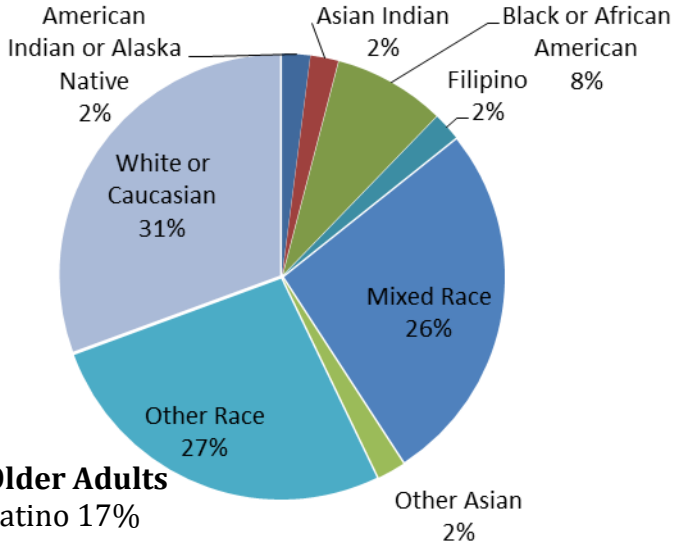
FSP DEMOGRAPHICS FOR FY 13/14

Race, ethnicity by age group

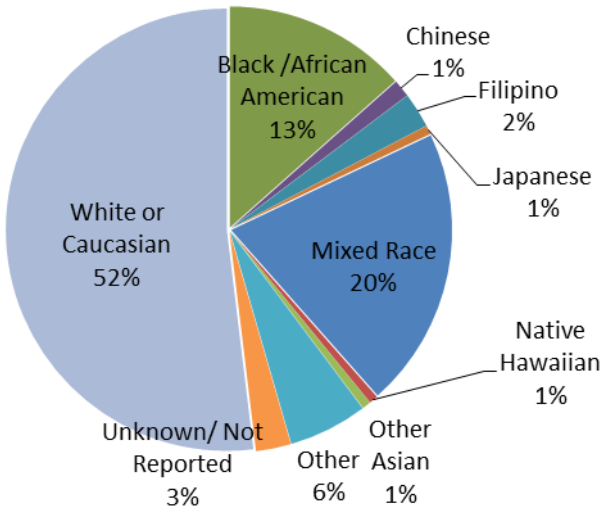
Child & Youth
Hispanic/Latino 39%



Transitional Age Youth
Hispanic/Latino 39%



Adults & Older Adults
Hispanic/Latino 17%



FSP COST PER CLIENT

Based on currently contracted amounts, the average FSP cost per client was $23,403, based on number of slots, with age breakdowns as shown in the table below. Cost-per-person figures do not fully reflect 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.

Program	Clients served	MHSA funded slots	Cost per client
Children/Youth FSP's	**130**	**80**	**$39,718**
Children/Youth in Out-of-County Foster Care Settings FSP	23	20	$26,982*
Integrated Clinic and School-based Services FSP	56	40	$31,412*
"Turning Point" Comprehensive FSP	51	40	$34,532*
Transitional Age Youth (TAY) FSP's	**49**	**40**	**$34,532**
"Turning Point" Comprehensive FSP	49	40	$34,532*
Enhanced Supported Education Services	45	N/A	$3,655
Supported Housing Services	16	20	$10,000*
Adult/Older Adult FSP's	**303**	**252**	**$16,457**
Adult and Older Adult/Medically Fragile FSP	237	207	$15,603*
FSP Housing Support	90	90	$14,335
Comprehensive FSP and Housing Support	35	30	$27,008*
Integrated FSP	31	15	$7,133*

*Cost per client calculated based on # of slots

FSP PERFORMANCE OUTCOMES

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 through June 30, 2014, demonstrate notable improvements across two key dimensions for FSPs, Hospitalizations and Psychiatric Emergency Service (PES) visits.

- **Hospitalizations** decreased significantly after FSP enrollment, ranging from 11 percentage points for clients enrolled one year to over 20 percentage points for clients enrolled 5 years or more.
- **Number of hospital days** experienced by clients decreased from 5 days for clients enrolled for one year or more to 13 days for clients enrolled five years or more.
- **Psychiatric Emergency Services (PES) visits** decreased significantly ranging from 12 percentage points for clients enrolled one year or more to 17 percentage points for clients enrolled 5 years or more.
- **PES admissions** decreased significantly ranging from .5 to 1 less PES admission per client per year.

In addition, the following is a summary of some key data outcomes for 788 clients of the FSP program, who were served by Edgewood (365), Caminar (350) and Telecare (73) through June 30, 2014. Edgewood served Child clients (aged 6-21) and Transition Age Youth (TAY) clients (aged 17-25. Telecare and Caminar served primarily Adult clients (N = 333 aged 26-59). Some clients began FSP as TAY (N = 27, aged 17 – 25), and some clients began FSP as an Older Adult (OA) (N = 63, aged 60+). A full report of outcomes developed by the American Institute for Research in partnership with BHRS, will be available in January 2016.

Percent change from before enrollment to during one year of the FSP

Outcome	Child, Youth and TAY (227)**	Adult & Older Adult* (317)**
Unemployment		-14%
Homelessness	N/A (<10 data points)	-21%
Mental Health Emergency	-77%	-49%
Incarceration	-9%	-25%
Arrests	-67%	-90%
School Suspension	-51%	
School Attendance	77%	
Out-of-home placement (at discharge)	-17%	

*A small number (6) of the Adult & Older Adults in this sample began FSP as TAY
**The data represents clients that completed at least one year of FSP services.

About 10% of these individuals enrolled discontinue their services then reestablished their services, greater than 1 year after discontinuing. If an individual returns within one year of their initial discontinuation from the program, then they are not considered a new enrollment.

FSP PROGRAMMATIC HIGHLIGHTS FOR FY 13/14

Children and Youth Placed in Out-of-County Foster Care Settings

Background - Fred Finch Youth Center (FFYC) provides a wraparound-services model in the East Bay Wrap Full Service Partnership (EBW-FSP) to promote wellness, self-sufficiency, and self-care/healing to youth who are San Mateo County Court Dependents who now live out of County. When foster youth live out of their court dependent county, they often have difficulty accessing mental health services. The wraparound model helps provide intensive community based care that is rooted in a strengths-based approach. The youth and family receive individualized services to maximize families' capacity to meet their child's needs and thereby reduce the need for residential placement. All youth in the EBW-FSP are members of the sub-class for Katie A. services.

To be eligible for EBW-FSP, youth must live outside of San Mateo County and demonstrate medical necessity. Child Welfare Workers refer youth to the program. BHRS screens the referrals through the inter-agency placement review committee process. After approval, the FFYC Program Manager receives notification that a specific youth has been authorized to receive services and staff coordinates a start date. Recommendations for interim care, including psychiatric and emergency care, are given as needed.

Services are aimed at helping youth strengthen safe and healthy relationships, develop coping strategies and connect care givers and youth to support in their communities (both community and natural supports). The main goal of the EBW-FSP is to assist with "placement stability" and a reduction in mental health symptoms. This is accomplished using an active, individualized and family driven plan of action.

The EBW-FSP team can consist of a combination of staff including a Care Coordinator, Psychiatrist, Youth Partner and Parent Partner. Families have access to on-call clinician to help during crisis and encourage de-escalation techniques.

Demographics -Total enrollment – 23

- Gender – 57% Female; 43% Male
- Home language – 100% English
- Ethnicity/Race – 30% Hispanic/Latino
    - 35% Black/African American
    - 17% Mixed/Multi-racial
    - 13% White/Caucasian
    - 7% Other
    - 4% Chinese

From July 1, 2013-December 31, 2013 report:

- Admissions – 2
- Discharges – 0

Outcomes - 80% report decrease in mental health symptoms; 70% report their placement as "stable;" 65% report improved caregiver relationship. This information is gathered from a Community Functioning Evaluation (CFE),

From January 1, 2014-June 30, 2014 report:

- Admissions – 1
- Discharges – 2

Outcomes – 87% report decrease in mental health symptoms; 53% report their placement as "stable" or not worsening; 67% report improved caregiver relationship. This information is gathered from a Community Functioning Evaluation (CFE).

Two youth closed service, 1 youth began college at SFSU and he was attending and stable at the time he ended services. He was living in a stable housing situation and had plans to move with peers to be closer to campus. The other youth closed to services was returned home to his mother. FFYC worked to help the family get set up with local services.

The program continues to remain fully staffed in the Care Coordinator and Parent Partner positions with a newly hired a Youth Partner. FFYC program is committed to hiring people with lived experience and will continue to find ways to support this type of employee.

Challenges - A current challenge is the difficulty in getting all parties to attend the Child and Family Team Meetings (CFTs). Over this past year, there has been some improvement in this area, perhaps due to Katie A. requirements. The program still holds the meetings without Child Welfare Workers or other key figures present. Factors that contribute to attendance issues includes: scheduling priorities and location. The program will continue to make an effort to encourage all important stakeholders to attend CFTs and continue to provide notes highlighting discussions to members who are present or absent.
Another challenge to services is the spread of locations that participants live in. The program presently serves youth in Brentwood, Antioch, San Jose, Manteca and Modesto. While these areas are within travel distant parameter (under 80 miles from offices), they are in high traffic corridors and make scheduling somewhat challenging. The program continues to explore creative ways to increase services in these locations.

In FY 13-14, Fred Finch Youth Center served 23 youth.
Cost per client: $26,982 based on 20 slots

Short-term Adjunctive Youth and Family Engagement (SAYFE) for Children/Youth/TAY

Background - This FSP has the capacity to serve 40 youth at any given time. In the current fiscal year, Edgewood changed the name of the program, in light of negative associations with the acronym ISIS, to Short-term Adjunctive Youth and Family Engagement (SAYFE).

Edgewood Center for Children and Families was awarded the contract to provide integrated clinic-based FSP services for the Central/South Youth Clinic (outpatient), as well

as the integrated FSP for intensive school-based services which are provided in the Therapeutic Day School (TDS) setting, school-based milieu services, and the Non-Public School setting. Youth served are 6 to 21 years old. These two integrated FSPs provide a full array of wraparound services to support the existing mental health teams. Services are open to all at-risk clients and specifically target underserved Asian/Pacific Islander, Latino, and African American youth.

The After School Intensive Services Program within the San Carlos Youth Center served youth ages 6-15 years old and provided supports for youth M-F, 2:00-6:00 p.m. every week, and one Saturday per month 11:30 a.m.-3:30 p.m. The Center continues to offer a multitude of services including: youth groups, independent living skills, educational support, social skills building, recreational groups and outings, peer-to-peer support, transportation assistance, healthy meals, and a weekly Aikido (non-violent Japanese martial art) group.

Youth are primarily referred to the 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 level of treatment is provided in effort to help stabilize a youth in their home environment and prevent (or transition from) a higher level of care (e.g., psychiatric hospital, residential facility, juvenile hall, etc.) In the FSP, a variety of services are provided to youth and their families. All treatment is individualized, strengths-based, and actively engages the youth and family. These services may include case management, 24/7 crisis support, family conferencing, individual therapy, family therapy, group therapy, family partner services, caregiver support groups, behavior support, Therapeutic Behavioral Services (TBS), access to the After School Intensive Services (ASIS) program (youth aged 6-14) and access to the Transitional Aged Youth (TAY) Drop In Center (youth 18 and older).

Demographics - Total enrollment – 56

- Gender – 45% Female; 50% Male; 5% Unknown
- Home language – 79% English; 20% Spanish; 1% ASL
- Race – 45% Hispanic/Latino
    - 46% Other
    - 18% Mixed/Multi-racial
    - 13% White
    - 5% Black/African-American
    - 2% Chinese
    - 2% Filipino
    - 2% Japanese

Success Stories - In October, 2013, an 11 year old female graduated from CY. This youth had been referred to program two years prior with a history of violence and explosive outbursts. She was diagnosed with Depression and Oppositional Defiance Disorder. By the time of her transition, she was able to advocate for herself in an appropriate manner, was utilizing her coping skills, attending school regularly and had not been hospitalized for over two years.

After nearly one year in the CY program, a 19 year old male youth who was diagnosed with Bipolar Disorder, Polysubstance Dependence and ADHD, was stable, regularly taking his medications, had graduated from High School and was attending college classes and participating in therapy. During this reporting period, this youth and his family made the decision and began the transition from the Child/Youth program to Turning Point TAY.

In June 2014, a SAYFE youth who successfully graduated from the program had recently turned 18 and had signed consents to remain in the program for an additional few weeks to secure support into adulthood. She advocated for a psychiatric assessment, despite concerns form her caregiver. The caregiver struggled with mental health issues, which may have affected her views on having her daughter take medication. The youth worked with the treatment team to help her caregiver become more open to psychotropic medications.

An 8 year old girl, member of the Katie A subclass, had been in a number of different placements. The caregiver who participated in SAYFE C/Y wraparound services for approximately 2 years had been a warm and loving environment. The youth was on track to be adopted, until the youth's biological father began making threats. This led to several interventions by HSA, emergency response, SAYFE crisis response team, C/Y clinician, and C/Y family partner. It was determined that she should be moved out of county when the biological father's rights were terminated. As the fiscal year drew to a close, she was preparing to be adopted by a family out of county.

Challenges - During the 2013-2014 Fiscal Year, FSP services in San Mateo County underwent a great deal of change. Edgewood's contract was up for renewal and the opportunity was used to incorporate feedback given by youth, families, staff, and County partners; apply lessons learned throughout the years; and adding ways to better serve children, youth, and families. As a result, the new contract clarified roles and expectations of service providers and added new specialized, infrastructure (e.g., implementing dedicated QA/QI and admin support), and leadership (e.g., creating more senior level direct service positions and entry level management positions) roles to the FSP team.

Cost of Living: the rising cost of living continues to present a challenge for families who are unable to locate affordable and suitable housing.

- Families are frequently living in households with multiple members, impacting quality of life, privacy, and safety.
- Families are frequently relocating out of county which results in an abrupt termination of services.

The strategies:

- The county is working to create more affordable housing and staffs are helping families complete applications and access these resources.
- Staffs have begun to meet more in settings outside of the home, to ensure that youth have the emotional and physical space to engage in treatment.
- When families relocate to other counties, staffs work with them to ensure that there are resources in place prior to their move, to ensure continuity of care.

Recruitment/Retention: of staff who were qualified (e.g., had the language capacity, lived experience, or necessary credentials) to treat the population.

- A new Director assumed the position mid-year and two positions of the mid-manager tier remained vacant, resulting in increased workloads for all members of the leadership team.
- Direct-service positions were also peppered with vacancies, which lead to staff carrying a higher than usual caseload. This, undoubtedly, lead to feelings of being overwhelmed and burned out; which in turn created additional vacancies.

The strategies:

- Aggressive recruitment efforts resulted in filling multiple positions at the direct-service and leadership levels.
- Workloads were paired down to be more reasonable and to accommodate predictable short-term increases (due to family crises or vacant positions).
- Use translation services in times when unable to meet the language capacity of a family (e.g., ASL).
- Additionally, training opportunities were provided for all staff to ensure that they became more culturally competent in treating gender non-conforming youth.

Caregiver mental health needs: caregivers with undiagnosed and untreated mental and physical health issues, which affect their ability to engage in their children's treatment.

- Parentified youth who have grown accustomed to caring for their caregivers.
- Caregivers feeling like sessions are overwhelming, unnecessary, or only occur to make reports on them.

The strategies:

- Providing both case management assistance and family partners to support caregivers, in effort to prevent responsibilities falling to the youth in the home.
- Allowing youth the opportunities to engage in age appropriate activities (e.g., ASIS).
- Meeting caregivers where they are (emotionally and geographically) in effort to demonstrate that SAYFE is working with them, not against them.

In FY 13-14, SAYFE FSP served 56 youth, 29 clinic-based and 27 school-based.
Cost per client: $31,412 based on 40 slots

"Turning Point" for Children, Youth, and Transitional Age Youth Comprehensive FSP - This Comprehensive FSP program, provided by Edgewood Center for Children and Families, helps the highest risk children and youth with serious emotional disorders remain in their communities and with their families or caregivers while attending school and reducing involvement in juvenile justice and child welfare. Specialized services to TAY (aged 16 to 25) with serious emotional disorders are provided to assist them to remain in or return to their communities in safe environments, support positive emancipation including transition from foster care and juvenile justice, secure, safe, and stable housing and achieve education and employment goals. The 80 slots are divided between two 40-slot teams, one for children/youth and one for transition age youth.

Child and Youth (C/Y) – CY has a capacity to serve 40 youth and families at a time. CY served 51 unduplicated youth.

Background - Participants within CY are referred from a variety of sources, primarily San Mateo County Human Services Agency (HSA – child welfare) and Juvenile Probation. No matter the referent, these youth all come to CY with high levels of need. CY provides the highest level of care for children and youth in their community setting. During this reporting period, enrollees had a moderately high level of acuity, with a high incidence rate of youth coming out of multiple prior hospitalizations (28%) and extended juvenile justice stays (44%). There was also a moderately-high incidence of co-occurring substance abuse (24%) and developmental delays (11%). These numbers are most notable as the average age for CY participants from July to December 2013 was just over 14 years old (14.12).

CY youth receive a variety of services, based upon their individualized treatment plans. These services may include case management, 24 hour crisis support, family conferencing, individual therapy, family therapy, group therapy, behavior support, therapeutic behavior services (TBS), access to the After School Intensive Services (ASIS) program (Youth aged 6-14 years), and access to the TAY Drop-in Center (youth 18 and older).

In order to better meet the intense needs of the children, youth and families participating in CY, the FSP After-Hours Crisis Response team refined the On-Call training provided to new staff and managers. During this reporting period, protocols and guidelines were more clearly outlined in writing and every staff now receives weekly reminders that they need to check in with the Manager on Call with any crisis line call.

Demographics - Total enrollment – 51

- Gender – 31% Female; 67% Male ; 2% Unknown
- Home language – 88% English; 10% Spanish; 2% Unknown
- Race – 37% Hispanic/Latino
    - 29% Other
    - 25% Black/African-American
    - 24% White/Caucasian
    - 16% Mixed/Multi-racial
    - 4% Unknown
    - 2% Filipino

To better meet the needs of diverse service users, the cultural diversity of the CY staff team is also strong with 18% African American representation, 32% Latino, 39% Caucasian, 7% Filipino and 4% Japanese-American and 32% are bi-lingual Spanish. There are three Therapeutic After School Support Specialists (TASS and formerly called peer partners) serving the new ASIS Program at the San Carlos Youth Center, and two and a half family partners on staff within the Turning Point.

ASIS served 20 youth between the ages 6-14 years old and continues to be open to provide supports for youth M-F, 2-6p every week, and one Saturday per month 11:30 a.m-3:30 p.m. Attendance has maintained stability, with the highest attended days serving as many as 12 youth from CY, SAYFE, Collaborative and Kinship programs combined. The average age of

attendees is 9.5 years old, and of the 20 enrollees, 13 were male and 7 female. The cultural diversity of attendees is strong, as well, with 30% Caucasian, 20% Latino, 5% Asian/Pacific Islander, 5% American Indian/Alaska Native, 25% African-American and 15% declining to answer. The ASIS program continues to offer a multitude of therapeutic services including: independent living skills; educational support; social skills building; recreational groups and outings, peer to peer support, transportation assistance and healthy meals.

Challenges - Challenges brought about opportunities for learning, safety and cultural awareness as well as for supporting one another with clear communications.

1) The CY Program Manager left the agency in June 2013. That position has remained open since that time. The CY staff has been well supervised by other staff, including the Directors of the FSP and TAY Programs. Additionally, the FSP Director gave a 90 day notice during this time period as she was moving out of state and transitioned at the end of December. A new FSP Director was hired and began in January 2014 and the former FSP Director continues to offer remote support as needed.

2) The rising cost of living in the Bay area, specifically the Peninsula and San Mateo County continues to present a challenge for families who are unable to locate suitable housing which is affordable. The county has responded by collaborating with developers and building additional low-cost housing units and subsidizing a number of units for families with children and youth accessing mental health services and supports. The wait lists for these units is substantial and the paperwork is daunting, so staff support parents and caregivers in completing required applications. Even with these supports, however, there are still youth and their families living in difficult circumstances, including two families who were living in transitional housing.

3) During this reporting period, there seemed to be increased concern regarding communication between HSA, Juvenile Probation, BHRS and Turning Point as well as some confusion around contract expectations. In an effort to address this, the FSP Director, in consultation and collaboration with participating managers from BHRS, Probation and HSA moved the date, time and location of the bi-monthly consultation meeting (FRED) so that it was more convenient for all parties. While this seemed to aid in some of the communication, there continued to be some confusion about expectations of Turning Point staff by the Courts and Probation and a lack of clarity around contract specifics. The FSP Director met with concerned parties as did BHRS Managers and Directors. The new FSP Director continues to be actively engaged in ensuring high levels of communication and collaboration.

4) Finally, a number of the youth being referred to CY have parents with undiagnosed and untreated mental and physical health issues of their own, which seems to lead to difficulty in their ability to fully engage in their children's treatment.

In FY 13-14, Turning Point Comprehensive FSP for Child, Youth served 51 children/youth. Cost per client: $34,532 based on 40 slots

Transitional Age Youth (TAY) - Turning Point's Transitional Age Youth (TAY) Program has a capacity to serve 40 individuals between the ages of 17-25 at one time. During FY 2013-14 the program served 49 unduplicated TAY.

Background - The TAY Program provides intensive community based supports and services to youth identified as having the "highest needs" in San Mateo County who are between the ages of 17-25. The primary referrals for the TAY Program are San Mateo County Behavioral Health & Recovery Services (BHRS), Human Service Agency (HSA)foster care, and the juvenile justice system; the primary referrals during this reporting period were from BHRS and HSA (Katie A and AB12 identified transition age youth specifically). During this reporting period, 15 youth graduated from the program.

In addition to providing individualized support, the TAY Program also offers group/peer based support through the Support for Emerging Adult (SEA) programming at the Edgewood Drop-In Center site in San Bruno. This programming offers a safe environment, meals, groups and activities, resources, and staff support. In addition to serving the 40 transition age youth enrolled in the program, the SEA programming is also open to any San Mateo County youth between the ages of 18-25.

Demographics - Total enrollment – 49

- Gender – 37% Female; 63% Male
- Home language – 92% English; 6% Spanish; 2% Other
- Race – 37% Hispanic/Latino
    - 31% White/Caucasian
    - 27% Mixed/Multi-racial
    - 27% Other
    - 8% - Black/African-American
    - 2% Filipino
    - 2% American Indian
    - 2% Asian Indian

Outcomes – July 1, 2013-December 31, 2013

- 46 unduplicated TAY were served
- 57% of the youth who attended were from the community and unattached to Edgewood programs; of these:
    - 53% are former foster youth. Of these former foster youth, 27% are considered homeless by the U.S. Department of Housing standards, 24% identify as LGBTQQI and 12.5% are young adult parents.

Often these individuals have "fallen through the cracks" or refused services; through the SEA programming they are able to access support and appropriate resources/referrals. Groups and activities may include: career/vocational workshops, recreation activities, educational support and opportunities, health and wellness activities, and off-site outings.

During this reporting the following were introduced:

- Weekly Dialectical Behavior Therapy Skills groups for identified enrolled clients. These groups meet in the afternoons at the Drop In Center site.

- A closed Facebook Group for limited numbers of participants monitored by Peer Partners and Education & Enrichment Manager, used for sharing upcoming events and to elicit feedback, ideas and have dialogue with hard to reach 18-25 year olds.
- A holiday dinner for all enrolled clients and anyone they considered family. The "Fancy Dinner" was prepared and staffed by the TAY Program staff and included full dinner service, music and entertainment, and a White Elephant gift exchange.

During this reporting the following continued:

- Tech Tuesdays a 2 hour timeslot each week for participants to have one on one or small group workshops on all things tech related
- Community Meeting, a weekly participant and Peer Partner led discussion on issues, concerns and ideas regarding SEA programming and the greater community
- Weekly Cooking and Nutrition Group

In the TAY population, indicators of success may include a decrease in high risk behaviors, psychiatric hospitalizations, incarceration, substance use, isolation, and/or homelessness; and an increase in educational and/or vocational attainment, peer and social support, community involvement, and personal health and wellness. The program defines success as the steps taken by TAY to address their needs, build their skill sets, enhance their knowledge base, and/or share their strengths.

Success Story - A recent success of a mother and daughter (age 22), includes the dual enrollment and successful attendance of courses at the College of San Mateo. They have found much enjoyment in encouraging each other, motivating the other when symptoms appear, and sharing the knowledge they are learning in their respective classes. Mother reports feeling more confident, less isolated, and hopeful as she plans for re-entry into the workforce. The daughter reports feeling more confident, less anxious about her mother's challenges, and more able to focus on her own health and wellness; leading her to feel more positive and relaxed overall.

Outcomes - January 1, 2014 through June 30, 2014

- 43 unduplicated TAY were served
- 61% of the youth who attended were from the community and unattached to Edgewood programs; of these
    - 48% are former foster youth. Of these former foster youth, 25% are considered homeless by the U.S. Department of Housing standards,24% identify as LGBTQQI, and 10% are young adult parents.

During this reporting period the following were introduced:

- 3 transition age youth led workshops at the Drop In Center, they included:
    - Zombie Make-Up Tutorial (by a 20 year old make up artist who is studying make-up design for films and movies)
    - Creative Writing (by a 21 year old who loves to write)
    - Web Hacks (by a 19 year old who wants to be a programmer)

During this reporting the following were continued:

- Weekly Dialectical Behavior Therapy Skills groups for identified enrolled clients continued through March. These groups were held at the Drop In Center location included 6 transition age youth and 4 transition age youth program graduated who acted as 1:1 DBT coaches.
- Community Meeting, a weekly participant and Peer Partner led discussion on issues, concerns and ideas regarding SEA programming and the greater community

Success Story - In February there was an update from a mother of a 19 year old young woman who had graduated from the program in the fall of 2013. This young woman had been referred to the program as she was transitioning from a residential program after turning 18. She was adopted, had a history of abuse and neglect by her biological family, had struggled with attachment and relationships, and thus displayed self-harming and acting out behaviors. At 18 she was driven to assert her independence; she signed up for community college classes and found a job. The return back to the community however was bumpy; mother did not want her home, nor did she want her daughter to be with extended family as she still viewed this 18 year old as the 15 year old version of herself. This caused many fights, which resulted in the young woman taking steps to end her life.

Then the mother was diagnosed with brain cancer, the program worked with mother, daughter and extended family to help them to get through the current challenges, and prepare. When she graduated in the fall, this 19 year old was taking college classes, working, and living with an aunt and uncle; mother was receiving medical treatment and the extended family had come together. The update received said, "I want to thank you again for the support you offered my daughter and myself. Would you believe I am finally following through on the many end of life things we talked about? I am spending time with the family and creating a video for them. There are still some ups and downs with __ but we understand each other so much better now and the love has come back into the relationship!"

Challenges - In the fall of 2013, the San Benito Apartments was full and supported a cohort of 19-22 year olds preparing to take their turn at the apartments. These 3 individuals worked hard at Eucalyptus House (a Caminar run social rehabilitation program) and successfully transitioned into San Benito apartments by December of 2013 while residents moved on to their own apartments or YAIL, a Caminar housing program. During the second fiscal year reporting period, Caminar gained additional residents as additional apartments were secured at the site, moving the capacity to 6 (4 rooms in a shared apartment, 2 individual apartments) supported a cohort of 19-23 year olds who were working toward building independent living, socialization, and emotion regulation skills by living on-site and engaging in specialized support with the Independent Living Skills Specialist and Behavioral Specialist. With 5 individuals living in the apartments and an additional 2 living in supported/subsidized apartments in the community, a weekly Community Housing meeting was started to allow for conversations, community building, and learning. Topics included: tenant rights, roommate relationships, healthy eating, fire safety, emergency preparedness, and shopping on a budget.

There continued to be a decrease in psychiatric emergency visits, celebrating program graduations and involvement in work and school, empowered participants taking on leadership roles within the program and out in the community, and newly enrolled participants assessing their strengths and needs in preparation for their first Family/Team Conferences. While there were many successes, the program and a team did face a terrible tragedy. A recently referred young woman who was receiving services by multiple providers due to symptoms of schizophrenia was fatally shot by a sheriff's deputy. The tragic death of this young woman significantly impacted us all.

In FY 13-14, Turning Point Comprehensive FSP for TAY served 49 youth
Cost per client: $34,532 based on 40 slots

Enhanced Supported Education Services for TAY –

Background - BHRS contracted with Caminar starting in 2006 to provide enhanced supported education services to approximately 40 TAY ages 18 to 25 with emotional and behavioral difficulties and/or alcohol or substance use issues, 20 referred by FSP provider Edgewood and 20 TAY identified by Caminar. Supported Education includes the following:

- Summer Academy to help students build their confidence and self-esteem and have a better chance of success in school and employment. A team teaching model of peer counselors, a core instructor, case management services, and guest speakers.
- Two additional "Transition to College" classes were provided. Three specialized classes on a rotating basis throughout the year are also offered: Wellness and Recovery, Peer Counseling, and Advanced Peer Counseling.
- Academic Counseling in coordination with DSPS, a Master's level academic counseling intern, develop student individual educational plans (IEP), oversee completion of required DSPS paperwork, and provide personal support to students.
- Linkage to employment provides services to link students with employment.

Demographics - Total enrollment – 45

- Gender – 39% Female; 51% Male ; 9% Unknown; 1% Transgender
- Home language – 28% Eng; 2% Spanish; 1% Tagalog; 1% Chinese; 68% Unknown
- Race – 12% Hispanic/Latino
    - 34% White/Caucasian
    - 28% Unknown
    - 11% Black/African-American
    - 3% Mixed/Multi-racial
    - 3% Filipino
    - 2% Pacific Islander
    - 1% Asian
    - 1% Chinese
    - 1% South Asian/Indian
    - 1% East Indian

Outcomes - Unduplicated student count (students were enrolled in both the Introduction to Peer Counseling courses and the Advanced Peer Counseling courses concurrently)

Fall 2013 Classes

- Total Transition to College program core class enrollment-*Career 122*, *Introduction to Peer Counseling* classes-total unduplicated students 23

Spring 2014 Classes

- Total Transition to College program core class enrollment-*Career 126/127*, *Advanced Peer Counseling* classes-total unduplicated students 22

- Total class count - 45
- Total GPA- 2.9
- Retention rate- 85%
- Total 'Transition to College' program core class (unduplicated) enrollment- 23
- Total (unduplicated) Transition to College contacts, support, engagement activities- 106
- Percent of students who rated their classes as satisfied or above- 87%

Successes - an increase in contacts and engagement activities with TAY, achieving an 80% retention rate in Transition to College classes, and in providing services to 45 TAY.

Challenges - There were continued challenges engaging TAY in educational activities and completion of educational goals. Caminar and the College of San Mateo's DSPS program (Disabled Student Programs and Services) developed an enhanced structured and supportive cohort program called "Connections" that consisted of academic skills classes, planned outreach, individualized support, and coordination with community supports and services. The elements of this program include: expected meetings during the semester with a DSPS counselor and the Transition to College staff, concurrent classes developed for academic and personal skills development, educational planning, and peer counseling skills. The expectation is with structured and supportive entry or re-entry, outcomes will be an improved retention rate and measurable student academic success.

In FY 13-14, 45 transition age youth were served by this program.
Cost per client: $3,655.

TAY Supported Housing –

Background - Mental Health Association (MHA) secures and manages 20 units of high quality housing for TAY FSP enrollees and collaborates with the Edgewood TAY FSP. Addressing the housing needs of TAY is an important aspect of the work within the TAY Program at Edgewood. Through a partnership with the Mental Health Association (MHA) of San Mateo, the TAY Program is able to provide housing subsidies and a small cluster of apartments in order to reduce the risk of homelessness and increase the probability of stable housing as youth transition. Teaching daily living skills, medication management, household safety/cleanliness, budgeting, and roommate relationship are a part of the treatment and education of the youth accessing housing support.

Demographics –
TAY utilizing MHSA housing dollars for FY 13-14, which includes applying housing dollars for: rent, housing subsidy, security deposit, and/or use of one of the dedicated beds.

- 16 TAY served
- 37.5% Caucasian, 31.3% Latino, 12.5 Native American, 12.5 Asian, 6.3% African American
- Youngest: 19 years, Oldest 24 years
- Average age: 21.5

Successes - success is measured with each day TAY are housed in safe and appropriate housing. With dedicated beds at Ohevet's and Maple Street Shelter, emergency and temporary housing options are available, decreasing the numbers of TAY living on the streets, under bridges, in tents, and in vehicles. For those not ready to give up life on the streets, success has been found utilizing a harm reduction-safety first model; offering food, hygiene products and a couch for catching up on sleep at the Drop-in Center, skills practice and safety planning with staff anywhere in the community, and showers and storage of personal items at the San Carlos office. Through this intervention a number of participants have been helped in making the deliberate transition from street dependence to supported community housing.

In FY 13-14, enrolled clients lived in the following locations/entities:

- Caminar: Redwood House
- Caminar: Eucalyptus House*
- Caminar: YAIL Program
- Cordilleras (Mental Health Rehabilitation Center)
- Cordilleras: The Suites (Adult Residential Facility)*
- Golden Gate Regional Center (GGRC) Host Homes
- StarVista: THP Plus Program
- Mateo Lodge: Wally's Place*
- Shelter Network: Maple Street Shelter**
- Mental Health Association: Spring Street Shelter
- Mental Health Association: SAYAT (housing voucher for community living)
- Ohevet's Board & Care**
- Silver Hotel
- Larkin Street Shelter
- Edgewood San Benito Apartments*
- Edgewood Scattered Site Apartments*
- Independent apartments (found with support of TAY Case Managers and Craigslist)*
- Homes, garages, and/or couches of friends and/or family

*Indicates MHSA dollars have been utilized to subsidize individual TAY, as appropriate.
**Indicates MHSA dollars have been utilized for a dedicated bed(s).

Challenges -

1. Identification of Developmental and/or Culturally Appropriate Options
    a. The lack of appropriate housing options for those not meeting criteria for a social rehabilitation program and yet not ready (based on skills, behavioral management, safety) for supported housing (such as YAIL, THP-Plus, Edgewood San Benito).
        i. Developmentally delayed or impaired transition age youth who also struggle with mental illness (not meeting criteria for GGRC).
        ii. Former Foster Youth with mental illness.
        iii. Pregnant or parenting with a mental illness.
        iv. Street dependent youth.
    b. Lack of "youth friendly" housing options.
        i. The current housing system generally holds TAY to adult standards and does not account for age appropriate needs, skills, and relationships.
        ii. Severe Mental Illness (SMI) diagnosis is a requirement for approval by Adult Resource Management to access adult mental health beds.
        iii. Medication compliance is often required or preferred. Enrollees under psychiatric care but not currently taking medications, displaying medication ambivalence, and/or using holistic/alternative methods, are often denied community housing or placed lower on the waiting lists.
        iv. Length of stay is under 6 months, and in some cases closer to 3 months.
        v. Roommates/shared room situations.
        vi. Curfew which conflict with age appropriate activities including: night classes, evening workshops or self-help groups, activities at youth centers, recreation or athletic activities, and peer socialization activities.
        vii. Group participation requirements which conflict with school/work/pre-vocational schedule.
2. Continuity & Permanence
    a. The lack of long-term, affordable and appropriate housing options for TAY.
        i. Upon graduation from Edgewood, youth no longer have access to a housing subsidy. Waiting lists for housing subsidies or vouchers are 3 years on average.
        ii. Most housing programs are time limited or available only while in the program.
    b. Bay Area rents continue to increase and even a Section 8 Housing Voucher is no longer enough of a subsidy to aid individuals in covering the rent.

Strategies - It is a commitment to this population which drives the TAY Program at Edgewood to continue to identify new strategies and enhance existing ones. Partnership and collaboration with providers, housing programs, community members, families and youth continue to result in the most effective strategies. Understanding that there is no one size fits all model of housing for this population and to strive to create and support others in the creation of a spectrum of housing options for TAY of San Mateo County.

Maintaining relationships with the managers at the Silver Hotel and Ohevet's Board & Care Homes, has given enrolled and former clients options for current and long-term housing. While each option has its pros/cons, they meet the needs of some of the clientele. As permanency is important to this population, unrestricted length of stay is notable, and for

these two entities, they also offer managers who are invested in supporting and mentoring transition age youth, thus they become natural supports to clientele. Additionally, MHA strives to work closely with the directors/managers at all housing programs/entities utilized by this population to ensure early identification and intervention of problems or areas of growth.

Strategies that continue to be helpful include the requirement that all transition age youth with "housing" as an identified need complete an Independent Living Skills (ILS) Assessments with an Occupational Therapist through MHA. This assessment yields detailed information regarding skill level, learning styles and appropriateness for community housing. In addition, the TAY Program has implemented the use of the Casey Life Skills Assessment (CLSA) for this same sub-population of youth, in order to inform the work of the Independent Living Skills Specialist, as well as the entire team working with each individual youth.

While sharing a room or a living space is a normative practice for 18-25 year olds, this is not always in the best interests of TAY. Most come to us with a significant trauma history, many come with challenges in setting boundaries, others come with little experience of having their own space. For these reasons, in addition to the ability to manage behaviors/symptoms, shared rooms and sometimes shared apartments do not meet the needs of TAY. In these instances other options can be searched, work with housing programs/entities to create spaces that address this need, and work with the transition age youth in building skills and maintaining safety.

Strategies for success in San Benito, a scattered site apartments include:

- High level of engagement with the Community Behavior Support Specialist and Independent Living Skills Specialist during the first 90 days of living in the apartments.
- Holding residents accountable to tracking and fulfilling the 20 hour a week off-site activity (school, work, pre-vocational, Edgewood Drop In Center (DIC), treatment/recovery appointments or meetings) requirement.
- Weekly attendance at the Apartment Living meeting facilitated by the Housing & Advocacy Manager. Content includes- apartment safety, roommate relationships, cleaning, tenant rights, community safety, budgeting, and other topics identified by staff or residents.
    - Allowing residents to "try it their way" and celebrating the success or reviewing what did not work without fear of eviction.
    - Creation and ongoing review of Safety Plans and coping skills by each resident and their treating team members.
    - Offering incentives to attend Independent Living Skills, Educational, and Vocational workshops at the Drop In Center (DIC).
    - Weekly check-ins by the on-site resident manager.
    - As needed phone or in-person check-ins by the After Hours Crisis Response team as a health/safety prevention measure.

Finally, this year MHA began exploring housing options for transition age youth outside of San Mateo County and aided 3 in moving out of this county; 2 moved to Santa Clara County and 1 to Alameda County. For most transition age youth, they would prefer to stay in this county, most feel this is their home and that they have a network of support here. Still, they and their supporters recognize the options are limited, and if the supporters are unable to house them, leaving the county may be the best option. The "housing of the future" dialogue will be increased with all caregivers, supporters, and extended family members of transition age youth addressing both the future needs of the enrollees but also those of their supporters. This year there were multiple family members who open their homes to their transition age youth after years of separation and tenuous relationships. While this trend is hopeful, this may not fit the needs of the transition age youth or their supporters. Thus, MHA will continue to explore housing options in Santa Clara and Alameda Counties with the hopes of formalizing partnerships with programs or entities that meet the needs of the transition age youth population.

MHA plans to continue improving and enhancing housing support, whether it is direct or indirect, for/with TAY. MHA hopes to continue building relationships with community housing programs in hopes of broadening the options available to TAY and identifying the best supported housing design to meet the needs of this population.

In FY 13-14, 16 transition age youth were served by MHA Supported Housing.
Cost per client: $12,500

FSP and Housing Support Program for Adult, Older Adult, and Medically Fragile –

Background - This FSP program, ran by Telecare, Inc., provides services to the highest risk adults, highest risk older adults/medically fragile adults and Outreach and Support Services for potential FSP enrollees receiving outreach and support services. The purpose programs is to 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, and 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.

The overall goal of the program is to divert from the criminal justice system and/or acute and long term institutional levels of care (locked facilities) seriously mentally ill and dually diagnosed individuals who can succeed in the community with sufficient structure and support. The program is grounded in research and evaluation findings that demonstrate that diversion and post incarceration services reduce incarceration, jail time and re-offense rates for offenders whose untreated mental illness has been a factor in their criminal

behaviors. The program also follows the model and philosophies of California's AB 2034 Homeless Mentally Ill Adult programs and the assertive community treatment approach, aiming to use community-based services and a wide range of supports to enable seriously mentally ill and dually diagnosed adults to remain in the community and to reduce incarceration, homelessness, and institutionalization.

The FY 09/10 approved expansion allowed for the introduction of the concept of integrated FSPs, in response to the need to be flexible in step-up/step-down processes in order to create a more seamless service delivery experience for clients. The word "integrated" reflects the FSP staff from community-based organizations in County-operated South/Central and North County clinics. Three levels of care are included in a redesigned FSP: an intensive level "1 to 10" (1 staff per 10 consumers/clients), a community case management level "1 to 27" (1 staff per 27 consumers/clients), and a wellness level of care.

The program works with board and care facilities and with consumers living in the community to prevent them from being placed in locked or skilled nursing facilities, and with residents of skilled nursing and locked facilities to facilitate their returning to a less restrictive setting. Referrals to the program are received from locked facilities, skilled nursing facilities, acute care facilities, board and care facilities, primary care clinics, Aging and Adult Services, community agencies, and from individuals/family members.

A full-time nurse enables the treatment team to more effectively collaborate with primary care providers and assist consumers in both their communications with their primary care doctors and in their follow-up. The licensed clinicians in the team oversee the completion of the multidisciplinary assessment and the development and implementation of a comprehensive service plan that involves all members of the team, the consumer and the family, contingent on the consumer's wishes. Peer Partners provide support, information and practical assistance with routine tasks, and cultivate a system of volunteer support. Similarly, when a family is involved and the consumer is supportive of their involvement, a Family/Caregiver Partner works with the family to build their capacity.

Telecare, Inc. was contracted in October 2009 for a total of 200 members: 75 Adult, 75 Older Adult/Medically Fragile, 40 Community Case Management and ten in a new Wellness category. In February 2011, there was an amendment to the Telecare FSP to more effectively align needs with BHRS resources: ten case management slots were reduced in order to add seven intensive slots, and the rest of the savings was shifted to support the Housing Support Program for a total of 187 slots.

During FY 2012-2013, Telecare FSP was contracted to provide services to a total of 229 unduplicated individuals (207 of these are MHSA funded, 22 are Criminal Justice Realignment FSP slots). These services encompassed three different levels of intensity. Staff to client ratios were, Full Service Partnership 1:10, Community Case Management 1:27 and Wellness 1:40. The report will largely focus on the MHSA element but the comingling of populations is noteworthy. The MHSA total slots remain full. Whatever openings that do exist only do so for a matter of a few days with referrals being a constant.

Demographics - Total enrollment – 237

- Age – 75% age18-59; 18% 60+; 7% Unknown
- Gender – 33% Female; 67% Male
- Home language – 97% English; 1.5% Spanish; 1% Tagalog; 0.5% Farsi
- Race – 16% Hispanic/Latino
    - 52% White/Caucasian
    - 17% Mixed/Multi-racial
    - 16% Black/African-American
    - 7% Other
    - 3% Filipino
    - 2% Unknown
    - 1% Chinese
    - 0.5% Japanese
    - 0.5% Native Hawaiian
    - 0.5% Other Asian
    - 0.5% Other Pacific Islander

Outcomes - Employment

- Not recorded = 18
- Competitive Employment = 7
- Non-paid work experience = 4
- Other gainful activity = 3
- Paid In House work (sheltered) = 2
- Supported Employment = 6
- Unemployed = 181

Successes - Over the past several years, Telecare and this program in particular have been moving towards being Co-Occurring competent to the degree of having developed and rolled out a basic training on substance abuse/mental health for the entire corporation and developing a stage of change appropriate, evidence based/promising practice based, engagement protocol. Both the basic training and the Stage of Change protocols have been brought online in the program as well as with the local MHRC since this is the dominant referral source. Furthermore, in addition to all staff getting trained to be co-occurring competent, all staff have received the 3 day WRAP training and half the staff are now certified WRAP facilitators. WRAP groups have been running along side of the Co-Occurring groups and all facilitators include Case Managers, Staff with lived experience and residential counselors.

Challenges - The overall cost of living continues to be a significant issue. This problem is further compounded because there is a certain economy of scale needed to develop the housing models that lead to the most stable housing in this community; that of supported independent living homes. The cost of housing married with the necessary economy of scale needed to develop and sustain such options leads to a co-mingling of the MHSA and AB109 populations. While both groups have psychiatric disabilities, the AB109 clients tend to have a more "criminogenic" disposition (whether from training by the criminal justice system or by makeup, I cannot say). The convergence of such dynamics leads to areas of concern and frustration from both side

Housing Support Services -

Background - Telecare also provides housing for the Adult and Older Adult/Medically Fragile FSP programs. Telecare provides up to 90 housing units of mixed types including augmented board and care, dormitory, congregate and supervised living, single room occupancy hotels, shelter and independent living.

In FY 13-14, Telecare served 237 clients (156 adults and 81 older adults/medically fragile). Cost per client: $15,603 based on 207 slots / Housing Cost per client: $14,335

Comprehensive FSP and Housing for Adults and Older Adults/Medically Fragile–

Background - Caminar was contracted to provide service beginning October 2009 for a maximum of 30 enrollees. The FSP provides intensive case management services including psychiatric services, injections (in-home when necessary), daily in-home medication monitoring and weekly medi-sets. Nurses provide in-home assistance with teaching skills to manage diabetes, assessment, coordination and communication with medical providers. On occasion psychiatrists see clients in their homes/in the field. The FSP transports clients to appointments, offers after-hours warm-line, and 24/7 emergency response.

Caminar's FSP program served a total of 35 unique clients for fiscal year 2013-2014. Five new clients were enrolled during this time period, and five were discharged. Of the new clients enrolled, one was transferred from a Caminar lower level of care program due to increased medical needs and one was referred from Telecare FSP program. Of the five discharges, one was closed to an IMD facility due to increased symptoms and duration of stay and one client went into a step down program, New Ventures.

Clients continue to experience major medical concerns in the FSP program. These clients will need long term medical assistance, but are currently being managed in the community or temporarily placed in SNIFs in the hopes of returning to the community. Since moving to a Strengths-based case management model, there are improvements toward a better quality of living and some success with clients moving to a lower level of care. All FSP clients continue to be seen weekly for at least 2 hours by their case managers, nurses, psychiatrists, assistant case managers and/or community support workers who provide medication support them in their home. Fifty percent (50%) of FSP clients have WRAP plans and 90% of them participated in self-help and other community activities.

Demographics - Total enrollment – 35

- Gender – 40% Female; 60% Male
- Home language – 86% English; 6% Spanish; 3%Tagalog; 3% Thai; 3% Other
- Race – 17% Hispanic/Latino
    - 51% White/Caucasian
    - 14% Other
    - 11% Black/African-American
    - 9% Filipino
    - 9% Mixed/Multi-racial
    - 3% Chinese

Outcomes -

- Homelessness: 6% (2 out of 31 this year)
- Hospitalizations: 46% (14 out of 30 clients this year)
- Incarcerations: 3% (1 out of 30 this quarter)
- Stable Housing: 754 remained in stable housing for at least 1 year
- In addition, this year 30% of clients provided their own transportation.
- 97% of clients lived in satisfactory living environments (apartments, SRO hotels, independent supportive housing or with family).
- 50 %of clients received housing subsidies and 13% received Caminar's Sponsor-based Shelter+Care Supportive Housing.

The REACH (Recovery, Empowerment and Community Housing) program served an average of 68 clients this year. The REACH program is contracted to maintain an active caseload of 55 clients in addition to a supplemental program for an additional 10 clients. Both programs also provide 24/7 Emergency Response and a Warm-line for clients to access for any issue they may have after hours. Caminar's REACH program had 12 discharges and 12 new intakes this year. Of those discharged, two went to a lower level of care in the New Ventures program, three went to Long Term Care for health reasons, and one client passed away. Of the new intakes, two came from a lower level of care, New Ventures program, one came from Cordilleras and one from Central County MH.

The following are average outcomes for this year for the REACH Program:

Homelessness:	5% (3 clients this year)
Hospitalizations:	58% (38 clients this year)
Incarcerations:	7% (4 clients this year)
Stable Housing:	95% remained in stable housing

13% of REACH clients are being provided with Caminar's Sponsor-based S+C Supportive Housing. 95% of the clients responding to the surveys in both FSP and REACH programs reported being satisfied with their services.

Challenges - This year the intensive case management programs, REACH and FSP, are continuing to experience lack of housing options especially given a clients' level of income and the high cost of housing. Landlords can rent to higher paying consumers and are doing so. Another concern is the increased medical needs of clients as they continue to grow older and their medical issues become a dominant component of their lives.

For FY 2013-14, Caminar FSP and Housing Support Program served 35 clients.
Cost per client: $27,008 based 30 slots

Integrated FSP Program –

Background - Mateo Lodge was contracted to run the South County Mental Health Clinic (SCC) to provide 50 hours of service per week for 3 different levels of intensity (task oriented case management, supplemental case management and FSP clinical case management). During this period a total of 31 unduplicated clients were served, 14 received service level C. (FSP).

A 1.0 FTE Mental Health Counselor and a 0.25 FTE Community Worker are assigned to SCC to provide case management services to a small caseload (up to 15 clients) of high risk, marginally engaged clients for six months to a year, with the goal of stabilizing and engaging clients in services at the SCC. Clients referred for supplemental case management are those who require services beyond the level an outpatient team or clinic can provide, but less than is needed for Full Service Partnership.

Demographics - Total enrollment – 31

- Age – 97% age 18-59; 3% age 60+
- Race – 16% Hispanic/Latino
    - 29% - White/Caucasian
    - 19% - Unknown
    - 6% - Black/African-American

Outcomes - There were 8 cases that carried over from the previous six months. 6 cases were transferred to Mateo Lodge's external FSP program just prior to the reporting period. Mateo Lodge also provided evening and weekend coverage on an as needed basis from the mobile support part of their agency. Two cases were closed during this period, one because the referral need was met and the other the client declined service. There were 20 referrals. Task oriented services were provided on an as needed basis and were used equally by all teams most often to assist in managing housing crises or transportation. Six clients received Supplemental Case Management. 14 clients received service level C. (FSP)

Outcome	**Number of Clients**
Connected to Community FSP	1
Moved out of County (stabilized)	5
Stabilized back to team	11
Case Management needs met	4
Deceased	3
Unable to Engage/lost voucher	3
Ongoing	3
Declined services after multiple engagement strategies	1

Staffing/Staff Training- During this time period there was a change in Supervisor and Case Manager (start date 06/13) with the addition of a second Case Manager (start date 10/13)

with lived experience to cover the 50 hours per week of contracted (Full Service Partnership) FSP services. Both Case managers are bilingual-bicultural Spanish speaking. One staff works 30 hour and the other 20 hour a week with overlapping days to attend the clinic clinical and staff meetings. Case Managers have taken the required new employee training both by Mateo Lodge and by the County. In addition, both CM's have taken the interpreter training and Motivational Interviewing, managing assaultive behavior, and dialectical behavior therapy. One CM has taken MH First Aid training in Spanish. Both Case Managers have been used as needed in the clinic to interpret for client/family members of clients not served by the FSP. The Supervisor and Program Specialist have met with the contract provider on a quarterly basis to review services and explore options for expanding clinical services and documentation to include treatment planning and providing CM for the clients who have Permanent Supported Housing vouchers.

Challenges -Most of the referrals for the embedded FSP program are because clients are not engaged with their treatment teams (not making it to appointments) or are not stable. The difficult to engage client is typically medication non-compliant and/or homeless with limited family/social support. Another challenge for clients with children and for undocumented clients is sparse resources. Use of culturally appropriate community agencies (faith based) has helped support recovery when limited financial support.

Due to the level of impairment of the clients referred, it has been challenging to make the initial connection with the client when they do not show for their appointments. There are clients who are homeless, with no social support, who unless they contact the clinic or are in hospital or jail, could not be contacted. There are clients who do not respond to phone calls. Warm handoffs by the team have had the best results for clients to engage with the Case Managers. Engagement strategies used are unannounced home visits (after safety evaluation), use of relatives with releases, hospital, jail, and joint home visits with a member of the treatment team.

For FY 2013-14, the SCC Integrated FSP served 31 clients.
Cost per client: $7,133 based on 15 slots

Community Services and Supports (CSS) – Outreach and Engagement (O&E)

The following are highlights for FY 13/14, per program:

North County Outreach Collaborative (NCOC) – North County Outreach Collaborative outreach is conducted by Asian American Recovery Services, Daly City Peninsula Partnership Collaborative, Daly City Youth Health Center, 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 MH services; 3) establishing strong linkages between community and BHRS

5,684 outreach encounters in FY 12-13.
Cost per person: Encounters are not unique individuals, data is collected anonymously.

East Palo Alto Behavioral Health Advisory Group (EPABHAG)–. Outreach and linkage services to gain access to Medi-Cal, other public health services, behavioral health, and other services is conducted by El Concilio of San Mateo County, Live in Peace, Free at Last, and Pacific Ma'a Tonga. EPABHAG is committed to bridging the mental health divide through advocacy, systems change, resident engagement and expansion of local resources leading to increased resident awareness of and access to culturally and linguistically competent professional services. EPABHAG provides the following services among others:

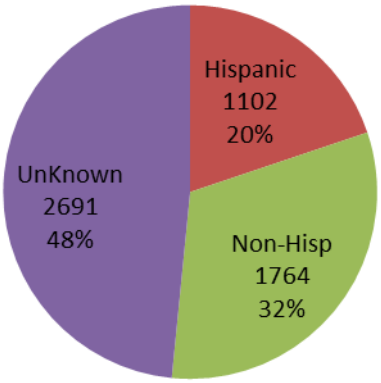
- Technical assistance to BHRS initiatives to increase community education activities and integration of mental health services with other community organizations.
- Community Outreach and Access (marketing and publicity, including translation).
- Promote increased East Palo Alto resident participation 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.

1,467 outreach encounters in FY 12-13.
Cost per person: Encounters are not unique individuals, data is collected anonymously.

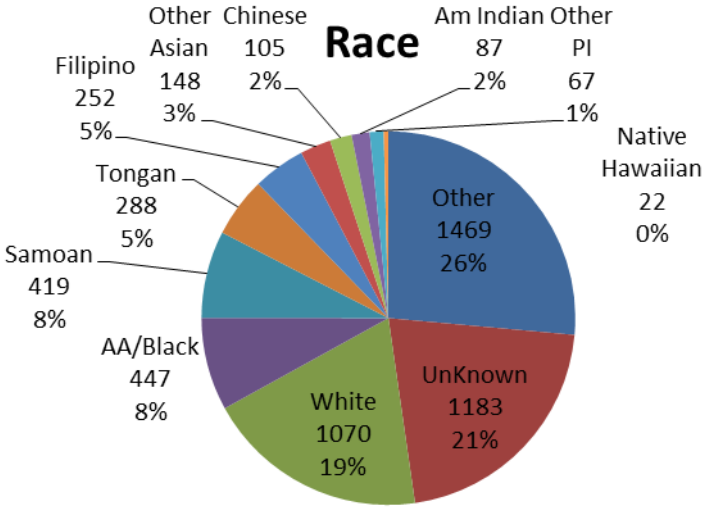
Demographics and Outcomes -

Gender:	Female	Male	Other	Unknown
	57.5%	**40.8%**	**1.6%**	**0.2%**

Ethnicity



Race



Language		%
English	3412	61.4%
Un Known	1251	22.5%
Spanish	451	8.1%
Tongan	138	2.5%
Samoan	103	1.9%
Cantonese	42	0.8%
Tagalog	41	0.7%
Mandarin	35	0.6%
Farsi	33	0.6%

Language		%
Arabic	16	0.3%
Vietnamese	7	0.1%
Other	12	0.2%
Portuguese	4	0.1%
Other Chinese Dialect	4	0.1%
Russian	3	0.1%
Lao	3	0.1%
ASL	2	0.0%

N = 5557, data methodology changed after the first quarter in FY 12-13, previously demographics were not reported for group encounters.

Location of Outreach	
Office	823
Other Community	225
Field (unspecified)	196
Home	161
Phone	102
School	57
Residential Care	42
Faith-based	23
Correctional Facility	17
Non-traditional	8
Homeless/Shelter	7
Age-Specific Community Center	5
Health Care/Primary Care/PES	5
Client's Job Site	4
Mobile Service	3

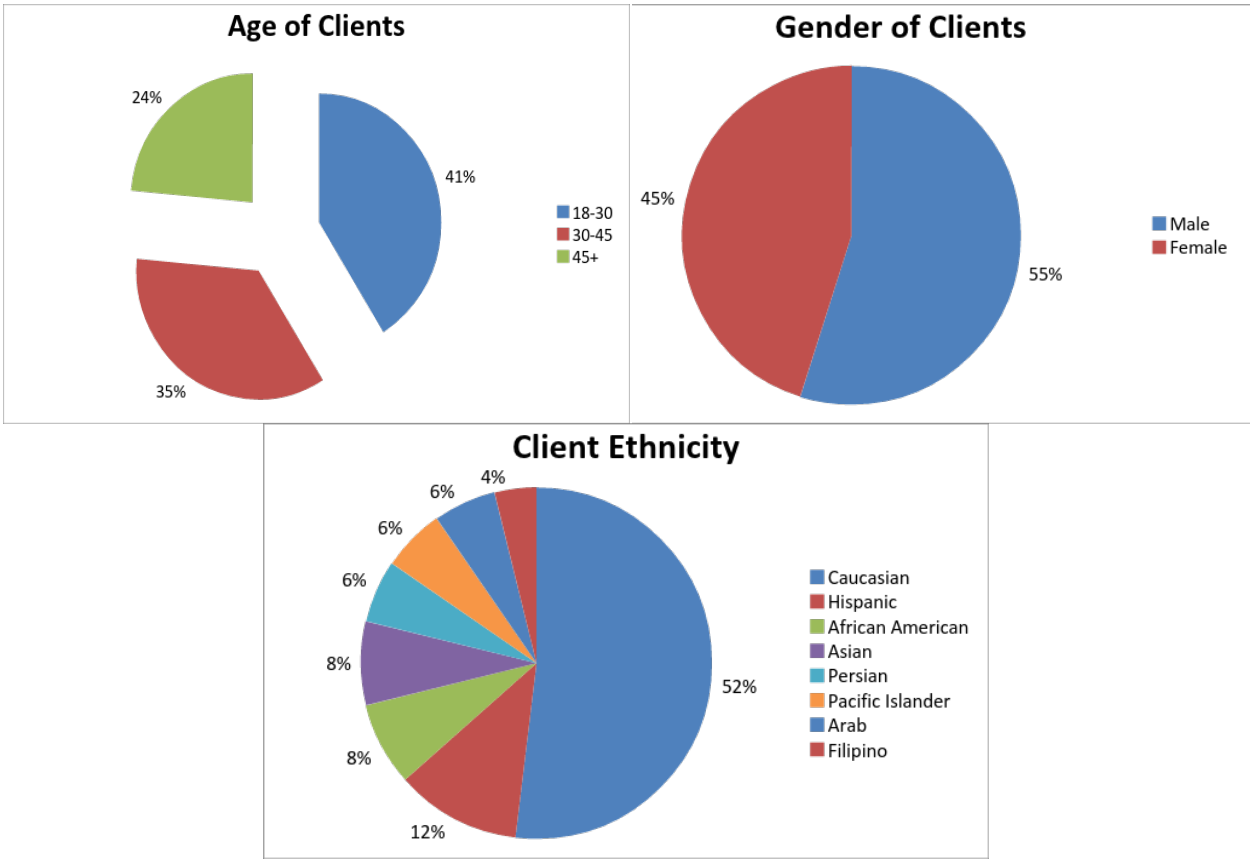
Referrals Made	
AOD	491
Medical	372
Housing	353
Mental Health	301
Food	272

Ravenswood Family Health Center – Ravenswood is community-based Federally Qualified Health Center (FQHC) that serves East Palo Alto. Ravenswood provides outreach and engagement services and to identify 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).
Ravenswood Family Health Center served 308 total clients.
Cost per client: $227

FAST Team –

Background - Funding for pre-crisis response, the FAST Team, began in May 2013, was contracted to Mateo Lodge, and provides in-home outreach services that offer engagement, assessment, crisis intervention, case management and support services (including information and education about behavioral health services and community resources, linkages to access outpatient mental health care and rehabilitation and recovery services among others) individuals who are experiencing severe emotional distress and their family or caretaker. FAST consists of a clinical case manager and peer counselors/family partners.

Demographics - The following charts and graphs reflect client demographics.

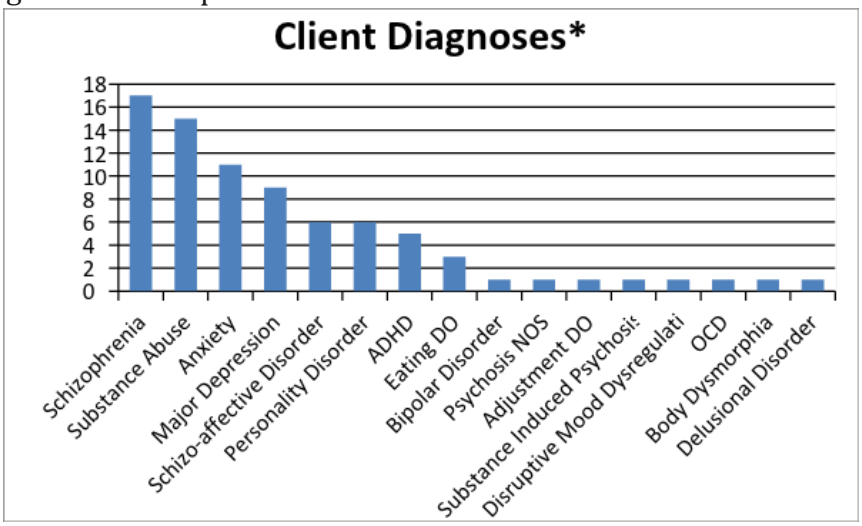


Client Language Preference –

Number of Clients	Language
1	Bi-lingual Tongan/preferred English
4	Bi-lingual Spanish/preferred Spanish
1	Mono-lingual Spanish
1	Bi-lingual Farsi/preferred English
1	Tri-lingual Cantonese and Mandarin/preferred English
2	Bi-lingual Mandarin/preferred English
38	Monolingual English
1	Bilingual Arabic/preferred English
2	Bilingual Tagalog/preferred English

Outcomes -

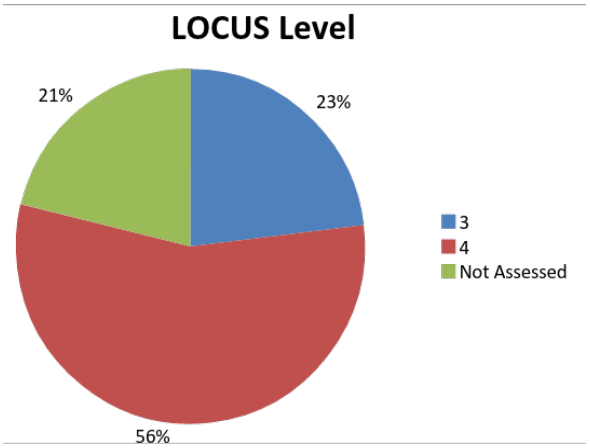
1. 28 clients were served; a) In-person visits with 23; b) Phone only contacts with 5
2. Average of 13 visits per client.



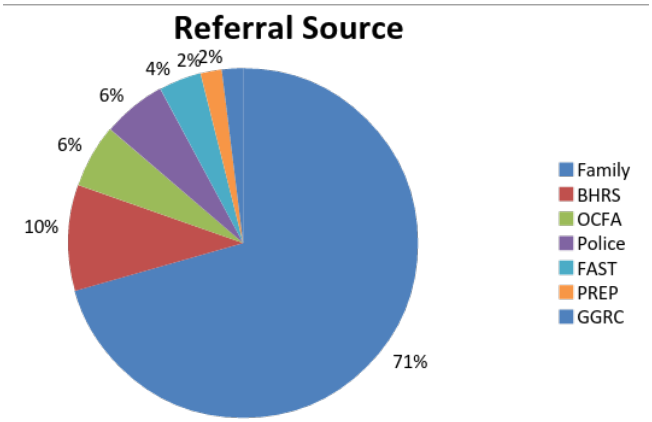
*Some clients have more than one diagnosis.

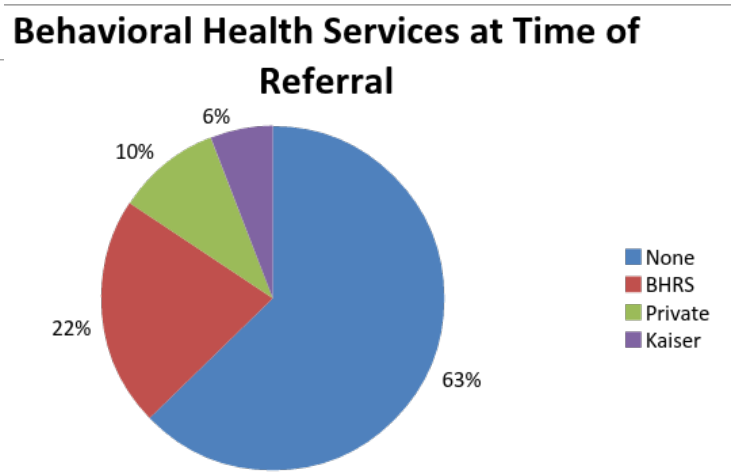
A LOCUS (Level of Care Utilization System) is a level of care tool to help determine the resource intensity needs of individuals who receive adult mental health services:

- Adult Day Treatment – Level 3
- Adult Rehabilitative Mental Health Services (ARMHS) – Level 3 or Level 2
- Assertive Community Treatment (ACT) – Level 4
- Intensive Community Rehabilitative Services (ICRS) – Level 4 or Level 3
- Intensive Residential Treatment Services (IRTS) – Level 5
- Partial Hospitalization – Level 4



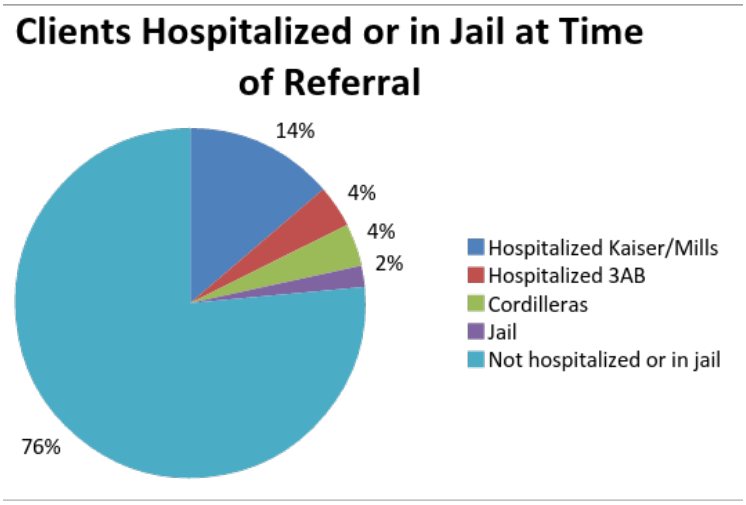
Referrals:

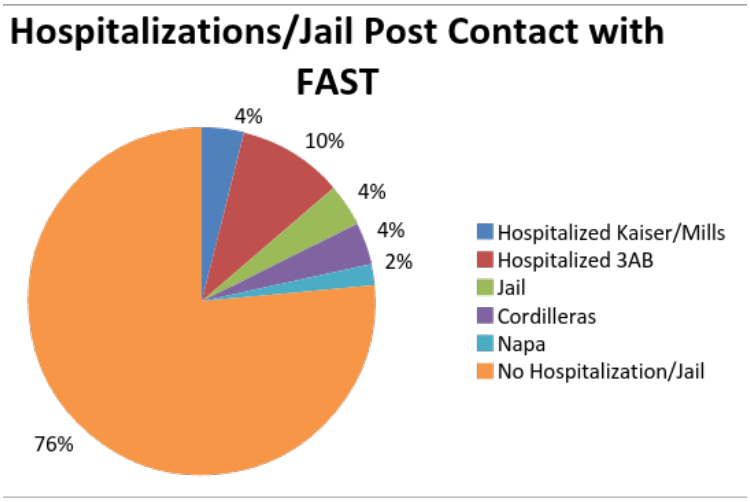




Linkages to Services

BHRS Outpatient	13	Shelter	1	DMV Assistance	1
Motel	6	Supported Housing	2	SSI Assistance	1
Redwood House	3	Vocational/Volunteer	3	Kaiser Outpatient	2
Transitional Residential	5	Education	3	Board and Care	1
Food Assistance	2	WRA	1	AA/NA	1





Two families chose to obtain restraining orders for their child who was living at home. In both cases the restraining order was violated, leading to jail.

Successes –

- Families are now directly contacting FAST for services.
- One FAST client referred two other families for services.
- Discharge planners from psychiatric inpatient facilities have referred at-risk clients
- BHRS have referred at-risk clients to FAST to help with engagement.
- Clients have found volunteer and paid employment as a result of support provided.

Challenges -

1. Training Needs for Peer and Professional Providers: Peers are an integral part of the success of the team. Besides the benefits of their lived experience, Peer Providers need additional training to help build skills and expertise for a demanding job in the community. Team leader and Director and CEO of Support Team also attended.
   Strategies to Address Training Needs
   - Weekly team meeting with Peer Providers, Team Leader, the Mobile Support Team Director and CEO to provide ongoing training and consultation.
   - Individual supervision by Team Leader.
   - Extensive training:
     a. Family Partner Training
     b. Motivational Interviewing
     c. Cognitive-Behavioral Training
     d. Mental Health First Aid
     e. Suicide Prevention (ASIST)
     f. Managing Assaultive Behavior
     g. Trauma-Informed Care
     h. LOCUS
   - Hired a psychiatrist to provide consultation and training to the team.

2. Getting the Word Out about FAST: FAST has worked hard to get information out to the community about the services and support the team can provide. The challenge is to get the information out widely, including the different cultural communities and families who may not have had much access to behavioral health treatment.
   Strategies to Inform the Community about FAST
   - The referral phone number for the Mobile Support Team and FAST is the same.
   - Printed business cards for FAST staff distributed to clients and professionals.
   - FAST program information added to Network of Care SMBHRS website.
   - Articles in Wellness Matters, along with ads giving basic program information.
   - Monthly NAMI meetings were attended by FAST and agency staff.
   - FAST information on NAMI website.

3. Engagement of Clients who are Unengaged or Minimally Engaged: looking for creative strategies to develop relationships and engage with clients who are not seeking services on their own and comes because of the concern of family members.
   Strategies to Engage Clients in Services
   - All visits occur in homes or in the field (i.e., coffee shops, going for a walk, etc.)
   - The client chooses the location to meet.
   - The privacy needs of family members and clients are respected, meeting separately as needed and allowing for changes of location to accommodate.
   - FAST staff members define the family broadly, in order to include individuals that the client feels are most supportive of him/her.

4. Clinical Challenges of Clients: The clients being served have intensive case management needs, including active co-occurring disorders, the severe nature of their symptoms, few opportunities for social, work or school activities and little experience in independent living.
   Strategies to Address Clinical Needs of Clients
   - FAST focuses on strengths and abilities of clients.
   - Providing unconditional acceptance of each family member and client while encouraging positive changes.
   - Striving to increase emancipation and independence of the client and enlisting the family member's support of these steps as culturally appropriate.
   - Helping family members make a plan for their own health and wellness.

5. Challenges in Referrals and Providing a Warm Hand-off: FAST is intended as a short-term, initial engagement team, helping clients access the longer-term services they need. Glitches in this process have made this connection difficult and clients have experienced severe delays in getting necessary supports and services.
   - Several months delay in providing a home-visit service by a psychiatrist for a home-bound client with severe anxiety and panic disorder.
   - Lack of availability of county case management/rehabilitation services. One client who refused medication reported being unable to get any other services. This client was motivated for employment. The clinic could have accepted the client for case management services.
   - Lack of availability of therapy services: BHRS and Kaiser Clinics are providing psychiatry, but have few resources for therapy to clients referred to and from.
   - Several months of delays in getting vocational services for clients referred.
   - Communication gaps: FAST does not receive adequate information from county/contract staff regarding referrals. Staff are unclear about confidentiality rules regarding their ability to talk to FAST.

   Strategies to Address Challenges in Referrals
   - FAST continues to work with individuals until a longer term plan is in place.
   - The issue was brought up at Leadership presentation.
   - The Team Leader will continue to address each issue as it arises.

In FY 2013-14, the FAST team served 51 clients.
Cost per client: $6,751

BHRS staff positions – Staff were also partially funded seven positions and included, two Older Adult System of Care Development staff positions, one Family Partner in the Office of Consumer and Family Affairs, one Communications Coordinator, a Patient Services Assistant at ACCESS, a Clinical Services Manager at ACCESS, and a Supervising Mental Health Clinician at SMART.

In FY 2013-14, CSS Outreach and Engagement partially funded staff served 241 clients.
Cost per client: $1,569

Community Services and Supports (CSS) – System Development (SD)

The following are highlights for FY 13/14, per program:

The Older Adult System of Integrated Services (OASIS) –

Background – OASIS serves older adults at risk of becoming or seriously mentally ill, including those served by specialty field-based outpatient mental health team, County clinics, community-based providers, mental health managed care network providers (private practitioners and agencies), primary care providers, and Aging and Adult Services. There is an emphasis on specific ethnic/linguistic populations for different regions of the County. For example, in the Coast region the focus is on Latino populations, while in North County the focus is on Asian populations, and in South and Central County the focus is on African American, Latino, and Asian and Pacific Islanders.

OASIS focuses on creating a coherent, integrated set of services for older adults in order to assure that there are sufficient supports to maintain the older adult population in need in their homes and community, and in optimal health. The intent is to assist seniors to lead dignified and fulfilling lives, and in sustaining and maintaining independence and family/ community connections to the greatest extent possible.

Demographics - Clients Served - 217

- New Referrals -14; Cases Closed - 38
- Chinese-speaking clients -26; Spanish-speaking clients -22

Successes –

- A new Spanish Speaking therapist was hired to replace the social worker who left. This clinician quickly built rapport with clients and was able to fill a void for those grieving the loss of their previous long-time social worker.
- In April of 2014, a multi-year contract with the Millbrae Manor enhanced Board and Care facility which had filed for bankruptcy, was signed. This facility houses over 20 OASIS clients. The contract relieved great concern felt by OASIS staff and clients, due to the uncertainty and potential uprooting of the clients.
- Regarding housing, in San Francisco where housing is infamously the highest in the country, one chronically homeless Spanish Speaking female client became one of only 10 recipients of MHSA subsidized housing units in a brand new development with on-site case management. This turned out to be gratifying to the client, client's family and staff alike.

Challenges –

- During the first two quarters of F/Y 13-14 the OASIS team adjusted to major staff and programmatic changes within OASIS. The long-time Supervisor/Manager of the OASIS was replaced with a BHRS supervisor who came with system-of-care adult

outpatient experience, but little in the way of medically fragile/older adult experience. Thus, OASIS staff was faced with the challenge of d*ealing* with the loss of a highly respected leader and expert in the area of older adult specialty care; adjusting to a new supervision and management style, increased oversight of quality improvement and quality assurance and programmatic changes due to the restructuring of BHRS into Community Service Areas.

- During the second half of FY 13/14, OASIS staff continued to adjust to the re-designed structure of the OASIS team, in which the new Program Specialist assumed a greater role in the clinical operations and oversight of the program in collaboration with the supervisor. Staff was also adjusting to a new supervisor who now had a dual role as a Clinical Services Manager which allowed less concentrated 1-1 time. Additionally, a long-time and well-liked Spanish speaking social worker left employment with the OASIS, leaving both staff and clients feeling a big loss.
- During the month of December, Millbrae Manor an enhanced Board and Care facility in which over 20 OASIS clients are housed and cared for, announced that it was filing bankruptcy. This was of great concern to OASIS staff and clients, as the uncertainty of the future of the facility, its relationship with the County, and potential uprooting of the clients created much stress and unanswered questions. This issue was to continue with many unknowns beyond this reporting period.
- It was determined that groups that OASIS had been providing clients for both social and mental health purposes were no longer a resource that could be offered. This was very disappointing to clients who were now being offered referrals to the Senior Peer Counseling program, phone-based support groups, and more intensive one-one services.

In FY 13-14, this program served 91 clients based on the clinicians partially funded by MHSA. Cost per client: $3,726

Senior Peer Counseling Services Program –

Background - The Senior Peer Counseling Program, provided by Peninsula Family Service, recruits and trains volunteers to serve homebound seniors with support, information, consultation, peer counseling, and practical assistance with routine tasks such as accompanying seniors to appointments, assisting with transportation, and supporting social activities. The Senior Peer Counseling program has been expanded to include a Chinese, Filipino and LGBT volunteers.
This year the goal for recruitment of peer counselors is to recruit 60 new peer counselors. Seventy-nine counselors have been recruited, 132 percent of goal. The annual goal is to train 36 new peer counselors.

Demographics -

- Latino- 199 clients, 54%; Chinese -29, 8%; Filipino-72, 20%
- LGBT- 9 clients, 3%
- English-speaking- 58 clients, 16%

Outcomes -

- Thirty-three counselors graduated from the three training classes held this year, 92% of goal. One English-speaking class was held in the fall and one Spanish-speaking and one English-speaking was held in the spring.
- Through this second quarter the Senior Peer Counseling Program has had 130 senior peer counselors participating in the program, 144% of goal. Thirty-nine counselors retired during the quarter, bringing the current total to 91.
- During the year 220 new clients entered the program and 101 clients' cases were closed. As of June 30, 2014, 367 senior peer counseling clients were active in the program and 468 clients have been served during the year, 144% of goal.
- The program currently has five groups in senior/community centers or non-profits throughout the county and staff is looking at other opportunities to start groups.
- A group targeting the Filipino community called "Kapihan "(Coffee Clutch) has really taken off at the Lincoln Park Community Center in Daly City which is why more than 50 new Filipino clients have been added to the roster. The group meets weekly and learns about community services and discusses their individual needs. One of the participants had the following comment:

"Kapihan" makes me forget my problems. It is getting to be a big part of my learning and social life. Sharing my problems is a big plus. Also, getting some solutions to my problems."

- Peninsula Family Service hosted a wonderful agency wide volunteer recognition event at Three Restaurant in San Mateo. At the event five Senior Peer Counselors were given awards for volunteering five years in the program.
- The LGBT Coordinator retired on June 27. Prior to retiring she coordinated, along with other PRIDE members, the screening of the movie Gen Silent in San Mateo. She also helped coordinate the second annual Pride Event on June 21 in Central Park in San Mateo. There is currently a recruitment for the position.
- Peninsula Family Service applied for additional funding from the Sequoia Healthcare District to provide a Spanish-speaking training and bimonthly supervision group in Redwood City and received $15,000 to cover the costs to do one class for 8 to 10 new counselors and ongoing supervision for the year.

Challenges - The biggest ongoing challenge is recruiting volunteers who will commit to the nine week training. The training model is being reviewed to determine if the 54 hour, twice a week for 9 weeks, can be modified to fewer up front hours, and more ongoing in service training can be done in Supervision Groups. Staff is also contacting other peer counseling providers in the State to see their training models.

In FY13-14, CSS funded 50% of Senior Peer Counseling (the remaining 50% is funded through Prevention and Early Intervention). The program served 468 total clients.
Cost per client: $605

Pathways, Court Mental Health Program–

Background - The Pathways Program serves seriously mentally ill (SMI) nonviolent offenders with co-occurring disorders. The program is a partnership of San Mateo County Courts, the Probation Department, the District Attorney, the Private (Public) Defender, the Sheriff's Department, Correctional Health, and the Behavioral Health and Recovery Services Division. Through criminal justice sanctions/approaches, and treatment and recovery supports addressing individuals' underlying behavioral health issues, offenders are diverted from incarceration into community-based services. Typically, a Pathways client is sentenced to three years' probation and remains as an active member of the Pathways Program for the three years. When they graduate from Pathways there is a formal ceremony in court where their case and their accomplishments are shared with all in the courtroom including prisoners who may become Pathways clients. Graduates receive a Pathways Certificate signed by the Pathways Judge. Pathways Graduates are no longer on probation but remain in the Pathways Program as Alumni for activities and to help guide and support others in the program.

Demographics -

- 45% Caucasian, 24% African-American, 17% Asian-American, 12% Latino, 2% Multi-Ethnic
- Age: 14% 16-25, 69% 26-60, 17% 60+
- Gender: 40% Female, 60% Male
- Insurance coverage: 52% SM Regions/Medi-cal, 24% Private Providers (Kaiser, Aetna, etc), 2% Veterans Administration, 2% Edgewood/Medi-cal and 10% Telecare-Full Service Partnership/Medi-Cal.

Outcomes - The Pathways Mental Health Court Program admitted 10 clients last year giving the program a total of 37 clients by 12/31/13. 7 clients celebrated successful completion of Probation and received a certificate and they an option to take a photo with the Judge and their treatment team. There are now a total of 57 Graduates and Alumni. The Pathways Mental Health Court Program admitted 8 clients during this second half year report. This gives us a total of 45 clients. 5 client successfully completed Probation and their success was observed in Judge Forum's court room where they were given a Certificate of Completion. The Pathways program has a total of 62 Graduates/ Alumni.

Successes –

- Pathways has had 2 clients graduate from El Centro Outpatient, 1 from the Women's Enrichment Center Day Treatment , 1 from Women' s Recovery Program and 1 from Asian American Outpatient. A Pathways Alumni was the recipient of the Consumer Hall of Fame Award. Pathways continues to offer the Clubhouse every Saturday held at the Heart & Soul facility in San Mateo from 9:00am-noon. Here, the group members have an excellent source of community, wellness and recovery. 8-15 clients are served and the group is facilitated by two Pathways staff.

- In the second half of the reporting period, Pathways had 3 clients graduate from El Centro Outpatient and 1 client completed Women's Recovery Program. One client receives Section 8 housing.
- Pathways had another Intern from Cal Sate East Bay who provided case management services and co-facilitates a group. The team also had an MFT volunteer doing assessments, court reports, individual therapy, group work and treatment planning. A contractor assists Pathways with court reports, treatment planning and supervision and in April, a new probation officer was assigned.
- This year there was a change of a manager that has been with Pathways since its inception. The team was able to celebrate his departure and welcomed the new manager that brings great experience to the Pathways Team. The team would also benefit from specialized forensic training to enhance treatment effectiveness. Some of the areas where training is needed is in PTSD treatment for adults and how to effectively work with criminogentic thinking.
- In November 2013, Pathways celebrated its annual Holiday Party with the Pathways staff, clients, family and providers; it was a festive occasion that served over 50 providers and clients. There was a team luncheon in December that included the Pathways Judge, the District Attorney and all Pathways staff. This allowed everyone to bond and celebrate the great work done as a multidisciplinary team.

Challenges - Enrollment numbers are slowly improving but this continues to be an issue due to the judicial system offering day for day jail credit for sentences. Some inmates who are not interested in treatment will mostly likely choose to complete their jail sentence rather than enter Pathways. However, all court programs have low enrollments numbers at this time. The increase in numbers can be attributed to maintaining good partnerships with Correctional Health staff and the Sheriff's department to assist us in identifying good Pathways candidates. The benefits of the program are promoted to community programs and with the help of probation clients are identified who have modifiable sentences who meet the programs criteria and lastly, staying connected with the Private Defenders Office for possible referrals. During this reporting year there were 3 clients excluded for not complying with treatment. Pathways had no new felony offenses committed.

In FY 13-14, Pathways served 91 individuals.
Cost per client: $3,409

Pathways- Co-occurring Housing Services – Shelter Network is contracted to provide two dedicated transitional beds per night, one fee-for-service one bedroom apartment on an as-needed basis; supported housing services for families with children; programmatic support; childcare services for women in the Pathways for Women program while they are attending clinical activities and meetings. A representative from Women's Recovery Association participates three hours a week in the Pathways for Women program meetings.

Mental Health Association manages the fiscal distribution of the Pathways Flexible Fund.

SYSTEM TRANSFORMATION AND EFFECTIVENESS STRATEGIES

System Transformation and Effectiveness Strategies includes a focus on recovery/resilience and transformation; increased capacity and effectiveness of County and contractor services through training, bilingual/bicultural clinicians, peers/peer-run services and family partners; implementation of evidence-based and culturally competent practices; family support and education training for all providers serving all ages.

Peer Consumer and Family Partners– San Mateo County BHRS has continued to support persons with lived experience working in the Youth System and Adult Systems. All these employees provide direct service to consumers/clients as well as support and bring their unique perspectives throughout the behavioral health system and community.

Peer Community Workers - In the adult systems, there are 10 Community Workers who have lived experience as a consumer/client. These positions are mostly full time, civil service positions that are embedded on clinical teams. The Community Workers represent diverse cultural and linguistic experience including bicultural and bilingual Spanish, Tagalog and Chinese as well as English speaking African American and Caucasian persons. Community Workers assist Adult by facilitating groups such as WRAP, WRAP for housing, Dual Diagnosis Group, Welcome Registration/Orientation for new clients, Crochet and Knitting Group, Healthy Living group, Case Management Workshop, Ash Thinkers, Ash Kickers, Chinese Family Support Group, Cooking with Ease, Stress group. They also help clients find shelter beds, connect to vocational resources and provide transportation. Community Workers participate in the following groups: African American Initiative, Lived Experience Speakers Academy and Speakers Bureau, Housing Committee, Mental Health and Education Workforce Collaborative: Integrated Care, Co-Occurring Change Agents, Housing Operations and Policy Committee, Change Agent Housing Committee, Change Agent Recruitment and Education and Community Service Area planning.

Family Partners - In the Youth System, there are 8 Family Partners with lived experience as a family member of someone with behavioral/mental health challenges. All but one position is full time and all are civil service positions. Seven are embedded on the youth clinical service teams and one is embedded in the Pathways Mental Health Court Adult team. The Family Partners represent diverse cultural and linguistic experience including bicultural and bilingual Spanish and Tongan, as well as English speaking African American. Family Partners provide individual support to parents of the youth, sharing their lived experience with the families they serve. They also provide group support to parents/caregivers by providing educational activities around children and their mental health. Groups co-facilitated by Family Partners are: WRAP, Parent Project, Peer to Peer Well Body Program, Equip Educate and Support (EES), Parent support groups, and NAMI Basics. Family Partners also participate on: African American Initiative, Latino Collaborative, North County Outreach Committee, and Co-Occurring Change Agents.

In FY 2013-14, 489 clients were served, Peer Partners 313 and Family Partners 176 clients. Cost per client: $1,959

Puente Clinic - This specialty clinic sponsored by Behavioral Health and Recovery Services, Golden Gate Regional Center and Health Plan of San Mateo serves the special mental health needs of clients with developmental disabilities. Since the inception of The Puente Clinic in 2008 until June 30, 2014, Puente has received 264 referrals.

Demographics - 39 referrals were received.

- Ages 18-29: 13, ages 29-39: 6, ages 39-49: 7, Ages 49-59: 6, ages 59 or above: 2.
- Only 3 did not meet Puente criteria and were referred elsewhere. Diagnoses of those referred: Autism-6, PTSD-5, Intermittent Explosive DO, Schizoaffective DO, and anxiety issues-4each, Other Mood disorders-5, ADHD, Impulse control DO, Schizophrenia(paranoid), Socialized conduct DO, adjustment DO, dementia and organic brain DO- 1 each.

Outcomes - One of many success stories to report is the case of a gentleman who came to us in November of 2008 after many years of institutionalization at Agnews Developmental center. Client had recently moved in to a group home in the community. He was diagnosed as autistic with profound intellectual disability, mood DO NOS, Pica, and nicotine dependent. Client had behaviors such as public masturbation, AWOLs, restlessness, difficulty sleeping, head banging, aggression toward staff and rectal digging. Client received psychiatric medication management. As of Oct. 2014 client exhibited less intense and frequent hyperactive periods deceased from every 2-3 weeks to one episode per month, now every 2-3 months and lasting less than a day rather than 3-4 days instead of one week. There has been reduced hyperactivity, PICA, and AWOLs.

A 54 year old gentleman diagnosed with mild intellectual disability, PTSD, dysthymia and paranoid and borderline personality traits. Client was returning to the community from Sonoma Developmental Center. Client had a history of self-harm, physical and verbal aggression, threatening self-harm, inappropriate sexual behavior (disrobing in public), making weapons and exhibiting psychosomatic symptoms. Client was moved in to a single bedroom apartment and was receiving SLS services. Client continued to show impulsive behaviors triggered by fears of not having enough money. His behaviors led to paranoid decompensation, psychotic symptoms, self-injurious behaviors and aggression to staff. This led to frequent psychiatric hospitalizations, sometimes up to several times in one week. Medication optimization, along with weekly psychotherapy and using adjunct services, such as a crisis management team were insufficient to address longstanding patterns of maladaptive behaviors. Puente recommended that the client be returned to a locked facility in order to optimize the safety of the community and the client.

In FY 13-14, the MHSA partially funds two 0.5 FTE clinical positions, and they served 126 total clients (63 clients based on FTE)
Cost per client: $1,931

Co-Occurring Contracts with Alcohol and Other Drug Providers - BHRS contracts with nine AOD providers for either additional bed days (for residential providers) or additional hours of service (for non-residential providers), or to enhance/supplement services provided to clients already in residential or non-residential treatment.

- *El Centro* - 336 UOS delivered, 101.8% of contracted amount
- *Free At Last* - 385 UOS delivered, 98.7% of contracted amount
- *Our Common Ground* - 1383 UOS delivered, 329% of contracted amount
- *Project 90* - 604 UOS delivered, 109.4% of contracted amount
- *Pyramid* - 912 UOS delivered, 116% of contracted amount
- *Service League* - 1230 UOS delivered, 100% of contracted amount
- *StarVista* - 1800 UOS delivered, 176.8% of contracted amount
- *WRA* - 509 UOS delivered, 48.9% of contracted amount

StarVista is contracted to serve an additional 10 girls with co-occurring disorders. The Girls Program is a court mandated treatment for adolescent girls with COD in the juvenile justice system. StarVista conducts individual, group and in-home family counseling sessions to girls with COD and their families.

In FY 2013-14, StarVista's AOD Juvenile Program served 13 clients.
Cost per client: $8,800 based on 10 spots

Evidence-based practice (EBP) expansion - 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.
In FY 13-14, clinicians served 219 youth and 1,003 adult clients.
Cost per client: $1,084

Child Welfare Partners – As part of the 2009-10 MHSA expansion plan, BHRS partially funds two clinicians serving high risk children/youth referred through Child Welfare to Partners program.
In FY 2013-14, Child Welfare Partners program served 37 clients.
Cost per client: $5,003

Prevention and Early Intervention (PEI)

PEI interventions target individuals of all ages prior to the onset of mental illness, with the sole exception of programs focusing on early onset of psychotic disorders such as schizophrenia. PEI programs are designed and implemented to help create access and linkage to treatment, improve timely access to mental Health services for individuals and/or families from underserved populations and are non-stigmatizing and non-discriminatory. San Mateo has focused its PEI dollars primarily on evidence-based interventions that have a proven track of success. PEI is approximately 15-20% of the MHSA budget and requires 51% of PEI funds be spent on children and youth ages 0 to 25.

PEI PROGRAM EVALUATION

In July 2013, Gibson & Associates was contracted to conduct an evaluation and provide data for two years of PEI implementation. The intent was to understand the impact these programs are having in terms of promoting mental health, reducing the risk of mental illness, and decreasing the severity and negative consequences associated with onset of mental illness. See Appendix 3 for the first year report, for services implemented in fiscal years 2013-14.

Eight San Mateo County PEI programs were evaluated:

- Project Grow – Middle School Initiative
- Teaching Pro-Social Skills
- Project YES! & AC-OK, Seeking Safety Interventions
- Project SUCCESS
- Early Childhood Community Team (ECCT)
- Crisis Hotline and Youth Intervention Team (YIT)
- Prevention of Early Psychosis (PREP)

The full report includes a project description, in the areas of productivity, effectiveness/ impact, satisfaction with services, responsiveness to target community and MHSA requirements, implementation success and lessons learned. Here are a few highlights from each program:

- Project Grow Pollicita students showed strong gains across levels of stress and negative emotions and ability to manage feelings.
- Over 80% of Project YES! Participants surveyed learned to recognize important skills related to setting boundaries and seeking help when facing challenges or stressors.
- Significant decrease in AC-OK client-reported need for alcohol and drug treatment and reductions in their experience of stress and need for treatment for stress.
- All Teaching Pro-Social sites exceeded an increase of 10% in positive social skills.
- Project SUCCESS students demonstrated gains in self--esteem and view of their future.
- ECCT teachers and families increased capacity to understand child's behaviors and respond effectively.
- Over 75% of Crisis Hotline callers surveyed, felt connected to the counselor and found the call helpful.
- PREP clients demonstrated reduction in symptoms and hospitalizations with the strongest and most valid gains in reductions in anxiety and depression.

While there was considerable difference in the quality, quantity and validity of data available for each program this first year, there was sufficient evidence that each project was having a positive impact. In the cases where data was weaker, program managers were able to make commitments to strengthen data collection in the next fiscal year, 2014-15. The following highlights overall evaluation process findings and areas where BHRS has taken action to make improvements in data collection and reporting:

Overall Process Findings and Outcomes
✓ Every project evaluation validated client satisfaction and/or positive client impact.
✓ Areas for improvement for each project were identified.
✓ Staff attrition impacted services and data collection efforts.
✓ Most PEI projects lacked capacity for participating in an external evaluation.
✓ All PEI programs now have a consistent evaluation plan currently being implemented
✓ PEI program reports will now include impact and satisfaction data, along with the usual service dosage, demographics , successes and challenges
✓ The evaluation plan has been incorporated into the Request for Proposal and will be incorporated into the new contracts.

We anticipate this report will provide additional impetus to our ongoing dialogue with consumers/clients, family members, service providers and other key community stakeholders about PEI programs and services.

PEI PROGRAMS FOR AGES 0-25

Early Childhood Community Team (ECCT) – Early Intervention

Background – ECCT incorporates several major components that build on current models in the community, in order to support healthy social emotional development of young children. The ECC Team comprises a community outreach worker, an early childhood mental health consultant, and a licensed clinician and targets a specific geographic community within San Mateo County, in order to build close networking relationships with local community partners also available to support families.

Outcomes -

1st half of FY13-14

- Mental health consultation services were provided to 4 childcare programs in the Coastside region, serving 24 families and 20 staff. Consultation activities included weekly visits with childcare providers, individual and group consultation meetings, meetings with parents, observations of classrooms and individual children and assistance with resources and referrals.
- Weekly child-parent psychotherapy services have been provided to 13 families in the Coastside region. Two additional families received a mental health assessment, but did not move into the treatment phase.
- Weekly child-parent psychotherapy services have been provided to 8 families in the Daly City/Northern San Mateo County region.

- The Case Worker provided services to 25 families which included case management, parent education, Parent-Child Activity groups, and assessment. Services are provided weekly, monthly or on an as needed basis.

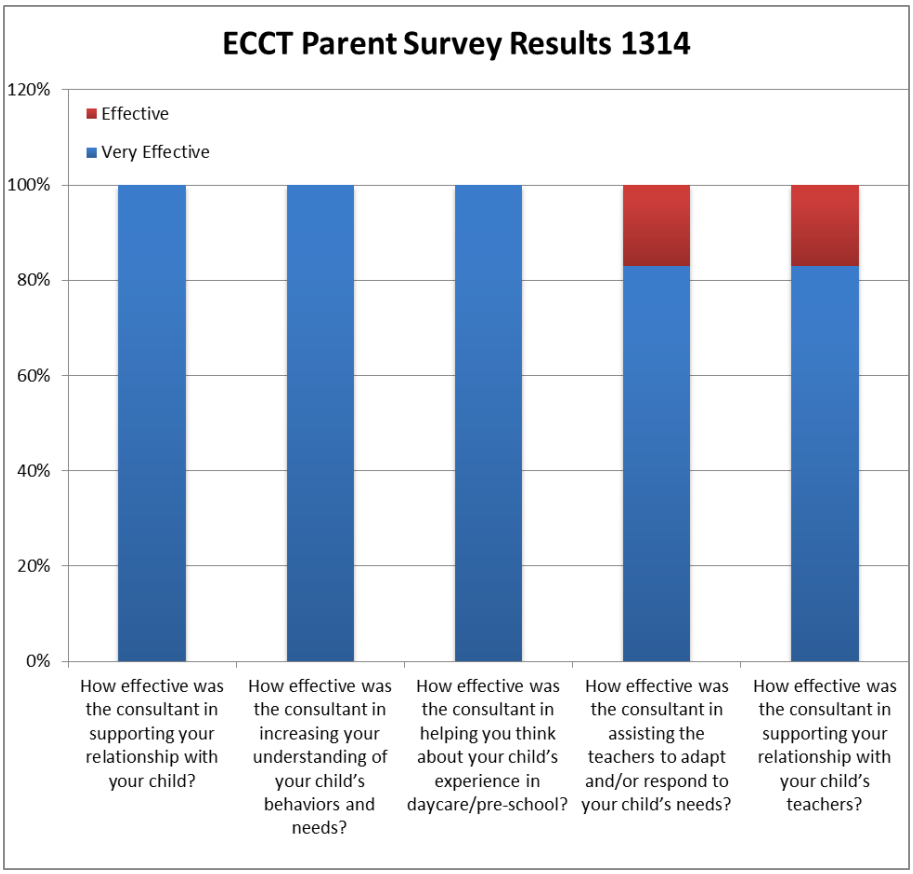
2nd half of FY 13-14

- Mental health consultation services were provided to 4 childcare programs in the Coastside region serving 116 children and 20 staff. More intensive case consultation was provided to 29 families. Consultation activities included weekly visits with childcare providers, individual and group consultation meetings, meetings with parents, observations of classrooms and individual children and assistance with resources and referrals.
- Weekly child-parent psychotherapy services have been provided to 14 families in the Coastside region and 8 families in the Daly City/Northern San Mateo County region. An additional 6 families received a mental health assessment, but did not move into the treatment phase. Weekly services include family therapy, collateral individual sessions, and additional collateral contacts such as school observations, participation in TDM or IEP meetings, etc. Most participants receive psychotherapy services for about one year.
- The Community Worker provided services to 28 families which included case management, parent education and assessment. An additional 26 children and their caregivers attended the Parent-Child Activity groups. Services are provided weekly, monthly or on an as needed basis.
- ECCT staff has collaborated to respond to the needs expressed by partners at the school district and the Coastside Clinic to provide multiple workshops this year. Themes included School Readiness, Children and Trauma, Social Emotional Development, and Positive Discipline. These presentations were adapted for each unique audience. In this manner diverse groups were served such as teachers, providers, and administrators as well as parents.

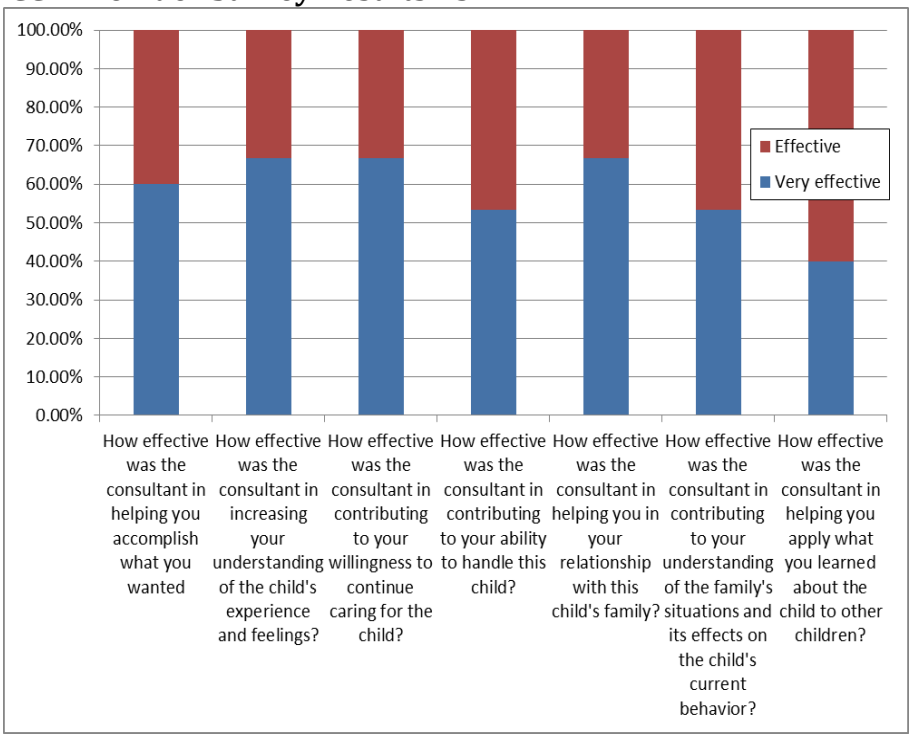
ECCT staff supported teachers and families participating in Kick off to Kindergarten this year by administering the ASQ-3 and ASQ-SE screening tools and providing needed referrals to any child identified with a potential need for additional support.

1. As a result of on-going mental health consultation, teachers at 4 childcare programs have demonstrated greater ability to understand and respond to the social-emotional needs of children in their centers. For 8 of the children provided case consultation, teachers were observed in a pre- and post-test assessment using the Arnett Caregiver Interaction Scale, which measures the relationship between teacher and child. In seven cases, teachers showed increased responsiveness and sensitivity to the children (the eighth showed no difference). In no case was a teacher rated in the lowest quadrant of this four-point rating scale and a total of five teacher-child interactions were rated in the highest quadrant during the post-test: in two of these cases, this rating represented a move from the second highest quadrant into the highest quadrant.

2. 29 families have increased their capacity to understand their child's behaviors and to respond effectively to their social-emotional needs. This increased capacity is noted in the parent surveys (results below) and also in informal comments made by parents in noting their satisfaction in working with the consultant. On the survey, parents included comments that indicate they enjoyed the work with the consultant, writing "she helped us to understand how to relate with my son" and "she helped me with other phone numbers of other people who helped me." Parents and teachers also noted differences in children's behaviors: the consultant was able to observe these differences in pre- and post-test assessments using the Devereux Early Childhood Assessment Clinical Form (DECA-C), which measures behaviors related to risk and resilience in preschool children. Over the course of the past program year and 6-12 months of working with the teachers and parents, for the six children for whom it was possible to complete a pre- and post-test assessment, statistically significant increases in protective factors were observed in three children and statistically significant decreases in behavior problems were observed in one of these three and also in one additional child. Additionally, 8 families have received referrals to additional services in the community.
3. Parents receiving child-parent psychotherapy services who reported symptoms of maternal depression at the onset of treatment currently report fewer symptoms and greater capacity to manage and understand their own mental health needs. Parents receiving child-parent psychotherapy services have reported gains in their understanding of their children's needs and behaviors, and in their ability to respond effectively to these needs. These clients' complete pre and posttest assessments using multiple measures, including the Parenting Relationship Questionnaire (PRQ), the Child Behavior Checklist (CBCL), the Parenting Stress Index (PSI), and the Keys to Interactive Parenting Scale (KIPS). Scores on the PRQ and PSI measures at the outset of treatment on average reflect low levels of attachment, involvement, discipline practices, and parenting confidence along with high levels of relational frustration and parenting stress. While these areas are not always the focus of clinical treatment, there are consistent improvements, or at least stable scores in these domains. It is also common to see a high level of concern for child behavior, and lower scores on the KIPS which is a parent-child interaction observational scale. There is typically improvements or at least stable scores on the CBCL and the KIPS as well at the close of services.
4. Families with resource needs have been supported with appropriate linkages and referrals to access services such as food, housing, child care and early education, legal and mental health services. Families with parenting and school readiness concerns have received relevant Parent Education services to support parents in better meeting their children's social-emotional needs and taking advantage of teachable moments. In the past, attendance at the Parent-Child Activity group was overwhelming, with more than 25 children plus their caregivers in consistent attendance. To better meet the needs of the community, the relationship with StarVista's Learning Together was leveraged in order to create a second group. There is now a robust, complementary groups running recurrently.



ECCT Provider Survey Results 13-14



The ECC Team feels proud of the successes of the project and of the sense of community collaboration they have helped to develop in the Coastside region. The staff on the ECC Team has continued to expand and extend their reach in this community through their responsive, thoughtful approach to developing long-term relationships with key community partners such as the local child care/preschool community, the community mental health clinic and the local school district. These community relationships have been the foundation upon which all of their work has evolved and have ensured that the services developed take into consideration the needs and the culture of the community.

A highlight of the collaborations this year was the participation in both the Coastside and Northwest County regional Community Service Area planning meetings. The meetings provided an important platform for networking and collaborating with other providers, as well as the opportunities for the staff to both share their expertise in working in these communities and to learn from their colleagues. ECCT staff is participating in ongoing meetings & collaborations with colleagues from other agencies and disciplines to continue to expand the reach of the services and to better meet the needs of the communities. Additionally, ECCT staff participates in a diverse array of outreach opportunities, including but not limited to: tabling at community fairs & special events, attending First 5's Bridges to Success initiative quarterly meeting, attending multi-disciplinary community training events like the PreK-3 Leadership Institute, and providing free workshops and developmental screenings. New connections made through these meetings & events will lead to increased awareness of the services, especially in the North County.

Successes:

- The presence of the ECC Team has further supported a strong system of care within the Coastside focusing on families with young children. As part of the philosophy of the ECCT Project, the ECC Team is committed to outreaching to underserved and unserved populations. All of the services offered through the ECC Team are provided within the community, embedded within childcare programs, schools, family resource centers, and community centers. By providing prevention and early intervention services within these community settings, there is access to families who might not otherwise seek out mental health supports. Additionally, offering mental health services in families' homes, at their child's school, or within familiar community agencies, provides flexibility in service delivery that enables the ECC team to reach underserved/unserved families. By targeting the services within programs serving low-income, migrant, isolated, culturally diverse families, there is an aim to address economic, cultural and racial disparities within these communities, and the challenges of accessing mental health services that often accompanies such disparities.

  Strong relationships have been built with key community partners and successfully refer families to the local school district, other StarVista services, Coastside Mental Health and PretoThree, among others. Additionally, work with these partners

helps address gaps and needs in the community and to address the existing system of care for families with young children living in the Coastside.

- Mental Health Consultation services have supported children with challenging behaviors, reducing their risk of expulsion and increasing the school's capacity to sustain these children in their programs. The consultant continues to support teachers and families around identified children in the classrooms. Teachers consistently report that the challenging behaviors they witness in the classroom are the biggest source of stress in their work. These challenging behaviors often bring up feelings of ineffectiveness, frustration, confusion, and concern, especially as experienced teachers report seeing more challenging behaviors more frequently. Despite significant experience and expertise, teachers continue to feel overwhelmed and worn out when encountering these increasingly challenging behaviors. In consultation meetings, consultants think with teachers about the meaning behind these behaviors and work with teachers to develop an understanding of the child's needs in order to develop an effective response. Consultants offer consistent meeting space with teachers as discovering which type of intervention will work with a particular child often takes multiple tries and tremendous effort on the part of the teaching staff. Consultants support teachers in these efforts by being an observer in the classroom, thereby being able to witness teachers' specific classroom experiences, and by helping teachers to develop an awareness of their own experience in a particular moment. Throughout all of this work, consultants provide encouragement and guidance to teachers while holding onto the hope for change that in light of the overwhelming work they manage teachers may not be able to hold onto themselves. Especially in light of the challenges with regards to staffing shifts and their effects on children, No children were expelled from any of the centers this program year. Unfortunately, two families did make the voluntary choice to remove their child from the center because of increased behavioral incidents as reported by teachers and a lack of trust: suspecting the changes in staffing contributed to these feelings among parents and teachers and made regaining that trust (of both the child and parent) difficult even once staffing began to stabilize.

- Mental Health Consultation services continue to support staff and families at early care and education settings in the Coastside and continue to have a significant impact on the families and staff at the four programs receiving this service in the Coastside: Half Moon Bay Head Start, Moonridge Head Start and Early Head Start, and Coastside Children's Program. The consultant, now in her third year, has established strong working relationships with the staff at these programs and is able to provide opportunities for staff to address both programmatic and child-specific challenges that impact their capacity to respond to the needs of the children in their program. The consistent presence of the mental health consultant has proven to be particularly meaningful in these settings as the programs experienced significant staff turnover within the past six months. Regardless of how well managed the changes at this level are, or how seemingly small the impact on services, staff turnover and change often leads to feelings of uncertainty among staff as they attempt to understand new leadership styles and to build new teams. In the past six months, the consultant has

worked with the centers to reflect on these changes and to facilitate effective working relationships.

Success Stories - This vignette is an example of a recent success from the Case Worker/ Parent Education perspective: "*I was working with a child, "J", who was having some minor behavioral issues in school. The teacher reported that he also lacked focus and seemed to get distracted easily. The teacher was concerned with his limited recognition of letters and numbers. During my weekly parent education sessions with the family I discovered that mom would get very anxious and frustrated while trying to teach her son. We went over some new techniques and tried different approaches to teaching her son through games and colors and fun activities. Towards the end of our work together, mom was smiling, laughing and having fun alongside her son. She reported that even when she fell back into old routines with her son she wouldn't get as frustrated anymore. Mom applied herself at trying new strategies to support J's learning through a fun and engaging approach that felt better to both of them. In the end the teacher reported that J was almost up to speed with the rest of his classmates and that with mom's continued support she knew he would catch up*."

A highlight from the Clinical team is described here: "*The design of the clinical aspect of ECCT has provided me with the flexibility to meet the unique needs of each family, for instance to provide individual therapy to a mom and some work with a dad who were experiencing stress due to their son's behavior at school and at home. When beginning my work with the child, a 5-year old boy, it appeared that the parents' history of abuse and marital discord was impacting him significantly and therefore, individual work with the caregivers was needed. Mom was experiencing Post Traumatic Stress symptoms as a result of her childhood abuse that was impacting her parenting, relationship with others, trust, attachment relationship and self-esteem. In our work we began the healing process and mom was able to reframe and confront situations, feelings and thoughts. The parents were able to be more present for their child and make changes in their parenting. They were able to see how their relationship was impacting their child and are now making shifts in their relationship so their unborn child can have a different experience and try to provide their child with a different experience. Mom acknowledged that she was 'suffering' and that she had prayed for someone to come and help her. She said that was when my colleague and I were sent to work with her and her family and that it was the first time in her life that she was able to forgive herself for some of the choices she has made and to find her self-worth. Currently, mom reports a decrease in PTSD symptoms, increase in self esteem, and has stated that she realized that the abuse was not her fault and that she is someone of value. Dad is having a better relationship with their son who would previously hit him and reject his affection. He now is asking for dad and seeking his comfort. They have increased their activities together and dad is able to meet his child's needs."*

Challenges:
While thrilled with the success of the ECCT Project in the Coastside, there is recognition of the challenges for the:

- At the mid-year ECCT highlighted the concern regarding the challenges encountered around the establishment of vibrant community partnerships in the Daly City

region. Mental health services continue to expand in the community and ECCT currently has a waiting list for families throughout North County in need of child-parent psychotherapy. ECCT continues to have a working relationship with Our Second Home Family Resource Center. The opportunity to participate in Northwest County CSA was particularly helpful in efforts to identify additional/alternate partners to help support the reach and depth of services provided ECCT remains committed to establishing new connections, such as with the North County clinic and other community based providers in the region.

- The small Coastside team is running at maximum capacity and maintaining a moderate waitlist. Currently the bulk of the referrals to the Case Worker and Mental Health Clinician come via the strong partnerships there is with other providers. It is clear that there is a high need for services and that underserved and unserved populations could still be reached through additional outreach efforts. Moreover, when unable to serve a family, or a family's needs are outside the scope, additional options may be limited. This is particularly the case for those who cannot receive services through the County, such as parents who are uninsured and need mental health services or those families who have private insurance but cannot afford to drive to San Mateo or pay additional fees associated with mental health care.
- The June shooting of a young woman in the Moonridge community by a police officer exacerbated the sense of mistrust that already existed in the community and the resulting intensification of fear and isolation within families living there still pervades. ECCT is participating in ongoing efforts to respond to the community's need for healing and rebuilding trust, and proactively explored the impact of the shooting with the families and sites with whom ECCT works. A testament to the relationships that ECCT has established with families is that many past clients also reached out to staff to gain support in processing through this new trauma, and to get advice on how to discuss the incident with the young children in their families. Additionally, ECCT is participating in the Community Dialogues series being facilitated by PCRC and continue to monitor and respond to the impacts on families.
- The second half of this year marked a challenging time for the centers on the coast. Staffing changes at all four centers in February led to feelings of instability and mistrust among teaching staff, parents, and children. One center in particular saw over half of their teachers change in the course of three weeks (including one classroom in which all three teachers were new to the class). Such changes impact children attending the center significantly as they lose a reliable and consistent connection with an adult with whom they have developed trust and respect and the new staff saw major changes in the behaviors of the children following these staffing shifts. Similarly, parents reported feeling anxious about leaving children with new faces and frustrated in not knowing which staff were permanent and which were substitutes. Moreover, staff must respond the reactions of both children and parents while managing their own feelings, as the loss of long-term co-workers.
  The consultant was available to each staff member individually and to parents to reflect on the experiences of staff, parents, and children and to support staff and parents in thinking about how to talk to the children about the changes in a way that allowed them to begin to form relationships with new staff. The consultant also

worked with managers at the administrative level of the center to reflect on how the staffing decisions were made and how to support staff is building rapport with each other and with families in the wake of these considerable changes. These sorts of staffing changes necessitate flexibility in the way the consultant works with staff and families, and in response to these necessities, the consultant was able to shift the work to accommodate the needs of the staff and families to have space to reflect individually with the consultant. This flexibility on the part of the consultant is reflected in the results of a satisfaction survey.

- In the coming program year, several shifts for the staff members of the ECCT are anticipated. The current consultant in the ECCT Program will be transitioning to the role of Program Manager of the ECMHC Program. As such, a new consultant will be introduced at one of the center-based programs. The new Program Manager will work closely with the new consultant to ensure a smooth transition of the work in this center. The current Program Director of the ECMHC Program will transition to a new role as the Training Director of the Early Childhood and Family Services Department, of which the ECCT is a part. Her experience and expertise in developing and facilitating ECMH trainings within the ECMHC Program over the past ten years will provide a strong foundation that will benefit the Department and help to further strengthen StarVista's presence in San Mateo County as a leader in early childhood mental health services.

  The Community Outreach Worker/Parent Educator on the Coast is beginning to complete practicum hours and will be a mental health clinician trainee as part of StarVista's Learning Together 20 hours per week. To cover the other 20 hours allocated to the Community Worker position, Learning Together Parent Educator, who has in the past led playgroups and worked with families on the coast, will be picking up the additional hours. It is a best of all worlds scenario, as these team members already have a strong, collaborative working relationship and solid experience working on the coast and the County.

  Finally, the North County clinician will be leaving and a new clinician will begin working in this region in the coming months. All the clinician's clients have been referred to appropriate services and one will be continuing work with the new clinician once she begins. The strong culture the team has built will make it easy for these newer members to feel fully included in the team quickly.

In FY 13-14, ECTT-Star Vista served 83 child clients.
Cost per client: $4,422

Community Interventions for School Age and Transition Age Youth– *Prevention*

Project SUCCESS–

Background - Project SUCCESS, Schools Using Coordinated Community Efforts to Strengthen Students, is a program that prevents and reduces substance use and abuse and

associated behavioral issues among high risk, multi-problem adolescents. It works by placing trained counselors in the schools to provide a full range of prevention and early intervention services. It is a research-based program and uses interventions that are effective in reducing risk factors and enhancing protective factors. Project SUCCESS counselors use the following intervention strategies: information dissemination, normative and prevention education, problem identification and referral, community-based process and environmental approaches. In addition, resistance and social competency skills, such as communication, decision making, stress and anger management, problem solving, and resisting peer pressure are taught. The counselors primarily work with adolescents individually and in small groups; conduct large group prevention/education discussions and programs, train and consult on prevention issues with alternative school staff; coordinate the substance abuse services and policies of the school and refer and follow-up with students and families needing substance abuse treatment or mental health services.

Puente de la Costa Sur was awarded the contract to implement Project SUCCESS in the South Coast. Counselors worked outside of the school administration so were able to build trust and connection with the participants in a non-threatening way. Many of the students self-referred for individual therapy as a result of their group work. The Puente counselors worked very hard to utilize the curriculum in a creative and socially accepted way. Overall the attention to trust, confidentiality, connection to individuals, and advocacy were strategies that proved to be very helpful in the steps of the Project SUCCESS Model.

Outcomes - Puente assessed all students in the La Honda Pescadero Unified School District ages 10-18. Based on those assessments students were assigned to groups based on their level of use or family exposure; the User Groups, and the COSAP groups. Students were involved in groups of eight sessions each using the Project SUCCESS guidelines and tools.

Groups meet once per week for 8 weeks with the exception of the high school group which has met consistently once per week for the entire school year. The high school group members have chosen to continue working within the project success model and feel that they benefit from the group cohesion and trust that has been established thru the year. Many students have committed to meeting at least once during the summer.

- 8 Once per week 8 weeks Middle School Project Success Group
- 6 Once per week ongoing High School Project Success Group
- 67 Individual counseling clients for Project SUCCESS
- 20 Students Once per year Princess Project
- 6 Parents once per week - ongoing process group began June, 2014 in Spanish
- 96 Students Once per year Healthy Dating Workshop for All High School Students **

** *The workshop was held for the entire student body of Pescadero High School. Not all demographics are represented in the Demographics of People Served due to limitation of gathering identifying information.*

The project SUCCESS team currently runs youth groups in the district's elementary, middle and high schools. The high school age youth are either self-referred or are referred based on teacher recommendations. The elementary and middle school participants are assigned based on the Project SUCCESS Assessment. All of the youth participants are administered

the Hemmingway connectedness scale and the Coopersmith Self-Esteem inventory, pre and post group. In addition participants are asked to complete a satisfaction survey at the end of each 8 week cycle.
A unique feature of the high school groups is they have been asked to implement community service projects. The groups are asked as a component of the process to choose a group service project that will benefit the school; this promotes ownership and cohesion and gives the group a sense of purpose beyond the curriculum. Many of the high school youth participants self-refer and have been participating in the group for over two years. As a result, there is a strong cohort of high school youth who can advocate and become mentors to younger participants. Because of the small size of the community, it is inherently in the best interest to create an atmosphere that is both safe and trustworthy so that Project SUCCESS can continue to educate the youth about prevention. To do this Project SUCCESS will continue to try and be innovative and bring topics that are relevant and provide useful tools and information.

In the 1st half of FY 13-14, Project SUCCESS completed a parents group in Spanish. All of these participants have been administered the Becks Depression and the Coopersmith Self-Esteem survey as well as a customer satisfaction survey. In addition a writing project for Spanish speaking parents was implemented in two sessions. During January 2014, an English speaking parenting group with be held using the same pre-and post-test.

During the 2ndhalf of FY 13-14 reporting period, project SUCCESS staff successfully completed a middle school COSAP group and continued the ongoing high school User group. A unique feature of the high school group is that its members ask other students to join the group based on personal interactions. Many of the newer students are younger and the senior members of the group are able to see the benefits of having someplace safe to talk about drug and alcohol abuse, to clear up myths about certain drugs, and to have a place to get accurate information about the effects of drug and alcohol use on the body. The high school group has been validated by its members and so the stigma or concerns about confidentiality have been dispelled.

Successes –

- Two parenting classes were held, one in English and one in Spanish. Project Success materials were utilized to create an interactive setting.
- The Project SUCCESS staff at Puente are all either licensed or pre-licensed MFT or LCSW's. This provides the participants with the expertise needed to make sure that their prevention education services are executed with the highest regard for confidentiality and professional ethics. The staff is able to bridge the gap that occurs when prevention education is inadequate and a mental health referral is needed. This ability to offer wrap-around services means that Project SUCCESS is able provide prevention education in a group setting, and act as individual therapists to those who require a higher level of care.
- A Puente clinical staff member and two chaperones took 20 young ladies to the princess project in Santa Clara to pick out a prom dress and accessories free of charge. Many of the young ladies come from rural low socio economic families and

wouldn't have otherwise been able to afford to buy a dress and attend the prom. Feedback from this event was very positive. As a side note, many of the young men in the high school commented that they would like to have a similar program that would allow them to either borrow tuxedo's or be given appropriate clothes to wear to the prom. This is valuable information and Project SUCCESS will reach out to community partners to try and establish some type of donor fund to make this possible for the next academic year. Project SUCCESS promotes healthy dating because it goes hand in hand with drug and alcohol prevention education. Puente staff believes that this type of event is extremely valuable as a way to bring a greater sense of self-esteem and sense of self-worth to the students. The hypothesis is that if you feel good about how you look, and you have the self-confidence and understand the boundaries of healthy dating, that you will be less likely to use drugs and alcohol as a way to mask the fear and insecurity when self-esteem and confidence are lacking.

- All high school students attended a healthy dating/domestic violence prevention workshop developed and put on by Puente project SUCCESS staff. The topic of healthy dating has come up continually as a concern for students, teachers, and family members. Because this topic is tied to closely the use of drugs and alcohol by youth Puente wanted to target the whole school and provide a comprehensive overview, and handouts with phone numbers for the National Domestic Violence Hotline, and the Child Abuse and Prevention Hotline. In addition the students were given the Power and Control wheel of physical and sexual violence. The feedback from the students was unanimous with everyone who responded asking that the workshop be done in small groups with more time for dialogue, and question and answer. This valuable information will be shared with the School District Staff in hopes that there will be more time to focus on this important topic.
- In June a project SUCCESS counselor began an ongoing once per week process group with six Spanish speaking women with children. This group will be self-motivating and loosely organized around promoting "healthy family systems."

In FY 13-14, Project Success served 67 individuals, and 34 students in groups, 6 parents in a group people.
Cost per client: $3,731 based on 67 indviduals

Seeking Safety

Background - Seeking Safety is an evidence based treatment model to address trauma related symptoms and co-occurring substance use issues. It targets Transition Age Youth (TAY) through their contacts with community-based organizations. Strategies specific to Seeking Safety include, coping skills, reinforcement of negative consequences, present moment awareness, behavior modifications, identifying risky behavior, and establishing triggers, creating tools and preventing relapse of substance abuse or behaviors. It is conducted in group and individual format; with diverse populations; for women, men, and mixed-gender groups; using all topics or fewer topics; in a variety of settings; and for both

substance abuse and dependence. It has also been used with people who have a trauma history, but do not meet criteria for PTSD.

El Centro's AC-OK Seeking Safety El Centro's AC-OK Seeking Safety program targets TAY and young adults, the vast majority of whom were referred by the Department of Probation. El Centro named its Seeking Safety program the AC-OK Program as it conveyed a more positive image than Seeking Safety.

El Centro delivers weekly Seeking Safety group sessions at El Centro's Redwood City clinic and in Half Moon Bay. Seeking Safety is an approach to help people attain safety from trauma/PTSD and substance abuse. AC-OK served 40 TAY involved in the juvenile or adult justice systems. El Centro was unable to engage sufficient numbers of Half Moon Bay residents to sustain attendance for groups in that Coastside community, however El Centro offered 130 individual counseling sessions to 18 Coastside residents and conducted outreach to promote the program via participation in community events, networking with other providers in the area, communicating with probation officers. As a result, El Centro plans to initiate groups in Half Moon Bay in 2015.

Demographics -

Ethnicity		
Caucasian	13	39.4%
African American	2	6.1%
Asian	0	0
Latino	17	51.5%
Multi	0	0
Native Amer.	0	0
Pacific Islander	2	6.1%
Other	6	18.2%

Age at Intake		
18-20	15	37.5%
21-23	15	37.5%
23+	10	25%
Gender		
Male	28	70%
Female	12	30%

Outcomes - Weekly open-enrollment groups were delivered at El Centro's clinic in Redwood City and while the Redwood City site conducted 51 groups in 2013-14 (3 above its goal), no groups were conducted in Half Moon Bay. As El Centro leadership recognized that groups were simply not engaging consistent attendance, it shifted service delivery to offering individual counseling services while continuing outreach to community providers to promote group participation. During 2013-14, El Centro served a total of 18 clients with 130 individual counseling sessions an indication that services are in demand, but that more work must be done to engage a sufficient threshold level of participation in the groups.

Referral Source		
Probation	33	82.5%
Family		
Self	2	5%
Another Agency	3	7.5%

Other	2	5%

Reasons cited for clients leaving the program include re-incarceration, relapse, moving out of the area, job scheduling or movement to a higher level of care. El Centro captures this data in exit interviews, but until now had not entered the reasons into a database.

See Appendix 3, PEI Program Year 1 Evaluation Report for additional program outcomes.

Challenges - El Centro began holding monthly program planning meetings with the program manager, two group facilitators, administrative assistant and the CFO. These meetings focus on a review of data related to attendance/participation, retention, and quality of data being collected. They have also initiated a practice of entering data as assessments are completed so that results can be used for program improvement purposes. Data collection now includes administration of the pre-posttest developed by an outside evaluator which will provide better data on client use of coping skills and the impact of alcohol, drugs and stress on social, family and work relations. To improve attendance, in Redwood City and increase the number of sessions attended by clients, El Centro is initiating a second group in Redwood City on another day to provide more options for participation. Lastly, El Centro is building upon its outreach efforts and individual client work in Half Moon Bay and will begin offering a Coastside group in 2015.

In FY 2013-14, Seeking Safety program at El Centro served 40 clients.
Cost per client: $1,000

Caminar's Seeking Safety YES program, provides individualized outreach, assessment, and population specific groups to Transition Age Youth (TAY) throughout San Mateo County. In order to "meet the youth where they are at" services are offered in a variety of settings and locations (e.g. youth drop-in centers, hospitals, residential facilities, and substance recovery facilities). Groups are offered a minimum of once weekly at each location and incorporate a variety of youth specific adaptations to address the unique needs of the TAY.

Demographics – A total of 147 unduplicated clients were served in the 2013-14 fiscal year.

Ethnicity	Caucasian	Afr. Am.	Asian	Latino	Pac. Isl.	Nat. Am	Multi	Other
147	31/21%	17/12%	2/1.4%	76/52%	11/7.5%	2/1.4%	6/4.1%	2/1.4%

Caminar's TAY ages 16 to 27 at six different locations with the vast majority of participants 25 or under. The addition of 26 and 27 year-olds is mainly to accommodate Cordilleras participants who are more comfortable in a TAY group. Sites are listed below:

- Cordilleras Mental Health Center, located in Redwood City (3 groups)
- Redwood House, located in Redwood City and operated by Caminar (2 groups);
- South County BHRS Clinic, located in Redwood City (1 group);
- Eucalyptus House, located in Daly City and also operated by Caminar (1 group);
- Edgewood Drop-In Center, located in San Bruno; and
- Youth Services Center, located in the city of San Mateo where Caminar offers four separate groups with five groups being offered in 2014-15.

Outcomes - Caminar YES staff provided 261 Seeking-Safety groups at 6 different sites. Staff utilized all 25 Seeking Safety topics at least once, often much more frequently, during the reporting period. 100% of surveyed clients expressed overall satisfaction with the program. 100% agreed/strongly agreed with the following 3 statements:
1) "The YES Staff treat me with respect"
2) "YES staff really listen to what I have to say about things;" and
3) "I feel that staff believes I can recover and create a meaningful life."

For the statement "I found this group helpful;" 12 clients (70%) strongly agreed, 3 (18%) agreed, and 2 (12%) disagreed. 100% of surveyed clients identified increased awareness of at least 2 new coping skills. Surveyed clients on average identified the increased awareness of 9 new coping skills as a result of their participation in the YES groups.

On a typical week, YES staff hold the following number of one-hour groups and group size ranges from 1-6 members per group:

- 2 groups at Redwood House (Monday & Friday at 10:30 am),
- 3 groups at Cordilleras (Monday, Wednesday & Friday at 12:30 pm),
- 1 group at South County BHRS, (Monday at 2 pm),
- 5 groups on 3 different units at the Youth Services Center (Tuesday & Thursday at 2 and 3:15 pm; Wednesday at 2 pm),
- 1 group at Eucalyptus House (Wednesday at 4 pm), and
- 1 group at the Edgewood Drop-In Center (Wednesday at 6:30 pm).

YES staff included the Program Director, a full-time Case Manager who facilitates the groups and a part-time Assistant Case Manager who co-facilitates 5 groups per week. Also, the South County BHRS site offers a co-facilitator for its weekly group, and Youth Services Center provides a co-facilitator for the 3:15 pm groups on Tuesday and Thursday. The program was without a full-time case manager during November and December, but the Program Director and Assistant Case Manager continued the majority of groups each week (the Friday Redwood House and Cordilleras groups were postponed without detrimental effect to the site or program). See Appendix 3, PEI Program Year 1 Evaluation Report.

Challenges - The greatest challenges are client turnover and last-minute site-specific schedule changes. Clients participate voluntarily and enjoy their experiences. But they are not always at a location at the time of the group (e.g., a client(s) just may not be at South County or Edgewood on a given Monday afternoon or Wednesday night. Also, Youth Services Center clients are routinely in and out of custody). The other, though much less frequent, obstacle to effective groups is site-specific. Groups can be cancelled at the last minute. For instance, if there is a "code" or emergency lock-down at the Youth Services Center, then groups may be cancelled or shortened (or "groups" are held individually through client jail cell doors). Staff flexibility and creativity have allowed the program to navigate the challenges without any significant problems.

In FY 13-14, Seeking Safety at Caminar served 147 clients.
Cost per client: $816

Middle School Initiative, Project Grow –

Background - The Middle School Initiative, utilizes a variety of strategies to assist children and youth in the middle school setting who are having behavioral issues. The program works not only with the students, but with parents and teachers, providing technical assistance to the teachers, and support and education to the parents. A notable characteristic of this program is that many students refer their peers to the program, which indicates a high level of buy-in on the part of the clients.

Asian American Recovery Services', now HealthRight 360, Project Grow is a school-based mental health program designed to serve middle school students with a history of trauma. It uses a Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) approach, and involves both students and their families. Staff consists of a clinical supervisor who oversees all aspects of the program, two school-based therapists, and a family partner whose role is case management and family support.

Demographics - HealthRight 360 conducted Project Grow in two middle schools with different student populations, educational climates and issues. Parkway Middle School serves a student population that is 78% Latino with almost 70% of students low-income, as reflected by their eligibility for Free & Reduced Lunch. Pollicita serves a more diverse population with 47% Asian and 43% Latino with 58% of students eligible for Free & Reduced Lunch. The schools are but 3 miles distant from each other with both schools located near the San Bruno Mountain State Park.

Outcomes - Parkway Heights has a student population with a high number of immigrants from Spanish-speaking countries, a high administrative staff turnover in the past several years, and low student performance. Parent work long hours on differing shifts, resulting in students left without much supervision. A number of students have parents who are still in their countries of origin, or families that are isolated and/or lacking a support system. The staff member developed a good working relationship with the head academic counselor and collaborates extensively, especially with students with attendance problems.

Pollicita tends to have families that are more stable economically despite having children on Medi-cal; these families tended, however, to have a higher incidence of family conflict which affected their children. The administrative staff has also had a number of changes over the last three years but the school environment remains consistent and stable.

In both programs, the most frequent cause of trauma histories is family violence. Many of the children have histories of ongoing or multiple traumas, making them particularly vulnerable to mental health issues. Most of the program's clients present with difficulties regulating affect, especially anger, low self-esteem, and deficits in problem-solving skills.

Project Grow has had a stable and committed staff for the past three years, enabling clients to maintain a supportive relationship with clinicians over their time as middle school students. This has been particularly helpful for students with inconsistent, disengaged, or absent parents. In fact, the most challenging aspect of the work of project Grow has been trying to engage with parents who fail to keep appointments or return phone calls. Lack of parental involvement is painful for the students; this is processed in their sessions wherein counselors assess the impact of this on the child's sense of self-worth. Counseling for a number of students involves helping them to identify other supportive adults and to learn to use this support in handling the issues in their lives. While the focus of the program is resolution of trauma, work with the students also encompasses helping them to experience success, thereby building self-esteem and a sense of competence. To this end, staff also tries to identify strengths in each child and to involve them in community activities that reflect their strengths and interests. In this regard, it has been invaluable to have a Family Partner who helps to hook kids up with recreational and creative opportunities.

All 39 children seen in this program received individual therapy, scheduled on a weekly basis. Family sessions were provided on an as-needed basis, with 15 clients receiving this service during this reporting period. The program's Family Partner has significant contact with 22 children and 17 families; these contacts included issues around housing, employment, immigration, domestic violence, health, mental health, and translation for IEPs and other related appointments.

Other program activities on the part of the clinicians included participation in IEP meetings, collateral contacts with teachers, the school psychologist, the academic counselor, the principal and vice principal, and one family therapist . All of these collateral contacts were for issues of individual clients. For one client, the individual clinician or Family Partner also attended a monthly team meeting of all therapists.

Fifteen students reported that they were "very satisfied" or "extremely satisfied with the program. Of these, all fifteen felt that their counselor was "very helpful' or "extremely helpful". Two students felt that they were "satisfied" with the program, with one feeling "somewhat satisfied". The latter three students all reported that they felt that their counselor was "helpful". Eight students commented that they would change "nothing" about the program (including the student who report being only "somewhat satisfied" in his evaluation of the program). They other comment regarding what she would change about the program was "have food – KFC, Taco Bell, etc". Many students were specific that the program helped in one or more of three areas: coping with their feelings, getting along with their parents, and improving their grades. See Appendix 3, PEI Program Year 1 Evaluation Report for additional program outcomes.

In FY 13-14, Project Grow served 39 clients.
Cost per client: $4,080

Teaching Pro-Social Skills –

Background - The Human Services Agency (HAS) delivers Teaching Pro-social Skills (TPS) groups in San Mateo County public elementary schools where HSA Family Resource Centers are located. These schools generally receive referrals from teachers for students with classroom behavioral issues. TPS addresses the social skill needs of students who display aggression, immaturity, withdrawal, or other problem behaviors. Students are at risk due to issues such as growing up in a low-income household and community; peer rejection; low quality child care and preschool experiences; afterschool care with poor supervision; school failure, among others.
Demographics - Of the 38 children participating in the program, 26 come from homes where Spanish is the home language. HSA's TPS program targets at risk youth ages 6-9, by implementing on Teaching Pro-Social Skills six to ten-session series each semester at the following school locations:
• Bayshore Elementary School in Daly City
• Hoover Elementary School in Redwood City
• Fair Oaks Elementary School in Redwood City
• Taft Elementary School in Redwood City
• Belle Haven Elementary School in Menlo Park

Outcomes - HSA's contract calls for approximately 8 students per group and stipulates that additional individual counseling services and/or linkages to other relevant services will also be provided. Contract negotiations between HSA and BHRS were not concluded until December and so HSA only operated TPS for one semester during 2013-14.

The lead Community Worker who facilitated all the TPS groups is bilingual Spanish speaking. The PSWs who helped to coordinate the groups and have relationships with the teachers and the parents are all also bilingual Spanish speaking. In fact, one of the groups at Hoover was conducted in Spanish due to the language needs of the children in that group. See Appendix 3, PEI Program Year 1 Evaluation Report for additional program outcomes.

In FY 13-14, Teaching Pro-social Skills served 38 clients.
Cost per client: $3,335

PEI PROGRAMS FOR ADULTS AND OLDER ADULTS

Total Wellness - *Early Intervention*
PEI funds a few key program elements of a larger initiative called Total Wellness, details of the Total Wellness project can be found under the Innovation Component program description. Included in the PEI Total Wellness is an integrated training piece for primary care providers; it entails a universal prevention strategy that focuses on education of professionals on co-morbidity and related issues. The trainings target all types of providers (BHRS staff, leadership and interns; contract providers; San Mateo Medical Center personnel; and Board and Care operators). The trainings aim at providing professionals with the necessary information to help them understand the interconnectedness and the interdependence between mental and physical health.

A total of 11 trainings/presentations on integrated care were provided by Total Wellness. Examples include what integrated care looks like, Total Wellness integrated care services offered, specific interventions to promote physical health outcomes of clients addressing physical health needs in SPMI population, lifestyle changes in SPMI population, interactions between NRT and psychotropic medications.

Primary Care Interface – *Early Intervention*

Background – Primary Care Interface program focuses on identifying persons in need of behavioral health services in the primary care setting, thus connecting people to needed services. Services funded include system-wide co-location of BHRS practitioners in primary care environments to facilitate referrals, perform assessments, and refer to appropriate behavioral health services if deemed necessary. The model utilizes essential elements of IMPACT model to identify and treat individuals in primary care who do not have Serious Mental Illness, and are unlikely to seek services from the formal mental health system.

Outcomes –
Between July 1, 2014 and December 31, 2014, 824 patients were opened to BHRS in the primary care clinics and 33 clients were transferred to adult and youth regional treatment services. Between January 1, 2015 and June 30 2015, 1,076 clients were opened to BHRS and 31 clients were identified as seriously mentally ill. Additional impacts:

- Implementation of Welcome Orientation and Process groups for patients without urgent need for service but who would not be served in any other way
- Mandarin/Cantonese speaking Interface therapist directly involved in North CHI (Chinese Health Initiative) outreach plan
- Additional resources available to adult clients with history of trauma through seeking safety group
- First Vivitrol injection given in primary care 3/2014.
- Increase outreach and access to MH services to underserved Chinese speaking
- Seeking Safety for adults and Girls group to provide additional resources for clients
- Added more Medication Assisted Treatment (MAT) approaches for clients with substance abuse diagnosis.

The performance outcomes survey is another strategy used to improve access to underserved communities. The feedback provided from such surveys has resulted in groups, evening hours and reduced time between referral to appointment time. Interface clients are referred to PPN (private provider network) if they are mild to moderate and seeking a therapist for ongoing counseling or need a provider that can accommodate a weekend appointment.

Successes - increased services to underserved Chinese speaking clients through CHI outreach and Interface having a diverse and culturally competent (Spanish, Cantonese,

Mandarin, Hindi, Male, Female) providers. The team is comprised of clinicians, psychiatrists and one co-occurring case manager. Two of the clinics Fair Oaks Health Center and South San Francisco provide evening appointments to serve the needs of the community. The addition of MAT services is also a response to meeting the needs.

Challenges - There have been several significant changes, none more important than the closing of the Willow Primary Care Clinic which was housed on the Veteran's campus in Menlo Park. Some of the comments made by the patients treated by Interface were:

- How will I get to the new Health Center in Redwood City?
- I do not have transportation.
- Who will be my new provider?
- Will I still receive mental health and AOD(Alcohol and other Drug) services?
- Why is this happening?
- Some of the comments made by the primary care staff were:
- I do not want to move.
- Who will I be working with?
- How will Menlo Park and East Palo Alto patients get to the new clinic?

All of these issues were addressed in community forums, Kaizen Events, team building exercises, social and staff mixers. Turnover in primary care clinics means constant training of staff on referrals and services offered. The Interface Unit Chief retired in 4/2014 which meant new leadership both within Interface and primary care. In an effort to address this challenge clinicians and/or supervisor participate in clinic provider meetings as often as necessary to introduce services to new providers and review referral process for everyone.

Another challenge was in service environment at Fair Oaks Health Center. The Interface providers went from being within primary care to offices on the administrative floor of the clinic which has resulted in less than optimal integration. This challenge continues without a solution. Space is an issue in all the primary care clinics.

Providers bring access issues for underserved communities to the attention of leadership. The CHI outreach pilot was a result of clinician recognizing a health disparity (3% of the Chinese population is identified as having SMI and only .001% is served by San Mateo County). The need for outreach to the Chinese speaking community was brought to the attention of MH leadership with resulted in collaboration with North East Medical Services). A Chinese outreach worker was recruited and an Interface therapist fluent in both Cantonese and Mandarin became part of the pilot. Strategies used included gathering feedback from community in the form of a round table event and series of presentations.

In FY13-14, MHSA funded Primary Care Interface clinicians served 1,245 clients.
Cost per client: $653

PEI PROGRAMS FOR ALL AGE GROUPS

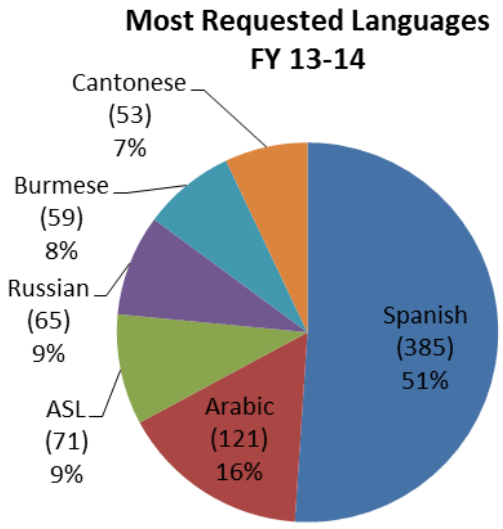
Office of Diversity and Equity (ODE) – *Prevention*
ODE was established within BHRS in 2009 primarily as an information and resource hub for data, training, dialogue and collaboration regarding diversity and social justice. ODE promotes cultural competence and addresses health inequities through the following current projects and Health Equity Initiatives.

Since 2009, ODE has offered 121 classes (including Parent Project, Mental Health First Aid, Youth Mental Health First Aid, Digital Storytelling, Photovoice, and Stigma Free San Mateo).

In 2013-2014, ODE had 943 participants in these six programs. This does not include Stigma Free San Mateo County Educational Sessions, Vignette Screenings, Tabling, and Public Stigma Storytelling Showcases, other ODE programs, and participation in Health equity Initiatives. It is safe to assume that the total number of people reached was well over 1,000. ODE published a booklet in April 2014 titled "Eliminating Disparities, Inequities, and Stigma in Behavioral Health" available at www.smchealth.org/bhrs/ODE.

In FY 13-14, the ODE Cultural and Linguistic Standards Team reviewed contract agency Cultural Competence plans with AOD and provided feedback and recommendations to agencies based on a rubric. Thirty-one Cultural Competence Plans were received. ODE provided a technical assistance workshop in December 2013.

ODE also oversees language access services. In FY 2013-14 BHRS made **733** requests for in-person interpretation and document translation assistance in **30** languages and dialects. This represents the highest on record since the Health System's centralized language assistance service was implemented in 2008.



Requests for services decreased for most languages in FY 13-14 compared to the previous year except for the following languages. It will be important to keep an eye on these as they may represent potential emerging monolingual communities in San Mateo County.

Language	FY 12-13 (# requests)	FY 12-13 (# requests)	% Increase
Arabic	84	121	44%
Russian*	29	65	124%
Portuguese	31	34	10%
Tagalog	11	22	100%
Tongan	5	12	140%
Korean	1	9	800%

***Russian is the one language that not only increased in FY 13-14 but also surpassed the total number of requests for both Cantonese and Burmese. Unfortunately we cannot determine from this data if the changes we see are just one client using the LAS service many times or if this means actual population change/growth in the community.

Program highlights for FY 13/14, per ODE program include:

***Culturally-Relevant Provider Trainings* –** The following two trainings are provided at least once annually.

In 2013-2014, Melanie Tervalon, MD, MPH conducted a large scale cultural humility training for behavioral health providers in San Mateo County to improve the cultural responsiveness of our system of care.

The "Working Effectively with an Interpreter in a Behavioral Health Setting" mandatory training aims to enhance the cultural competency and humility of BHRS staff as well as to help providers learn to effectively communicate with clients when they don't speak the client's language. The training was conducted once in 2013-2014, 52 people attended. The average pre-test score was 58% correct and the average post-test score was 80% correct; hence, the average increased by 22% from pre to post training.

***Digital Storytelling* -** Digital Storytelling is a shortened form of digital media production allowing community members to share their own personal stories by creating a 3-5 minute video. Digital stories may include any combination of video, sound, music, animation, photographs, and other images in order to capture the individual's lived experience.

Digital Storytelling had 31 participants in 2013-2014, including:

- Members of San Mateo County Behavioral Health & Recovery Services' African-American Community Initiative share experiences of discrimination, self-discovery, and faith.
- Members of San Mateo County Behavioral Health & Recovery Services' Spirituality Initiative tell their stories of spirituality, family and recovery.
- A group of College of San Mateo Chinese international and Chinese-American students share their experiences around culture, family and social pressures.

Health Ambassador Program - ODE launched the Health Ambassador Program (HAP) in 2013. Community members are encouraged to participate in a series of workshops and trainings hosted by ODE. HAP graduates will gain vital tools and knowledge to become a community leader. All Health Ambassadors begin by graduating from the Parent Project—a 12-week course that teaches parents the skills to improve their relationship with their children as well as effective prevention and intervention strategies. After completion of the Parent Project, individuals continue to increase their skills and knowledge in behavioral health and substance use related topics by completing four of the eight public education programs offered by ODE.

Individuals interested in broadening their skills on how to help people who have a mental illness or may be experiencing a mental health crisis are encouraged to attend an 8-hour Mental Health First Aid certification training, the 12-week NAMI Family to Family program, the Applied Suicide Intervention Skills Training, and/or a Wellness Recovery Action Plan workshop. All programs increase an individual's mental health literacy and reduces stigma.

Community members with lived experience who are interested in sharing their story can participate in an 8-hour BHRS Lived Experience Educational Workgroup, Photo Voice Project and/or Digital Story Telling workshop. All three opportunities provide individuals an opportunity to use their voice and share their unique story related to health and mental health issues.

Health Ambassadors are also encouraged to become advocates in Stigma-Free San Mateo and the BHRS Health Equity Initiatives. In this work, individuals engage in outreach, education and dialogue with members of our communities to reach our goal of a stigma free County.

Becoming a Health Ambassador can potentially lead to opportunities to work and volunteer amongst other dedicated individuals; teach both youth and adult courses in their community; assist in identifying unmet needs in their community and help create change; or become a Community worker/Family Partner.

Mental Health First Aid – Mental Health First Aid is a public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders.

Mental Health First Aid is offered in the form of an interactive 8-hour course that presents an overview of mental illness and substance use disorders in the U.S. and introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and reviews common treatments. Those who take the 8-hour course to become certified as Mental Health First Aiders learn a 5-step action plan encompassing the skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care.

The 8-hour Mental Health First Aid USA course has benefited a variety of audiences and professions, including: primary care professionals, employers and business leaders, faith communities, school personnel and educators, state police and corrections officers, nursing home staff, mental health authorities, state policymakers, volunteers, young people, families and the general public.
Mental Health First Aid had 322 participants in San Mateo County classes in 2013-2014.

Parent Project – 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. Parents/caregivers learn and practice skills such as:

- appropriate ways to discipline
- preventing or stopping alcohol, drug and tobacco use
- improving communication skills
- improving grades and school attendance.

On January 16, the Office of Diversity and Equity hosted its second Parent Project Reunion for their most recent Parent Project program graduates. Parent Project is an interactive 12–week course that teaches parents/caregivers parenting skills and focuses on how to improve their relationship with their child(ren). Participants learn effective identification, prevention and intervention strategies.

Between September and December, a total of four Parent Project classes were facilitated. Forty-six parents graduated from the Parent Project in East Palo Alto, Half Moon Bay, Redwood City and Daly City. Classes were facilitated in English and Spanish as well as provided culturally informed discussions and guest speakers.

Parent Project graduates, their children, facilitators and community partners attended the celebration event. Graduates shared their experiences and take-aways from the workshop, reflecting upon their experience and the value received from completing the course. “The classes were very useful because at the time I really needed support. I would like to take another course because I feel that as parents we need to learn from each other so that we feel stronger and can raise our kids. I feel very grateful to those that guided me and supported me, thank you and I’m happy to be here again.” - Salma, Parent Project graduate
“I took the Pacific Islander Parent Project class and as a mother of children from the Pacific Islands, I thought it was really important…I had a lot of problems with one of my sons and if this class was available when he was a teenager he may not have gone down the path that

he went down. After that class I proceeded to take one and then another one...you learn something different from the participants and what the facilitators bring. " - Laura, Parent Project graduate "As a single parent in another culture it is very hard for us to understand our kids and the way they get raised here and the way they are exposed to things in school and the environment. That's why I decided to become a facilitator, to help my community and to help other parents that could go through what I went through." –Yolanda Ramirez, Parent Project graduate and facilitator.

The Parent Project© had 184 participants in 2013-2014. participants included parents of children at a wide range of schools and school districts (56 different schools, 17 San Mateo County school districts).

Photovoice - Photovoice's mission is to build skills within underserved communities by utilizing innovative participatory photography and storytelling methods. These skills enable individuals to represent themselves and create tools for advocacy and communication and positive social change.
Photovoice had 22 participants in 2013-2014.

Health Equity Initiatives:
African American Community Initiative – The BHRS Office of Diversity and Equity's African American Community Initiative (AACI) held its 6th annual Black History Month Summit on February 28, 2014 in East Palo Alto. This year's Keynote Speaker, Mr. Roland Williams (MA, Licensed Advanced Addiction Counselor (LAADC), Internationally Certified Addictions Counselor (ICADC, world renowned addiction specialist, counselor, interventionist, lecturer, trainer, teacher, author and consultant specializing in addiction related issues) eloquently addressed the event theme "Stigma Hurts Everyone. Let's Triumph Over Tragedy." Mr. Williams discussed the importance of culturally appropriate treatment strategies and how critical they (or the lack of them) can be in helping clients to successfully engage and participate in treatment. Many of his talking points gave poignant examples of how stigma, stereotyping and the lack of cultural awareness and humility present barriers and challenges for both clients and clinicians. As it applies to treatment and recovery, stigma and its effects means more than success or failure. The lack of access to culturally appropriate and effective treatment models and practices makes a critical difference for African Americans and other people of color. Other highlights of the event included displays of African artworks and historical memorabilia and screenings created by consumers and family members in AACI's recent Digital Storytelling Project. The Summit was followed by a community screening of "The Anonymous People," an acclaimed film about the national recovery movement. The film invites individuals and communities to join advocacy efforts to fight stigma and increase awareness that addiction is a treatable disease and that people do recover. The screening was presented in collaboration with Voices of Recovery San Mateo County.

In February, the AACI hosted the first Digital Storytelling Project by one of the BHRS Office of Diversity and Equity's Initiatives. The theme of the project was "The Griot Project – How Stigma Hurts." Griot is an African term for storytelling. The project goal was to give

participants an opportunity to share personal stories about how stigma has created barriers and challenges in their lives with regard to seeking and/or gaining access to services or treatment, or to their personal recovery. Facilitators supported participants in crafting their stories and creating audio and video multimedia representations of their experience. One East Palo Alto hosted the project at the Barbara A. Mouton Multi-Cultural Wellness Center. A participant shared his experience participating in this project: "In the beginning I was not sure what I was going to say about how stigma has played out in my life, let alone how I would say it. But as the workshop evolved, I was inspired and I took a creative way to express my feelings about stigma and how I have been able to recover from the negative impact of stigma in my life. The entire experience was liberating. What I realized through this project is that we deal with multiple stigma's at the same time. For example being black, gay and a mental health consumer. I was also inspired by the stories of recovery of the other participants, which gave me pause to appreciate each one of them for the precious human beings that they are. I deeply recommend the Digital Storytelling workshop. It is truly a healing experience."

***Chinese Health Initiative (CHI)* –** On June 25, CHI presented "Cultivating Wellness" at the Millbrae Library to introduce partners to the recently hired bilingual outreach worker, Sunny Choi. The outreach program was established to address the under-representation of Chinese individuals receiving behavioral health services from the county network of care. The under-utilization probably resulted from a combination of factors including lack of information about county services, stigma associated with seeking behavioral health care, language and cultural barriers, and limited availability of bilingual service providers and service programs. The event was a great success, drawing over 80 participants from the community. The BHRS Assistant Director, BHRS Deputy Medical Director and the Director, Office of Diversity and Equity, welcomed participants while Board of Supervisor Dave Pine; Lisa Chung, Senior District Representative of Senator Jerry Hill's office; and Wayne Lee, Mayor of Millbrae, helped kick off the event.

Three digital stories completed this year by Chinese young adults were shown, as an introduction of some of the behavioral health problems encountered by Chinese living in the county. These stories, made possible by a collaboration of CHI and the College of San Mateo, described the young people's experience with immigration, their conflicts in day to day living, their struggles with their families, their lack of resource for help and their yearnings for a better future.

A panel of experienced providers and individuals with lived experience presented their programs and/or their lived experience and gave suggestions for the best way to incorporate cultural factors in the design of an outreach program for the Chinese community. Presenters include: Anni Chung, President and CEO of Self Help for the Elderly; Christina Shea, Deputy Chief/Director of Clinical Services, Richmond Area MultiServices, Inc; Paul Chang, Executive Director, Pyramid Alternatives; and two individuals with lived experience. Finally, Sunny Choi, the newly hired outreach worker for the county gave a brief overview of the program and asked participants to sign on as partner agencies to collaborate in outreach efforts for the Chinese community.

Pacific Islander Initiative – The Pacific Islander Initiative (PII) was created to address health disparities within the community and to connect families to resources or services they may not know about, but are eligible for, through education and awareness, prevention and capacity building and leadership.

The PII held monthly meetings throughout the year, Let's Talk Dialogue: Journey to Empowerment Series; MANA at San Mateo High School and Cappuccino High School; hosted a facilitated retreat in August 2013 and planned for digital storytelling in FY 14-15. The PII helped coordinate a Mental Health First Aid training at a Tongan church in July 2013 and a Parent Project at Bayshore Elementary in February 2014. The Initiative hosted a Pacific Islander Resource Fair February 2014 for 34 attendees.

Filipino Mental Health Initiative – The mission of the Filipino Mental Health Initiative is to improve the well-being of Filipinos in San Mateo County by reducing the stigma of mental health, increasing access to services, and further empowering the community through outreach and engagement. FMHI strives to connect individuals to appropriate health, mental health and social services, and ensure culturally appropriate services through provider collaboration. FY 13/14 activities included:
10/3/13 – Youth Meeting, 3 attendees
10/26/13 – Mental Health First Aid, 35 attendees
11/8/13 Youth Meeting, 3 attendees
12/3/13 – Youth Meeting, 5 attendees
12/12/13 – Youth Development with John Yap, 6 attendees
2/11/14 – Sala Talk, 11 attendees
2/12/14 – Sala Talk, 4 attendees
2/16/14 – Needs Assessment Focus Group
3/14/14 – Sala Talk, Jefferson High School
4/26/14 - ALLICE event tabling
5/16/14 – Sala Talk, Jefferson High School

Latino Collaborative - The Latino Collaborative promotes holistic practices designed to build safe, strong, resilient families in San Mateo County. It works to increase access to stigma-free services and treatment involving mind, spirit and body to all San Mateo County residents, regardless of insurance eligibility. The Latino Collaborative believes that services that integrate Latino heritage, culture, spirituality and family values will nurture and strengthen the health of Latino individuals and families.

San Mateo County's 1st Latino Health Forum "Sana Sana, Colita de Rana!", hosted by the Latino Collaborative and the San Mateo County Healthy Weight Collaborative, was held in September at the Fair Oaks community. Over 200 people participated in this fun-filled event which educated adults and children about the importance of taking care of their physical, emotional and social health and wellbeing, with break out sessions such as cooking demonstrations, zumba classes, and children's activities. "Many Latinos have endured a range of life stressors, such as poor housing, abuse, trauma, stigma,

discrimination, assimilation and acculturation issues, which can lead to mental health conditions, substance use disorders, as well as obesity and other chronic diseases. The purpose of this event was to empower Latino families to take charge of their physical and emotional health." - Ziomara Ochoa, Latino Collaborative Co-Chair.

Native American Initiative- There was an initial meeting in May 2013 to launch this initiative. According to recent data, nearly 30 percent of American Indians and Alaska Natives are without health coverage. American Indians and Alaska Natives are also disproportionately affected by a host of chronic medical and psychiatric conditions. This initiative was formed in an attempt to decrease health disparities within these communities.

This initiative has worked to inform other providers of the need of culturally informed care. This has taken the form of one Lunch and Learn Event focused on historical trauma and substance abuse and one presentation about health disparities and increasing our abilities to work with Native Americans in San Mateo in a culturally informed manner.

The next steps are focused on recruitment efforts by creating a schedule of initiative meetings for the next year and informing our local providers and community members of these meetings. Additionally, in order to increase recruitment the initiative hopes to offer our community a Digital Storytelling Workshop to increase participation and their voice within San Mateo County.

PRIDE Initiative – The San Mateo County 2nd Annual PRIDE celebration was held on Saturday, June 14, at San Mateo Central Park. The event is a collaborative, grassroots event hosted by the SMC PRIDE Initiative, led by BHRS Office of Diversity and Equity, with the support of many community organizations. By Noon all 36 resource tables and the stage were in full swing. A host of politicians including Senator Jerry Hill, Board of Supervisors David Pine and Carol Groom as well as David Canepa, Mayor of Daly City, were there to kick off the stage and present proclamations. The Proclamations declare June to be LGBTQQI2S month and honoring the PRIDE Initiative's work in improving the quality of life of LGBTQQI2S residents of San Mateo County. Numerous performances filled the stage including The Raging Grannies, El Camino Reelers and Pavlov's Kats. Author Cynthia Chin-Lee hosted a theater reading of her book, Operation Marriage, hosted by Pollo del Mar. The PRIDE Initiative strives to bring to light those who are currently serving the community and connecting organizations with residents, creating a warm introduction to those seeking services and improving advocacy to strengthen the county.

Spirituality Initiative – The Spirituality Initiative works to build opportunities for clients/consumers, family members, providers and community members to collaboratively explore, increase awareness of, and support spirituality and its relationship to health and well-being, especially for those with or at risk of co-occurring alcohol/drug addiction and mental health challenges. Below are the FY 13/14 activities:

7/3/13 – Policy Training Psychiatry, 5 attendees
7/18/13 – Policy Training Coastside, 6 attendees
9/10/13 – Spirituality Matters Class, 11 attendees
9/12/13 – Policy Training at 401 County Center, 8 attendees
9/18/13 – Policy Training at Call Center, 8 attendees
9/19/13 – Policy Training at OASIS, 14 attendees
Reflections Group 10/8/13, 11/12/13, 12/10/13 – 14 attendees
1/28/14 StarVista Spirituality Training, 35 attendees
03/31/14 Spirituality Training 101, 30 attendees
Reflections Group 1/14/14, 2/11/14 – 11 attendees
3/26-28/14: The Digital Story Telling project for was 3 days and 3 consumers/family members participated to tell their story digitally. Stories with an emphasis on Spirituality were produced.
05/21/14 Berkeley MH, 24 attendees
Reflections Group-Coastside 29 total attendees (6 weeks): 4/7, 4/14, 4/21, 4/28, 5/5, and 5/12/14.

Stigma Free San Mateo County - Stigma Free San Mateo County (SFSMC) is a program to raise awareness and provide mental health education to reduce the stigma around mental illness and substance use disorders.

Stigma Free San Mateo County hosted a community kick-off event on September 9, 2013, at the Foster City Community Center Wind Room. The event talked about stigma around mental illness and substance use, the new Stigma Free San Mateo County campaign, and how people can help and/or get involved.

SFSMC conducted multiple presentations on stigma and mental health to numerous groups and venues, including Skyline College, College of San Mateo, Sequoia High School, and Westmoor High School. During the month of May 2014, SFSMC displayed a photo exhibit, Faces of Hope, at public buildings around the county. Faces of Hope shows the faces and tells the stories of San Mateo County residents who have found hope despite living with a mental health or substance use challenge. Sharing personal stories is a very powerful way to change the misperceptions and stigma of mental illness. Faces of Hope launch events were held at gallery locations throughout the County, and the public was invited to attend these free events and view the exhibits.

The San Mateo County Board of Supervisors, along with six City Councils (Foster City, Daly City, San Carlos, Burlingame, East Palo Alto, Redwood City), adopted Proclamations declaring the month of May as Mental Health Awareness Month. These Proclamations provided facts about mental illness and encourage residents to increase their awareness and education around mental illness. On May 1, SFSM hosted a community event called Stand Up for Mental Wellness, sponsored by the BHRS Diversity and Equity Council. This event was an opportunity to learn more about mental wellness through community voices and digital stories. The event also showcased a project by the San Mateo County Youth Commission that focused on mental health.

Throughout the year, 184 people signed pledges of support to end stigma in San Mateo County. Please see below a summary of the Stigma Free projects and activities for the year.

Stigma Free Projects and Activities	2013						2014					
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
Face of Hope: Faces of Mental Illness and Substance Use Photo Gallery												
-Recruit 7 participants from Lived Experiences Bureau, Stamp Out Stigma, and Initiatives												
-Take portraits and complete self-narratives												
-Secure locations for exhibit												
Stigma DVD screenings and community discussions												
-Host one screening and discussion each quarter												
Outreach Materials (Brochures/Cards)												
-Design Stigma Free San Mateo Brochures												
-Distribute outreach materials at events and meetings												
Stories of Lived Experiences and Stigma												
-Newspaper profiles												
-4 Wellness Matters articles per year												
-1 Photovoice session per year dedicated to stigma												
-1 Digital Storytelling session per year to stigma												
A New State of Mind screenings												
-Screen once per quarter at community and staff settings												
Mental Health Awareness Month event												
-Host community event each May												

Community Outreach, Engagement and Capacity Building

Crisis Hotline – StarVista provides a free, confidential 24-hour, seven days a week crisis intervention hotline. Trained volunteers and staff provide referrals for community resources and services for anyone who feels sad, hopeless, or suicidal; family and friends who are concerned about a loved one; anyone interested in mental health treatment and service referrals; and/or anyone who just needs some support through a personal crisis. The mental health clinician provided services to through 49 new cases (case management/phone consultation); 42 new youth served in youth outreach interventions (evaluations at school sites), 66 follow-up sessions with youth, 95 follow up contacts with collateral contacts; and 446 youth and adults served through community outreach.

The total number of clients served by the Crisis Hotline for FY 13-14 was 698.
Cost per client: $152

Voices of Recovery - in collaboration with Total Wellness, Voices of Recovery provides training, wellness services at BHRS sites, and health and wellness groups and activities. Trainings include health and wellness formal training and/or WRAP facilitator training, tobacco education, healthy eating, and physical exercise. Trained Wellness Coaches provide wellness calls, reminder calls, individual coaching or group WRAP support, Health and Wellness group activities, fairs and education forums, walking groups, cooking classes, and other social or education groups and activities.

San Mateo Medical Center (SMMC) Memorandum of Understanding (MOU) - provides for the behavioral health treatment needs of clients who seek services or are brought in for services to the Psychiatric Emergency Services (PES) and Acute Psychiatric Inpatient Units. SMMC PES provides back-up Call Center functions for the BHRS Call Center outside of regular business hours; twenty-four hour, seven day a week emergency psychiatric care through its PES and through the acute psychiatric care units 3A and B; is the designated Point of Notification for the BHRS Mental Health Plan for all admissions to psychiatric inpatient hospital services whether to SMMC 3A/B or to private hospitals; provides psychiatric back-up coverage through PES for the San Mateo County Correctional Health Services outside of regular business hours and for Canyon Oaks Youth Facility; and provides psychiatric medical staff services to clients at Cordilleras Mental Health Center.

San Mateo County Mental Health Assessment and Referral Team (SMART) MOU – was developed by the San Mateo County Health System and the American Medical Response West in which specially trained paramedic responds to law enforcement Code 2EMS requests for individuals having a behavioral health emergency. The SMART paramedic performs a mental health assessment, places a 5150 hold if needed and transports the client to Psychiatric Emergency Services or, in consultation with County staff, arranges for appropriate services. Access to SMART is only available through the County's 911 system.

Senior Peer Counseling Services Program - Peninsula Family Service trains volunteers to provide free peer counseling to older adults in their homes. Services are available in English, Spanish, Mandarin and Tagalog as well as for the LGBT community.

In FY13-14, PEI funded 50% of Senior Peer Counseling (the remaining 50% is funded through Community Services and Supports). The program served 468 total clients
Cost per client: $605

Ravenswood Family Health Center - Ravenswood is a community-based Federally Qualified Health Center (FQHC) that serves East Palo Alto and provides outreach and engagement services to identify individuals presenting for healthcare services that have significant needs for behavioral health services.

In FY 13-14, PEI funded 60% of Ravenswood Family Health Center (the remaining 40% is funded through Community Services and Supports). The program served 308 total clients, 60% of which equals 185 clients.
Cost per client: $227

PEI PROGRAM FOCUSED ON EARLY ONSET OF PSYCHOTIC DISORDERS

Prevention and Recovery in Early Psychosis (PREP) – *Early Intervention*
The PREP program braids together five evidence-based practices into one integrated treatment approach, and uses community education and outreach to facilitate early identification of individuals at risk of psychosis. Felton Institute's (formerly Family Service Agency) PREP program identifies and intervenes with transition age youth (14-25 years) experiencing a recent onset episode of psychosis and their families. The PREP Program provides evidence-based treatment and support for youth and families through an intensive outpatient model of care that includes the provision of: algorithm-based medication management, cognitive behavioral therapy for psychosis (CBTp), individual placement and support (IPS), assertive outreach, multi-family groups, cognitive remediation, and strength-based care management services.

The program began implementation in June 2012. Felton's contract called for it to begin engaging 80-100 eligible SMC residents and after a year of operations serve 48 clients a year. During the program year 2013-14, PREP engaged 84 potential clients with 46 of those engaged in the program. The contract did not stipulate a definition of clients served or stipulate a sustained caseload. While no stipulation in the contract indicated that 'under-served' populations be targeted, clearly PREP engaged highly diverse populations with almost two-thirds being from populations of color.

Caucasian 34.8%; Latino 32.6%; Afr. Amer. 4.3%; Asian 13.0%; Pacific Isl. 8.7%; Native American 0.0%; Mixed 2.2%; Other 4.3%;

During the 13-14 program year, PREP completed 49 Structured Clinical Interview for DSM-IV (SCID) assessments resulting in 18 new intakes during the year resulting in an increase in the caseload from 34 in July 2013 to 47 in June 2014. Data provided by PREP indicates that 91 family members were involved in treatment, with all but one of 46 clients having at least one family member identified as being engaged in treatment. The 91 family member figure represents formal staff-family member contacts and this total meets the contract requirement of 80-100 family members engaged.

During FY 13-14, 46 clients and 91 family members were enrolled and received PREP services. Cost per client: $17,391

STATEWIDE PEI SUSTAINABILITY

The California Mental Health Services Authority (CalMHSA) – In 2009 CalMHSA was formed and worked on developing strategic plans and executing a contract with the State Department of Health Care Services for $160 million ($40 million per year for 4 years) Statewide PEI funds to implement three PEI Statewide Programs:

- Suicide Prevention (SP) $10 million per year (25%)
- Stigma and Discrimination Reduction (SDR) $15 million per year (37.5%)
- Student Mental Health Initiative (SMHI) $15 million per year (37.5%)

Funds were allocated through FY 13/14 and in February 2014 CalMHSA Board meeting, members adopted a funding framework for sustaining CalMHSA PEI Statewide Projects. This framework includes using diverse funding to sustain the PEI statewide projects as well as local County PEI funds. Through the Stakeholder process, it was recommended that San Mateo County fund CalMHSA 2% of PEI funds

Innovations (INN)

Total Wellness (TW) –

In this reporting period from July 2013 through June 2014, Total Wellness continued to provide the full array of services including timely access/linkage to primary care and specialty medical care for enrolled SPMI clients. Each enrolled TW client is assigned a nurse care coordinator/manager to facilitate and coordinate all necessary physical behavioral health services. In addition, all clients are able to access and utilize the wide array of psycho-health education and wellness services provided by a multi-disciplinary team of primary care providers, behavioral health nurses, nurse practitioner, health educator, and peer coaches. The various wellness group activities offered to enrollees at both Central and South County Clinics include Total Nutrition, Diabetes, Well Body weight management, smoking cessation for different stages of client readiness, physical activities, community health classes, WRAP on Wellness, etc.

In this reporting period, more than 100 client enrollments were conducted (the actual number of enrollments can only be calculated based on Federal Fiscal Year; i.e. October 2013 through September 2014. There were a total of 151 unduplicated enrollments conducted during the FFY 13-14). Their baseline health data and behavioral health history were collected using standard National Outcome Measurement (NOM) questionnaire. NOM interview was repeated every six months again during the entire course of client's enrollment with Total Wellness. All clients' responses, both baseline and reassessments, were entered on a SAMHSA-supported web data portal, Transformation Accountability (TRAC). An internal excel database was developed to track all clients' health outcomes.

Also in this period, management staff of Total Wellness and BHRS met with stakeholders, community leaders, and key personnel from various funding sources to engage in sustainability planning activities beyond the Innovative MHSA and SAMHSA PBHCI funds. Successful outcomes from these activities included: first, MHSA has approved another one full year of Innovation funds through end of June 2015, to complete the evaluation components of the program. Second, SAMHSA has also approved another full federal fiscal year of no-cost extension of PBHCI grant through September 2015. Continuous efforts will be dedicated to exploring possible sustainability plans in addition to on-going training of staff for accurate billing and documentation of integrated health care services so as to maximize ShortDoyle billing and reimbursement.

Other programmatic activities during this reporting period included:

a) TW took part in two major resource fair events at the "Recovery Happens in San Mateo" that celebrated September as the National Recovery Month. "Recovery Happens in San Mateo" featured an official Recovery Happens Month Proclamation at the Redwood City's Hall of Justice, a two-hour Resource Fair in the courtyard, and a Recovery Happens picnic a week later. TW staffed a health promotion table at both of the resource fairs in the courtyard and at the picnic. It was estimated more than 500 attendees visited the table; the health & wellness Q&A game attracted many visitors throughout the day.
b) TW hosted an annual Bay Area SAMHSA PBHCI Grantee Collaborative Meeting here in San Mateo in August 2013. The purpose of the half-day meeting was for different Bay Area grantees to share lessons learned thus far and some future planning ideas.
c) TW collaborated with College of San Mateo's summer nursing program and sponsored a series of health and wellness educational workshops for the community. Some of the topics of the workshops included Nutrition, Effects of Smoking, Physical Activity, Oral Hygiene, and Facts on Diabetes.
d) TW Consumer and Family Advisory Committee that is consisted of five consumers and a family member, has continued to meet regularly on a monthly basis, discussing topics ranging from ways of continuous quality improvement of all TW services to promoting wellness to the larger community.
e) TW was recognized by the San Mateo County's STARS Award as an honorable mention for its excellent program performance. STARS Award is an annual acknowledgement of San Mateo County recognizing programs for either their excellent performance or for their innovative program design.
f) TW hosted site visits for various SAMHSA PBHCI Grantees and other prominent entities in the Bay Area. Some of these organizations that have conducted site visits to learn TW model included SF County, Catholic Charities of Santa Clara, Southeastern Foundations from Alaska, Community Partnerships of Stanford Department of Psychiatry, to name a few.
g) TW has actively developed and promoted the crucial emerging role of peer wellness coach in the contemporary healthcare service delivery and participated in the development of a toolkit for the role of peer providers in the integrated health settings through active participation as a member of the CASRA's (California Association of Social Rehabilitation Agencies) Advisory Group on "Peers in Integrated Healthcare." Other members of the Advisory Group included representative from LA county mental health, Veterans Administration, HMO-Kaiser, Gardner Health – a Federally Qualified Health Care organization, Larry Fricks -- the national peer trainer of WHAM (Whole Health Action Management) program, and CASRA staff & consultant group.

IMPACTS

1. Total Wellness clients have improved access to routine primary care services, better linked to needed specialty medical services, and stay linked with these services for as long as possible. The co-location of primary behavioral health care at the same sites as well as the crucial role of nurse care manager coordinating client care are key factors for these linkages to take place. Over 500 SPMI clients have been served since the inception in 2011.
2. Total Wellness has continued to demonstrate significant health outcome improvements of enrolled SPMI clients who have both behavioral health and chronic physical health conditions. These outcome improvements have been noted as soon as after 6 months in their enrollment in Total Wellness. An outstanding achievement is that TW is at the top 5% of all PBHCI grantees nationwide in achieving best client outcomes on both cholesterol and fasting blood glucose! As a result, San Mateo County Health System's Total Wellness has been mentioned nationally as one of the ten high-performing Grantees!
3. Providers, stakeholders, community leaders have expressed strong support for the expansion of Total Wellness to the entire San Mateo County in addition to the current two sites. San Mateo County BHRS Management has responded with commitment to continue and expand Total Wellness throughout the County.

PERCEPTION OF CARE SURVEYS

A total of 383 Perception of Care surveys were conducted during the reporting period (FFY 13-14). A brief analyses of the survey results suggested that majority of clients who were surveyed have a very positive experience of care with Total Wellness program, and felt supported and respected throughout their service duration. Furthermore, 93% of clients stated that they would recommend Total Wellness to a friend or family member who would need the services. Detailed breakdowns on some items are in below:

- Staff here believe that I can grow, change and recover.
  [90% agree/strongly agree; 10% disagree/strongly disagree/undecided]
- Staff help me obtain the information I needed so that I can take charge of my illness.
  [90% agree/strongly agree; 10% disagree/strongly disagree/undecided]
- I, not staff, decided my treatment goals.
  [84% agree/strongly agree; 16% disagree/strongly disagree/undecided]
- I like the services I received here.
  [95% agree/strongly agree; 5% disagree/undecided]
- If I had other choices, I would still get services from this agency.
  [92% agree/strongly agree; 8% disagree/undecided]
- I would recommend this agency to a friend or family member.
  [93% agree/strongly agree; 7% disagree/strongly disagree/undecided]

By the end of FY 13-14, Total Wellness served 1,638 clients.
Cost per client: $976

Workforce Education and Training

Workforce Staffing and Support
The current BHRS WET staffing includes 1 FTE WET coordinator and 1 FTE WET project support position. There are also 2 advisory committees/workgroups who provide support to WET projects and initiatives. They are the Workforce Development and Education Committee (WDEC) and the Lived Experience Education Workgroup (LEEW). The WDEC is the overarching advisory body for assessing and addressing training and workforce development needs that consists of BHRS and contract agency staff and clients/consumers. The LEEW is a subgroup of the WDEC and is made up of lived experience staff and clients/consumers whose efforts focus on the workforce development needs of current and former behavioral health clients/consumers.

The WET Coordinator performs the following duties:
- assesses the training and workforce development needs of BHRS and contract agency staff, and lived experience clients and consumers;
- plans, implements, and evaluates trainings;
- coordinates the BHRS internship/trainee program;
- oversees and facilitates the WDEC and LEEW activities and meetings;
- administers and oversees the contracts that create and promote behavioral health pathways;
- administers and implements the Lived Experience Academy training and Speakers' Bureau;
- supports the state Mental Health Loan Assumption Program (MHLAP) and the Cultural Competency Intern Stipend Program (CCISP);
- participates in regional and state WET collaborative meetings;
- provides trainings to staff and clients/consumers as needed
- coordinates Learning Management System (County online training system).

The WET project support position provides planning and logistical support to the coordinator to carry out the above WET tasks and also supervises the Cultural Competency Stipend Intern Program (CCSIP). This position will also provide assistance to the Learning Management System.

The current WET workforce staffing and support aspect of the WET Plan will continue for the next 3 years. The only change from the fiscal year 2013-2014 is that primary program staffing has gone from a total of 1.75FTE in 2013/2014 to 2 FTE in 2014/2015 and will continue at 2 FTE.

<u>Training and Technical Assistance</u>
This section addresses the following MHSA WET training guidelines: 1) Targeted Training for and by Consumers and Family Members, 2) Trainings to Support Wellness and Recovery, 3) Cultural Competence Training, and 4) Evidenced-Based Practices Training for System Transformation.

Targeted Training for and By Consumers and Family Members

BHRS continues to be committed to training and education by and for client/consumer and family members.

The Lived Experience Education Workgroup (LEEW)/Lived Experience Academy (LEA)

The primary purpose of the Lived Experience Education Workgroup (LEEW) is to identify and engage lived experience clients, consumers, and family members to prepare for workforce entry, advocacy roles, committee and commission participation, and other empowering activities. This group consists of BHRS and contractor staff, lived experience staff, clients/consumers, and family members. The LEEW plans, facilitates, and oversees the *Lived Experience Academy* (LEA), which trains clients/consumers and family members with behavioral health lived experience to share their stories as a tool for self-empowerment, stigma reduction, and education of others about behavioral health problems. Graduates then become part of the Lived Experience Academy Speakers' Bureau and are paid $35 per hour to speak at BHRS trainings and events around San Mateo County. Their participation greatly enhances BHRS trainings and events and provides staff and the community greater understanding of clients/consumers with behavioral health concerns.

In fiscal year 2013-2014, 6 speakers' bureau members spoke at 13 different engagements ranging from trainings on suicide prevention to community events such as the Housing Hero Awards. The program is currently being enhanced with input from past LEA graduates. A training for new speakers will be launched in early 2015 and participants will be eligible to join the speakers' bureau. The curriculum for this training is created and taught by LEEW community workers and family partners with lived experience. Other tools are being explored on how to improve training curriculum to align with the needs identified by peer partners and employers. The plan is to create a curriculum during this 3-year WET Plan cycle to train individuals about how to participate effectively on committees and commissions. The LEEW will continue to meet monthly to plan for future EAs and to provide ongoing training and support for LEA graduates. Currently, the WET team is applying for another grant to enhance the program to include more training and multi-media projects for participants.

CBT for Psychosis (CBTp) Project with Stanford University

In the fiscal year, 2013-2014, BHRS worked with Stanford University to provide a training for family members on CBTp. It was a well-attended and highly valued training. Approximately 60 family members attended and reported that the information and skills learned would help them support clients/consumers and family members with psychosis. Because of this training's success, BHRS is again working in partnership with Stanford University to apply for a grant that focuses on training family members in the CBTp treatment model. If awarded the grant, a large-scale training will be conducted by Dr. Kate Hardy for family members of individuals with psychosis. This training will be followed by a train-the-trainer program for identified family partners who will develop the skills to continue to train San Mateo County family members in the CBTp model. An advisory board of family partners will help create, develop, and implement the program.

Training to Support Wellness and Recovery

Wellness Recovery Action Planning (WRAP) with Inspired At Work

Wellness Recovery Action Planning (WRAP) has served as an excellent way to promote wellness and recovery for both clients/consumers and staff in San Mateo County. In 2013-2014, BHRS supported 1 BHRS and 1 CBO staff to become Advanced Level WRAP facilitators. Also, 17 new WRAP facilitators were trained and certified from both peer and behavioral health treatment sites around San Mateo County, and 18 WRAP groups were offered throughout San Mateo County. Since WRAP was introduced, 667 unduplicated persons have participated in a WRAP group by certified WRAP facilitators. BHRS is continuing its contract with Inspired At Work to provide WRAP training and facilitation opportunities for lived experience clients and staff as well as training and support for BHRS and contract agency family partners, community workers, etc.

Cultural Competence Training

Cultural Humility

In 2013-2014, Melanie Tervalon, MD, MPH conducted a large scale cultural humility training for behavioral health providers in San Mateo County to improve the cultural responsiveness of the system of care. Since then, BHRS has embraced cultural humility as one of its system-wide values. Dr. Tervalon developed a model of medical care of at Children's Hospital in Oakland that embodies cultural humility in the 1990s, and she now provides consultation and training on cultural humility for organizations and businesses across the U.S. In 2014-2015, she will conduct 2 large scale trainings and also a smaller, intensive 5-week train-the-trainer program. The train-the-trainer program is designed to teach participants how to effectively teach cultural humility in efforts to make this essential training more accessible to various groups and agencies in San Mateo county.

Working Effectively with Interpreters in a Behavioral Health Setting

This mandatory training aims to enhance the cultural competency and humility of BHRS staff as well as to help providers learn to effectively communicate with clients when they don't speak the client's language. The training was conducted once in 2013-2014, but will be conducted twice each year for the next 3 years of the MHSA WET training plan. This training is typically well attended, highly regarded, and is known to improve staff competence and knowledge on the appropriate use of 9 interpreters. In 2013-2014, 52 people attended. The average pre-test score was 58% correct and the average post-test score was 80% correct; hence, the average increased by 22% from pre to post training.

Spirituality 101

With the support of the Office of Diversity and Equity, the Spirituality Initiative created and implemented spirituality-related trainings during the fiscal year 2013-2014. Trainings were given at individual clinics and worksites to introduce and explain the BHRS Spirituality Policy, and a large-scale Spirituality 101 Training was conducted for all BHRS and contract agency staff to enhance the system of care's ability to address and support client/consumer spiritual beliefs, needs, and strengths. The Spirituality 101 training will again be conducted in 2014-2015, and Spirituality 102 and 103 trainings will be created and implemented throughout the next 3 years.

Cultural Competence Trainings Addressing Specific Populations
Over the next 3 years of the WET training plan, trainings addressing the issues, needs, and strengths of particular cultural groups (as identified by the community stakeholder process) will be developed and implemented. Some of the cultural groups/populations that will be addressed with these trainings include but are not limited to the LGBTQQI2S community, undocumented immigrants, and the Chinese community in San Mateo County.

Evidenced-Based Practices Trainings for System Transformation
The evidenced-based and promising practices trainings that occurred in the 2013-2014 fiscal year include: Applied Suicide Intervention Skills Training (ASIST), Mental Health First Aid, Motivational Interviewing (Part 1 and Part 2), NeuroSequential Model of Therapeutics (NMT), Harm Reduction Therapy, Management of Assaultive Behavior (Beginner and Advanced Courses), CBT for psychosis, and Cultural Humility.

Over the next 3 years of the MHSA WET Training Plan, the above evidenced-based and promising practices trainings will continue as they all reflect the 7 priority areas of training identified from the stakeholder process. BHRS and contract agency staff on DBT-informed care and Seeking Safety will also continue as those are evidenced based practices that reflect the priorities of trauma informed and co-occurring informed care. Other evidenced based practices that reflect the 7 priority areas such as Trauma-Focused CBT and Brief Family Therapy and provide trainings on these treatment modalities based on approval from the BHRS Evidenced-Based Practice Committee and budget capacity.

The Evidenced-Based Practice Committee is a diverse and multidisciplinary group of staff that reviews proposals from clinicians who want to implement a particular evidenced-based, promising, or community-defined treatment modality to ensure parity and cultural humility in deciding what treatment practices BHRS endorses.

Behavioral Health Career Pathways Programs
The stakeholder process identified workforce development areas that need to be addressed by the 3-year WET Plan Update. This process almost exactly reflected the objectives of the MHSA guidelines. The MHSA guidelines also highlight the need to identify, hire, and retain employees in hard-to-fill positions. This 3-year WET Plan update aims to use behavioral health career pathways programs to address the following goals

1) Attract prospective candidates to hard-to-fill positions through addressing application barriers and providing incentives.
2) Increase diversity of staff to better reflect diversity of the client population and retain diverse staff.
3) Promote the behavioral health field in academic training institutions in order to attract individuals to the public behavioral health system.
4) Expand efforts to create new career pathways for clients/consumers and family members within BHRS and its contract agencies, and provide ongoing development of peer and family workers.

Goals 1 and 2: Hard-to-Fill Positions and Staff Diversity

San Mateo BHRS has made strong efforts to identify hard-to-fill positions and the cultural linguistic needs of clients/consumers through two needs assessment surveys completed in July and November 2013; the survey findings were submitted to the Office of Statewide Health Planning and Development. These needs assessments identified the following as hard-to-fill positions: child/adolescent psychiatrists, geriatric psychiatrists, psychiatric mental health nurses, clinical nurse specialists, primary care physicians, *promotores*/navigators, and substance abuse counselors. BHRS has also identified linguistic needs through the Health Services Systems language assistance services and other county data. The county's threshold languages (other than English) include Spanish and Chinese, and other priority languages include Tagalog, Russian, and Tongan. Burmese and Arabic are currently being identified as emerging languages (and communities).

More BHRS staff who speak these languages and represent these cultural groups are needed to serve clients and consumers. To address hiring and retention for hard-to-fill positions, the following efforts are being made:

The state-funded *Mental Health Loan Assumption Program (MHLAP)* will continue to be implemented in San Mateo County to address the two-fold goals of 1) hiring for and retaining hard-to-fill positions and 2) increasing diversity of staff and retaining diverse staff. The MHLAP program provides student loan forgiveness for BHRS and contractor staff who work in hard-to-fill positions and exhibit cultural and linguistic competence and/or experience working in underserved areas. Applicants may receive up to $10,000 to repay educational loans in exchange for a 12-month service obligation. In 2013-2014, 22 awardees received stipends for a total of $163,478.

Another BHRS WET effort to address hard-to-fill positions and increase staff diversity is participation in the Behavioral Health and Human Resources Forums put on by the Greater Bay Area Mental Health & Education Workforce Collaborative (2013/14 and 2014/15). The purpose of these forums has been to influence county behavioral health human resources practices and priorities toward hiring staff that reflect the composition of the community being served. The forums generated ideas and steps that counties can take to improve application processes to reduce barriers and attract diverse employees (i.e. job descriptions, policies, advertisements, and media strategies). BHRS is reviewing these steps to see what changes can be made and will continue to participate in future forums and workshops to make its hiring processes more inclusive.

Goal 3: Promote the Behavioral Health Field

BHRS's Intern/Trainee Program and Behavioral Health Career Pathways Project are the primary WET activities that promote the behavioral health field in academic training institutions in order to attract individuals to the public behavioral health system.

Intern/Trainee Program
BHRS's Intern/Trainee Program provides training opportunities for approximately 40-60 psychology interns and masters-level trainees each year. BHRS partners and contracts with multiple graduate schools in the Bay Area and from other regions of the country to provide education, training, and clinical practice for their students at various behavioral health worksites in the county. Students' train and see clients at their placement sites for 20-30 hours per week during each academic year. Their training consists of weekly individual supervision, group supervision, didactic seminars, and system-wide trainings that introduce them to the most relevant treatment practices and issues in public behavioral health.

Behavioral Health Career Pathways Program
The Behavioral Health Career Pathways Program is designed to encourage San Mateo County high schools students to investigate future careers in Behavioral Health, increase students understanding and support of individuals with behavioral health challenges and reduce stigma related to behavioral health conditions and services. BHRS contracted with the Daly City Youth Health Center (DCYHC) and Jefferson Union High School District (JUHSD) for the third year in 2013-2014 to facilitate this project. There have been 300 high school juniors and seniors served over the 3-year span of this program.

During the fiscal year (2013-2014) the program was implemented in 3 sections of a psychology course at Westmoor High School in Daly City, and 102 students participated in the program. The 102 student participants represented the diversity of the North San Mateo County community—70% identified as Asian, 10% as Latino, 11% as multiracial, 3% as White, and 5% did not identify their race/ethnicity. Many of these students are from immigrant families, speak a second language, and come from households in which behavioral health conditions are not discussed. The program's curriculum educates the students about behavioral health careers and topics through guest speaker presentations and field trips.

The contract with DCYHC and JUHSD will continue for 2014-2015, and will consider ways to enhance the project with contract partners for the remaining 2 years of the training plan or potentially look into duplicating the program in a different region of the county.

<u>Goal 4: Career Pathways and Ongoing Development for Clients and Family Members</u>
Lived Experience Education Workgroup/Lived Experience Academy
As stated above in the Training and Technical Assistance section of this document the LEEW/LEA programs will be enhanced to expand the skills of and provide more opportunities for clients/consumers and family members to present/teach at trainings as well as develop advocacy skills for participation on committees and commissions.

Support for Lived Experience Workforce
Inspired at Work will continue to provide intensive training yearly for new-hire family partners and community workers to help them develop a strong skill base, understand the scope of their role, and develop confidence in their work.

Lived Experience Scholarship
The Lived Experience Scholarship provides up to $500 in scholarships for clients/consumers or family members to pursue their academic goals. In order to qualify for the Lived Experience Scholarship, the applicant must meet the following criteria:

1. Be registered for at least six units in a vocational, 2-year college, 4-year college, credential, or graduate program.
2. Desire to pursue a clinical, administrative or management career in behavioral health.
3. Is currently or has been previously a client/consumer or a family member of a client/consumer of county behavioral health services.
4. Be a resident of San Mateo County.

The application process is ongoing. This scholarship can be used to help students purchase computers and books and/or pay for tuition fees. This scholarship program was not funded in 2013-2014, but it will be reinstituted in 2014-2015 and will continue through 2016-17.

Also, other possible avenues for work and civic responsibility for lived experience clients and consumers will be explored during the course of this three years. Possible plans include creating a pathway for BHRS clients to become In Home Support Service (with Aging and Adult Services) workers for other BHRS clients, and/or a BHRS intern program for lived experience individuals who are pursuing their peer specialist certification at community college.

Financial Incentive Programs
Cultural Competency Stipend Intern Program
The Cultural Competency Stipend Intern Program (CCSIP) aims to support behavioral health graduate students (i.e. social workers, marriage and family therapists, psychologists, alcohol and other drug counselors, etc.) who are completing their internships in BHRS clinics/programs. $5,000 stipends are given to students who can contribute to the cultural competence/responsiveness of BHRS through linguistic capability, cultural identity and experience, and/or identification with or experience working with and advocating for special populations represented in San Mateo County (i.e. LGBTQQI2S, individuals living with disabilities, etc.) All students who receive a stipend participate in one of the county Health Equity Initiatives by attending the monthly initiative meetings and helping organize events and activities. They also conduct a cultural competence project during the year that is aimed at improving the cultural responsiveness of services and educating staff. In 2013-2014, 19 behavioral health interns and 1 Office of Diversity and Equity intern were awarded the stipend. 20 stipends will continue to be awarded each year for the three years of the WET Plan update.

Other Projects to Enhance Workforce Retention and Development
There are a couple other workforce development projects that will be started and/or continued over the next 3 fiscal years to promote job development and retention.

BHRS New-Hire Orientation

Starting in 2014-2015, all BHRS employees hired within the last year will receive a 5-session BHRS orientation. The orientation is designed to help participants understand all aspects of BHRS systems and programs, learn the career pathways available in BHRS, get to know BHRS management, and develop a positive sense of cohort with the other participants. This orientation will be held each year for the next 3 years.

BHRS College

The BHRS College is an 8-session professional development workshop to help participants develop skills outside their job areas and understand the role of BHRS in the broader context of county government and the Health Services System. This workshop is provided annually.

Mentoring

BHRS is currently investigating implementation of a mentor program for staff members (including peer and family partner staff) within BHRS. Employee mentees would be matched with a mentor who is in a job classification that they want to learn more about and/or are interested in as a future career goal. A BHRS mentoring program was implemented in the past through a partnership between WET and the Latino Collaborative, but the program was not sustained. There will be an input session of past participants and interested new participants to learn what aspects of the last program worked and what adjustments need to be made to create a sustainable mentoring program.

Housing

Supportive housing is an evidence-based practice that enables individuals to live independently in affordable housing with a level of service that allows the person to maintain housing, obtain stability both in physical and mental health and participate in a supportive community. Individuals show improvement in their health status, positive behaviors in the community and remain permanently housed. Services provided are based on the individual's goals and need and can include: independent living skills, medication support and management, crisis intervention, case management supported education, supportive employment, on site community activities and more.

APPROVED PROJECTS TO DATE

$ 6,762,000 MHSA funding was allocated for both construction and operation of supportive housing with $121,665 cost per unit not to exceed one third of total cost of unit; and up to $121,665 per unit for unit operating costs. BHRS is responsible for supportive services through Full Service Partnerships. Since the last Annual Update, Waverly Place Apartments in North Fair Oaks was funded, which development broke ground in 2015. All MHSA funded housing buildings are close to transportation and basic amenities. Each building design focuses on creating community among the tenants by including common areas, meeting spaces and walkways for tenants to meet each other.

Development	Units	Year Approved	MHSA Funding Amt
Cedar Street Apartments – developed by Mental Health Association (MHA). The City of Redwood City, County of San Mateo and the federal Housing and Urban Development (HUD) provided funding.	5 MHSA 14 total	2009 (opened in May 2012)	$524,150
El Camino Apartments – developed by MidPen Housing in South San Francisco. Funding provided by City of South San Francisco, County of San Mateo Dept of Housing, state of California and others.	20 MHSA 106 total	2010 (opened in Sept 2012	$2,163,200
Delaware Pacific Apartments – developed by MidPen Housing in San Mateo. Partners in the funding include the City of San Mateo, County of San Mateo Dept. of Housing, state of Calif and others.	10 MHSA 60 total	2011 (opened in Nov 2013)	$1,081,600*
Waverly Place Apartments – developed by MHA . Funding provided by San Mateo County Affordable Housing Funds, City of Redwood City CDBG/HOME Funds, San Mateo County CDBG/HOME funds.	15 MHSA 16 total	2015	$1,973,895
	50 MHSA		$5,742,845

*updated amount from last Annual Plan

Cedar Street Apartments - Approved in 2009 (5 units)

El Camino Apartments - Approved in 2010 (20 units)

Delaware Street Apartments - Approved in 2011 (10 units)

Waverly Place Apartments – Approved 2015 (15 units)

APPENDIX

APPENDIX 2. INNOVATION PROJECT PLANS

INNOVATIVE PROJECT DESCRIPTION

County: San Mateo **Date: February 16,2016**

Project Name: Neurosequential Model of Therapeutics (NMT) within an Adult Service System

PLEASE NOTE: Using this template is **OPTIONAL**. It is being provided as a technical assistance tool to staff who wish to make use of it. Regulatory requirements for the Innovation (INN) Component of the Three-Year Program and Expenditure Plan, and Annual Report, can be found in Section 3930 of the Innovation Project Regulations. In some cases, the items contained in this **OPTIONAL** template are more specific or detailed than those required by the regulations.

Project Overview

1. **The Service Need**

Describe what led to the development of the idea for your INN project and the reasons that your project is a priority for your county. What primary problem or challenge are you trying to address?

The San Mateo County Health System, Behavioral Health and Recovery Services (BHRS) led a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan FY 2014-2017. During this CPP process, **the need for providing alternative therapy and treatment options to broaden and deepen the focus on trauma and provide better outcomes in recovery for BHRS clients**, was prioritized in both the needs assessment process and strategy development sessions, which included generating ideas for potential MHSA Innovation projects. Over 300 individuals participated in close to 30 input sessions throughout the County.

The Innovation ideas were brought to the San Mateo County MHSA Steering Committee in March 2015 by stakeholders, MHSA Steering Committee members and BHRS staff and stakeholders in the form of potential projects. The Steering Committee made recommendations on which projects to move forward for further exploration. Expanding the NMT approach to help improve outcomes for BHRS adult clients with histories of trauma was identified as a top priority by the Steering Committee as *a way to bring alternative therapy and treatment options through a rigorous trauma-informed way to adult clients.*

For the past several years, BHRS has had a number of champions that have advocated strongly for raising awareness of how trauma impacts those with behavioral health challenges and for transforming our services into a trauma-informed system of care in an effort to minimize impact of trauma and maximize recovery for BHRS clients. A trauma-informed system of care fosters compassion for and empowerment, promotes understanding and coping and applies a strengths-based approach that can help those affected by trauma develop skills and relationships that lead to healing. Trauma is frequently undiagnosed or misdiagnosed, therefore appropriate interventions are often overlooked or unaddressed.

In 2012, BHRS began providing extensive training to staff and providers in the Youth System on the Neurosequential Model of Therapy (NMT) approach from the Child Trauma Academy (CTA) and Dr. Bruce Perry. The NMT model was first referenced in 2006, Perry, B.D. (2006) The Neurosequential Model of Therapeutics: Applying principles of neuroscience to clinical work with traumatized and maltreated children In: Working with Traumatized Youth in Child Welfare (Ed. Nancy Boyd Webb), The Guilford Press, New York, NY, pp. 27-52.

Some BHRS staff have gone on to become trainers to help sustain and expand this work in the county and be a resource to neighboring counties on this model. Additionally, the San Mateo County Board of Supervisors has provided funding to support alternative treatment methods that can be tailored to the specific needs of youth clients as may be recommended through the NMT assessment and treatment planning process. From a small sample reviewed in the summer of 2014, 100% showed improvement self-regulation and 63% in the remaining three domains; sensory integration, relational, and cognitive.

2. **The Proposed Project**

*Describe the project you are proposing. Note that the "project" might consist of a process (e.g. figuring out how to bring stakeholders together), the **development of a new or adapted intervention or approach**, or the implementation and/or outcomes evaluation of a new or adapted intervention. Include sufficient details so that a reader without prior knowledge of the process can understand **what you're proposing to do**, **how you will implement the project**, **what participants will experience**, and **any other key activities associated with development and implementation**.*

NMT is a developmentally sensitive, neurobiology-informed approach to clinical problem solving and working with at-risk children. NMT is not a specific therapeutic technique or intervention. The NMT approach integrates core principles of neurodevelopment and traumatology to inform the work with children, families and the communities in which they live. NMT provides a "scientific" model that locates the neurobiological reason for an individual's emotional and behavioral problems. If the deficit is neurobiological, a holistic approach, one that can be adapted to each individual case, and integrated with multiple forms of targeted therapies can help regulate brain functioning.

The proposed project will adapt, pilot and evaluate the application of NMT to an adult population and will include:

1) The adaptation of and formal training on the NMT approach, core concepts and metrics, of BHRS clinicians providing longer-term individual services or residentially-based services.
    - CTA will train a select number of 2-3 staff from up to 6 different BHRS adult system of care programs to bring the NMT model into their clinical work.
    - Target BHRS programs will either currently be doing Trauma Informed Care (TIC) work or have an opportunity to transform to a more TIC approach. It is estimated that approximately 75-100 clients will receive an assessment and relevant interventions annually.
2) Implementation of the NMT approach by trained staff and follow through on the NMT-derived key recommendations.
    - The NMT approach includes a metric assessment (NMT "mapping" process), described below and making recommendations of specific interventions and services to target the areas of the brain identified through the metrics.
    - Monthly consultation groups among NMT trained staff help strengthen skills, maintain fidelity, and discuss and derive recommendations based on a completed metric
3) Track improvement of the NMT metric domains for the select adult clients to allow BHRS to determine whether the NMT approach can improve recovery for the adult client population and outcomes. In the NMT model, there are four functional domains that are targeted in the recommended interventions: Sensory Integration, Self-regulation, Relational, and Cognitive. These four domains are evaluated after a metric reassessment is done and changes in these domains are scored. Narrative outcomes are also collected to reflect successes/achievements made with the approach.
4) Ensure fidelity to the NMT model, this is required by the CTA for continued certification

The NMT "mapping" process helps identify various areas in the brain that appear to have functional or developmental problems; in turn, this helps guide the selection and sequencing of developmentally sensitive interventions that may include alternative therapies (music, dance, yoga, drumming, various sports, therapeutic massage, etc.) where appropriate. The goal is to find a set of therapeutic activities that meet the individual's current needs in various domains of functioning (i.e., social, emotional, cognitive and physical). See attached NMT Overview document from the Childhood Trauma Academy for additional background on the approach and sample

INNOVATIVE PROJECT DESCRIPTION

3. **Innovative Component**

Describe what about the project (potentially including project development, implementation or evaluation) is new, changed or adapted. What are you doing that distinguishes you project from similar projects other counties and/or providers have already piloted? What efforts have you made to investigate existing models or approaches close to what you're proposing? For example, literature reviews, internet searchers, or direct inquiries to/with other counties.

NMT has been integrated into a variety of settings across infants through young adults. Yet, there has not been any outcome research conducted in an adult setting or population and it has not been implemented anywhere in a formal and intentional manner for an Adult System of Care. It is well documented that the brain's capacity for change decreases with age and early intervention is more effective and therefore, neurodevelopmental approaches have been primarily implemented as an intervention for children and there is little to no available research on the impact on adults.

Expansion and evaluation of the current BHRS NMT program to the adult system of care would be the first program of its kind. The Child Trauma Academy (CTA) and its creator, Dr. Perry are very supportive of this proposal and will collaborate with us on its adaptation, implementation and evaluation of this project.

NMT is a CTA copyrighted approach so we have the CTA as evidence that this has not been implemented anywhere within an adult system of care. The CTA is planning their 2nd international symposium where professionals from across multiple disciplines feature innovations in research, clinical practice and education in all areas related to maltreatment and trauma and there is no evidence that others have implemented or piloted a similar project. In addition, BHRS staff have reviewed and summarized previous MHSA Innovation Projects and vetted the ideas with the MHSOAC to ensure there is no duplication and that there is collaboration where appropriate.

4. **Learning Goals or Objectives**

Describe your learning goals or objectives. What is it that you want to learn or better understand over the course of the Innovative Project? (There is no minimum or maximum number of learning goals required, but we suggest at least two or three. Goals might revolve around understanding processes, testing hypotheses or achieving specific outcomes.)

During the BHRS comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan FY 2014-2017, **the need for providing alternative therapy and treatment options to broaden and deepen the focus on trauma and provide better outcomes in recovery for BHRS clients**, was prioritized in both the needs assessment process and strategy development sessions. The Learning Goals of this project are intended to address this need:

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 clients?

Outcome objective:

- At least 40% decrease in psychiatric hospitalizations and use of psychiatric emergency services (PES)
- Positive changes in pre/post patient questionnaires (TBD)

Learning Goal #2: Are alternative therapeutic and treatment options, focused on changing the brain organization and functioning, effective in adult clients?

Outcome objective:

- At least 60% of adult NMT clients will show improvement in each of four NMT functional domains: Sensory Integration, Self-Regulation, Relational, and Cognitive.

5. **Learning Plan (or Evaluation)**

For each of your learning goals or objectives, describe the approach you will take to achieving the goal or meeting the objective. We suggest including brief information across the following categories, as applicable:

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 clients?

1. Target participants (for example, who you plan to administer a survey to or interview);
   All clients receiving NMT approach (metric assessment and recommendations that are NMT/neurodevelopmentally-informed) will participate in the evaluation plan.

2. Name and brief description of any specific measures, performance indicators or interview tools;
   Tools may include but not limited to, pre/post mental health questionnaires and hospitalization data. An evaluation plan will be developed by a contract evaluator.

3. Evaluation methods (e.g. interviews, focus groups, ethnographic observation, surveys, analysis of encounter data) Data will be aggregated from individual metric assessments, pre/post health questionnaires and encounter data are all possible methods to be included. An evaluation plan will be developed by a contract evaluator.

4. *Preliminary* plan for evaluation administration, participant recruitment, data collection and cleaning, and analysis. 2-3 staff in each of, up to, 6 BHRS programs will be selected to receive the NMT training. The selected staff will apply the NMT approach to their caseload including any required data collection. Data cleaning, analysis and reporting will be conducted by a contract evaluator.

Learning Goal #2: Are alternative therapeutic and treatment options, focused on changing the brain organization and functioning, effective in adult clients?

1. Target participants (for example, who you plan to administer a survey to or interview);
   All clients receiving NMT approach will have a metric assessment or **"mapping" process** described above in question 2.

2. Name and brief description of any specific measures, performance indicators or interview tools;
   The NMT "mapping process" provides scores in four functional domains (Sensory Integration, Self-regulation, Relational, and Cognitive) and rescored as a follow up or post assessment.

3. Evaluation methods (e.g. interviews, focus groups, ethnographic observation, surveys, analysis of encounter data) Assessment as described above.

4. *Preliminary* plan for evaluation administration, participant recruitment, data collection and cleaning, and analysis. Same as described above.

6. **Contracting**

If you plan to contract out the INN project and/or project evaluation, describe the County's relationship to the contractor(s) and how the County will ensure quality as well as regulatory compliance.

The County will conduct a Request for Proposal or "bidding" process to select a qualified evaluator. This process along with a contract negotiation and management process ensures that the selected contractor provides quality work. The contractor will be selected based on experience conducting community program evaluation, successful contract history, cultural competence and other metrics.

INNOVATIVE PROJECT DESCRIPTION

Additional Regulatory Requirements and Project Details

7. **Certifications**

Please attach documentation of all of the following:

i. Adoption by County Board of Supervisors
ii. Certification by the county mental health director which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act (MHSA)
iii. Certification by the county mental health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements, and that all expenditures are consistent with the requirements of the MHSA
iv. Documentation that the source of INN funds is 5 percent of the County's PEI allocation and 5 percent of the CSS allocation.

8. **Community Program Planning**

Please describe the County's Community Program Planning process for the INN Project, including inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community. Include a brief description of the training the county provided to community planning participants regarding the specific purposes and MHSA requirements for INN Projects.

BHRS led a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan FY 2014-2017, that included generating ideas for potential MHSA Innovations projects. Over 300 diverse stakeholders in close to 30 input sessions throughout the County to ensure that all stakeholder groups and demographics were represented. Details on the demographics, stakeholder group representation and engagement can be found in the Three-Year Plan.

As described above on question 1, the Innovation ideas were brought to the San Mateo County MHSA Steering Committee in March 2015 by stakeholders, MHSA Steering Committee members and BHRS staff and stakeholders in the form of potential projects. The Steering Committee made recommendations on which projects to move forward for further exploration. This was then followed by a Letter of Interest process to further identify need, capacity and interest.

A one-pager summary of Innovation Guidelines (based on the proposed new guidelines that were recently implemented) was provided at all sessions and a presentation to go over the purpose, requirements and answer questions.

9. **Primary Purpose**

Select **one** of the following as the primary purpose of your project. (I.e. the overarching purpose that most closely aligns with the need or challenge described in Item 1 (above).

a) Increase access to mental health services to underserved groups
b) Increase the quality of mental health services, including measurable outcomes
c) Promote interagency collaboration related to mental health services, supports, or outcomes
d) Increase access to mental health services

10. **MHSA Innovative Project Category**

Which MHSA Innovation definition applies to your new Innovative Project (circle one):
a) Introduces a new mental health practice or approach

b) Makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community

c) Introduces a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting.

11. **Population (if applicable)**
    a. Estimate number of clients expected to be served annually : **75 - 100**
    b. Describe the population to be served, including relevant demographic information such as age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate:

A select, up to 6, BHRS programs are still to be determined. Nonetheless, an initial look at adult programs providing longer-term individual services or residentially-based services that are currently be doing Trauma Informed Care (TIC) work or have an opportunity to transform to a more TIC approach serve the following population demographics:

Age Group: Adults 18 to 59 - 76%; Older Adults - 23%
Gender: Female - 53%; Male - 47%
Ethnicity: Hispanic/Latino - 35%; Non-Hispanic/Latino - 64%
Race: White/Caucasian - 38%; Hispanic - 19%; Filipino - 13%; Black - 8%; Chinese - 6%; American Native - 2%; Other Asian - 2%; Samoan - 1%
Language: English - 84%; Spanish - 12%; Tagalog - 1%; Chinese (Cantonese, Mandarin) - 1%; Other Non-English - 2%; ASL – 0.1%

12. **MHSA General Standards**

Using specific examples, briefly describe how your Innovative Project reflects and is consistent with all potentially applicable MHSA General Standards set forth in Title 9 California Code of Regulations, Section 3320. (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standard could not apply to your Innovative Project, please, for each, explain why.

a) Community Collaboration – NMT overview and core concepts trainings have been and will continue to be providing for a range of staff from partner agencies and community groups. Monthly consultation groups among NMT trained clinicians allow for cross collaboration. Recommendations are presented to the clients and families for their input. Additionally, clients and families will be engaged in selecting resources, materials, services and therapeutic activities and interventions
b) Cultural Competency – BHRS programs will be selected to serve a diverse San Mateo County population and provide equal access to all in terms of reaching geographic isolated, ethnic/racial, underserved and unserved communities. Therapeutic activities and interventions takes into consideration cultural and linguistic client preferences. All BHRS staff and contractor staff are required to complete cultural humility training.
c) Client-Driven – Clients are engaged in selecting therapeutic activities and interventions that match their preferences and needs based on the metric assessment.
d) Family-Driven – where appropriate, families are engaged in selecting and participating in therapeutic activities and interventions, parent/caregivers/others must be involved in learning and delivering some of the interventions to allow for consistent and repetitive
e) Wellness, Recovery, and Resilience-Focused – the NMT mapping process along with the recommendations for therapeutic activities that help support changes in the brain are based on these principles.

f) Integrated Service Experience for Clients and Families – BHRS provides an integrated service experience

13. **Continuity of Care for Individuals with Serious Mental Illness**

Will individuals with serious mental illness receive services from the proposed project? ☑ Yes ☐ No

If yes, describe how, if or when the Innovative Project ends, you plan to protect and provide continuity of care for these individuals.

Individuals participating in the NMT approach will be current BHRS clients in specific programs. Sustainability of the developmentally-informed approach to treating clients is accomplished through the training component, which includes a train-the-trainer and funding/resources to maintain the materials, service contracts and alternative activities.

14. **INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement**.

a) Explain how you plan to ensure that the Project evaluation is **culturally competent**. *Note that this is not a required element of the initial Innovative Project description but is a mandatory component of the Final Report. We therefore advise considering a strategy for cultural competence early in the planning process. An example of cultural competence in an evaluation framework would be vetting evaluation methods and/or outcomes with any targeted ethnic/racial/linguistic minority groups.*

b) Explain how you plan to ensure **meaningful stakeholder participation** in the evaluation. *Note that the mere involvement of participants and/or stakeholders as participants (e.g. participants of the interview, focus group or survey component of an evaluation) is not sufficient. Participants and/or stakeholders must be involved in contributing to evaluation planning, implementation and analysis. Examples of stakeholder involvement include hiring peer/client evaluation support staff, or convening an evaluation advisory group composed of diverse community members that weighs in at different stages of the evaluation.*

The evaluation plan will be developed by a contractor and include meaningful and diverse stakeholder participation through the MHSA Steering Committee. The committee ensures that MHSA planning, implementation and evaluation reflects local diverse needs and priorities. It is made up of diverse stakeholders and cultural groups and is open to the public. There will be opportunity to vet, provide input and participate in evaluation planning and implementation activities.

15. **Deciding Whether and How to Continue the Project Without INN Funds**

Briefly describe how the County will decide whether and how to continue the INN Project, or elements of the Project, without Innovation Funds following Project completion. For example, if the evaluation does (or does not) indicate that the service or approach is effective, what are the next steps?

As described above, the MHSA Steering Committee will be the primary venue for vetting next steps with diverse stakeholders. If the evaluation indicates that the NMT approach is effective for adult clients, clinicians can continue to implement this approach as part of BHRS effort to transform services into a trauma-informed system of care. There is a train-the-trainer component to CTA's training that will allow us to sustain and expand the application to a larger number of consumers. Funding to support the materials, contract services and therapeutic activities needed,

will be identified. Currently, Measure A (local sales tax initiative) funds support alternative treatment methods for youth clients.

If the evaluation indicates that the NMT approach is not effective for adult clients, trained clinicians in collaboration with clients and families will determine if, with modifications, the NMT approach may produce better outcomes. If so BHRS will determine the process for continuation at that time.

16. **Communication and Dissemination Plan**.

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your Innovative Project.

a) How will you disseminate information to stakeholders within your county, and (if applicable) to other counties?
b) How will program participants or other stakeholders be involved in communication efforts?

MHSA implementation is very much a part of BHRS' day-to-day business. Information is shared and input collected with a diverse group of stakeholders on an ongoing basis. All the MHSA information is made available to stakeholders on the San Mateo County Behavioral Health and Recovery Services MHSA webpage, www.smchealth.org/bhrs/mhsa. The site includes a subscription feature to receive an email notification when the website is updated with MHSA developments, meetings and opportunities for input. This is currently at over 800 subscribers, increased 300+ in the last year. Hard copies of materials are made available upon request.

The BHRS's e-journal, Wellness Matters is published the first Wednesday of every other month and distributed electronically to county wide partners and stakeholders, and serves as an information dissemination and educational tool, with a standing column written by the County's MHSA Manager. The BHRS Blog also provides a forum for sharing and disseminating information broadly. In addition, presentations and ongoing progress reports are provided by BHRS, and input is sought on an ongoing basis at the monthly Mental Health and Substance Abuse and Recovery Commission meeting at the MHSA Steering Committee meeting; at meetings with community partners and advocates; and internally with staff.

Opportunities to present at statewide conferences will be sought and stakeholders can help present the information. CTA hosts an annual international NMT symposium that features innovations in research, clinical practice and education in all areas related to trauma.

17. **Timeline**

A) Specify the total timeframe (duration) of the Innovative Project: 3 Years, 0 Months
B) Specify the expected start date and end date of your Innovative Project:
July 1, 2016 Start Date / June 30, 2019 End Date
Note: Please allow processing time for approval following official submission of the INN Project Description.

The initial training period is 12 months. This is a very intensive and in-depth training program. It will enable participating staff to use the NMT Metric tool for the assessment of clients, as well as the understanding of the model to inform their clinical practice with all clients. It also creates strong influence with team members, partner groups and family member in terms of the psycho-educational impact from the NMT implementation.

In the Youth system we experienced this type of meaningful change within the first two years.
We expect to see the same results in the Adult system, with the on-going expansion of the pilot over the additional third year.

C) Include a timeline that specifies key activities and milestones and a brief explanation of how the project's timeframe will allow sufficient time for

a. Development and refinement of the new or changed approach;
b. Evaluation of the INN Project;
c. Decision-making, including meaningful involvement of stakeholders, about whether and how to continue the Project;
d. Communication of results and lessons learned.

July 1, 2016 – October 2016

- CTA to refine training for adult population
- Evaluator to meet with BHRS and CTA staff to discuss evaluation plan
- Evaluation plan brought to MHSA Steering Committee for input

October 2016 – January 2017

- In-depth training period begins including evaluation plan components
- Establish consultation groups
- Service contracts and flex fund established for alternative therapies/interventions
- Somatosensory tools and materials purchased

January 2017 – December 2018

- Training continues
- Refine alternative therapy options/recommendations with client/family input
- Collect data needed for evaluation

January 2019 – June 2019

- Complete evaluation analysis and report
- Engage MHSA Steering Committee on issue of continuation of the project
- Disseminate final findings and evaluation report

18. **INN Project Budget and Source of Expenditures**

Training Program ($3,000 / staff person x 10) = $30,000
Service Contracts (non-traditional, MediCal reimbursable, somatosensory interventions identified through NMT assessments) = $75,000
Metric Assessment ($3,000/year)

Total $108,000 first year / $78,000 each subsequent year

INNOVATIVE PROJECT DESCRIPTION

County: San Mateo **Date: February 16,2016**

Project Name: Health Ambassador Program - Youth

PLEASE NOTE: Using this template is **OPTIONAL**. It is being provided as a technical assistance tool to staff who wish to make use of it. Regulatory requirements for the Innovation (INN) Component of the Three-Year Program and Expenditure Plan, and Annual Report, can be found in Section 3930 of the Innovation Project Regulations. In some cases, the items contained in this **OPTIONAL** template are more specific or detailed than those required by the regulations.

Project Overview

1. **The Service Need**

Describe what led to the development of the idea for your INN project and the reasons that your project is a priority for your county. What primary problem or challenge are you trying to address?

The San Mateo County Health System, Behavioral Health and Recovery Services (BHRS) led a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan FY 2014-2017. During this CPP process, **the need to decrease stigma and build the capacity of communities to engage in improving access to mental health services**, was prioritized in both the needs assessment process and strategy development sessions, which included generating ideas for potential MHSA Innovation projects. Over 300 individuals participated in 27 input sessions throughout the County.

The Innovation ideas were brought to the San Mateo County MHSA Steering Committee in March 2015 by stakeholders, MHSA Steering Committee members and BHRS staff and stakeholders in the form of potential projects. The Steering Committee made recommendations on which projects to move forward for further exploration. The Health Ambassador Program was identified as a top priority by the Steering Committee as *a way to engage individuals, families and communities to be active change agents regarding their health and decrease stigma related to accessing mental health services.*

The original Health Ambassador Program (for adults) was developed in January 2014 through a collaborative process with Parent Project® participants. Parent graduates wanted more ways to get involved, build on the skills they had learned and give back to their community. HAP participants complete a 12-week Parent Project® class and are encouraged to take 4 additional classes designed to educate or enhance their skill or knowledge about behavioral health. HAP graduates are then presented a "Health Ambassador Certificate" and became a critical liaison to San Mateo County's diverse communities by doing outreach, speaking at panels and community events, teaching psycho-educational classes, facilitating discussions or focus groups, etc. HAP graduates are also recruited to join committees, advisory groups, Health Equity Initiatives and commissions as informed members of the public and are supported through stipends throughout their participation.

A Letter of Interest process further identified the need, capacity, and interest, which led to the focus on youth. While the value of peer support work is well documented, youth peer support in mental health is not. Training curricula designed for youth and young adults are limited. More specifically, the process by which Health Ambassadors become liaisons to the community is innovative, collaborative and client focused.

2. **The Proposed Project**

*Describe the project you are proposing. Note that the "project" might consist of a process (e.g. figuring out how to bring stakeholders together), the **development of a new or adapted intervention or approach**, or the implementation and/or outcomes evaluation of a new or adapted intervention. Include sufficient details so that a reader without prior knowledge of the process can understand **what you're proposing to do**, **how you will implement the project**, **what participants will experience**, and **any other key activities associated with development and implementation**.*

INNOVATIVE PROJECT DESCRIPTION

The idea for a Health Ambassador Program-Youth (HAP-Y) was created on the basis that informed youth can take a proactive role in reaching out to their peers and helping to keep their families and communities healthy. To become a HAP-Y ambassador a youth age 16-25 must complete 4 of the following trainings: Mental Health First Aid (Youth or Adult); Applied Suicide Intervention Skills Training (ASIST); NAMI Family-to-Family Education Program; NAMI Basics, Stigma Free San Mateo and/or Wellness Recovery Action Plan (WRAP), Digital Storytelling and/or Photovoice, and/or other youth focused course. After the completion of the specified classes, HAP-Y graduates are presented a "Health Ambassador Certificate" and became part of a BHRS Ambassador pool.

BHRS HAP-Y graduates can conduct outreach, speak at panels and community events, teach psycho-educational classes, facilitate discussions or focus groups, volunteer as point of contacts for resources and helping with local efforts such as the "Be the One" photo shoot campaigns and the annual "Stand Up for Wellness" event. HAP-Y graduates can also be recruited to join committees, advisory groups, Health Equity Initiatives and commissions supported by adult allies and provided stipends throughout their participation. The following is a proposed plan and may need to be changed based on implementation activities:

1. Adapt the current HAP model and process and HAP-Y curriculum appropriate for the youth participants;
2. Provide classes (WRAP, MHFA, ASIST, etc.) for participants, including youth with lived experience;
3. Conduct pre and post-tests, program evaluations, participant surveys, and data analysis;
4. Collect and analyze data on all courses offered, participant progress and how the program has supported HAP-Y graduates in achieving their goals.
5. Collect outcome measures to demonstrate the impact of HAP-Y on improving access to services for youth at risk of developing serious mental illness.

3. **Innovative Component**

Describe what about the project (potentially including project development, implementation or evaluation) is new, changed or adapted. What are you doing that distinguishes you project from similar projects other counties and/or providers have already piloted? What efforts have you made to investigate existing models or approaches close to what you're proposing? For example, literature reviews, internet searchers, or direct inquiries to/with other counties.

The following components meet the criteria for an innovative project:

1. *The proposed process for graduating as a youth Health Ambassador*
   The year-long psychoeducational process to graduate as ambassadors has not been evaluated to understand its full impact on ambassadors and the community. While the adult HAP program has been in implementation since January 2014, it's still rather new in terms of being able to report outcomes/impact on access to services. The proposed process, Health Ambassadors complete a specified number of established educational courses (WRAP, MHFA, ASIST, etc.), is an innovative process and evaluating its impact on youth can be transforming to MHSA prevention work.

2. *HAP curriculum and process for youth ambassadors*
   The current process for graduating HAP adults and the curriculum used are mostly targeted to adults and particularly parents/caregivers of high risk youth, as a prevention strategy. This process will be adapted to for youth ambassadors. While there are some courses available for youth, many will need to be adapted as well for youth participants.

3. *Effectiveness of youth ambassadors in increasing access to mental health services*
   From literature reviews, internet searches and direct inquiries with other counties (Kings County Youth Resiliency Project and Riverside County TAY Peer Training Curriculum) it is evident that research and youth peer support and outreach efforts in mental health services is lacking. The value of adult peer support work is well documented and somewhat for youth peer support in primary health care as well.

INNOVATIVE PROJECT DESCRIPTION

4. **Learning Goals or Objectives.** Describe your learning goals or objectives. What is it that you want to learn or better understand over the course of the Innovative Project? (There is no minimum or maximum number of learning goals required, but we suggest at least two or three. Goals might revolve around understanding processes, testing hypotheses or achieving specific outcomes.)

   During the BHRS comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan FY 2014-2017, **the need to decrease stigma and build the capacity of communities to engage in improving access to mental health services**, was prioritized in both the needs assessment process and strategy development sessions. Additionally, a Letter of Interest process further narrowed the need to **building youth capacity**. The Learning Goals of this project are intended to address these needs:

   Learning Goal #1: Is the HAP year-long psychoeducational process for developing Health Ambassadors an effective method for building youth capacity to engage them in reducing stigma and improving access to services?

   Outcome objective:

   - Positive changes in pre/post questionnaires for youth ambassadors(TBD)
   - Improved mental health outcomes for youth ambassadors with Lived Experience (e.g. depression, anxiety, hopelessness, developmental assets)
   - Positive mental health perceptions and experience from participants of youth ambassador-led outreach, presentations, efforts, etc. to measure stigma reduction

   Learning Goal #2: Are youth ambassadors effective in increasing access to mental health services for other youth, families and communities?

   Outcome objective:

   - Positive likelihood/perceptions with regards to accessing mental health services from participants in youth ambassador-led outreach, presentations, efforts, etc.
   - Referral and linkages made

5. **Learning Plan (or Evaluation)**
   For each of your learning goals or objectives, describe the approach you will take to achieving the goal or meeting the objective. We suggest including brief information across the following categories, as applicable:

Learning Goal #1: Is the HAP year-long psychoeducational process for developing Health Ambassadors an effective method for building youth capacity to engage them in improving access to mental health services?
Learning Goal #2: Are youth peer outreach workers effective in increasing access to mental health services for other youth, families and communities*?*

1. Target participants (for example, who you plan to administer a survey to or interview);
   - Youth ambassadors (graduates) may receive a pre/post survey to determine the appropriateness of the HAP process in building youth capacity.
   - Data will be collected on referrals made to demonstrate effectiveness in terms of leading to increased access to services.
   - Youth ambassadors with Lived Experience would benefit from a pre/post focused on their own wellness and recovery.
   - Participants in the youth ambassador-led outreach, presentation, etc.
   - Development of a thorough evaluation plan will be conducted by a contract evaluator

2. Name and brief description of any specific measures, performance indicators or interview tools (TBD).
   - Pre/post surveys to determine appropriateness of HAP process in building youth capacity
   - Health Screening tools such as PHQ9, GAD7, Search Inst. can be used in pre/post assessments with youth to demonstrate positive mental health outcomes
   - Pre/post surveys for participants in ambassador-led events to measure perceptions as it relates to stigma and accessing mental health services
   - Development of a thorough evaluation plan will be conducted by a contract evaluator.

3. Evaluation methods (e.g. interviews, focus groups, ethnographic observation, surveys, analysis of encounter data) TBD. Evaluation methods will incorporate pre/post surveys, encounter/event data, and formal health screening surveys. Development of a thorough evaluation plan will be conducted by a contract evaluator.

4. *Preliminary* plan for evaluation administration, participant recruitment, data collection and cleaning, and analysis.
A provider contractor will be selected to conduct the administration, participant recruitment and data collection aspects of the evaluation plan. A separate evaluation contractor will develop a thorough evaluation plan, conduct data cleaning, analysis and.

6. **Contracting**

If you plan to contract out the INN project and/or project evaluation, describe the County's relationship to the contractor(s) and how the County will ensure quality as well as regulatory compliance.

The County will conduct a Request for Proposal or "bidding" process to select a qualified evaluator. This process along with a contract negotiation and management process ensures that the selected contractor provides quality work. The contractor will be selected based on experience conducting community program evaluation, successful contract history, cultural competence and other metrics.

Additional Regulatory Requirements and Project Details

7. **Certifications**

Please attach documentation of all of the following:

i. Adoption by County Board of Supervisors
ii. Certification by the county mental health director which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act (MHSA)
iii. Certification by the county mental health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements, and that all expenditures are consistent with the requirements of the MHSA
iv. Documentation that the source of INN funds is 5 percent of the County's PEI allocation and 5 percent of the CSS allocation.

8. **Community Program Planning**

Please describe the County's Community Program Planning process for the INN Project, including inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community. Include a brief description of the training the county provided to community planning participants regarding the specific purposes and MHSA requirements for INN Projects.

BHRS led a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan FY 2014-2017, that included generating ideas for potential MHSA Innovations projects. Over 300 diverse stakeholders in 27 input sessions throughout the County to ensure that all stakeholder groups and demographics were represented. Details on the demographics, stakeholder group representation and engagement can be found in the Three-Year Plan.

As described above on question 1, the Innovation ideas were brought to the San Mateo County MHSA Steering Committee in March 2015 by stakeholders, MHSA Steering Committee members and BHRS staff and stakeholders in the form of potential projects. The Steering Committee made recommendations on which projects to move forward for further exploration. a Letter of Interest process further identified capacity and interest and a Request for Proposal (RFP) process is currently in selection phase for a project administration contractor.

A one-pager summary of Innovation Guidelines (based on the proposed new guidelines that were recently implemented) was provided at all sessions and a presentation to go over the purpose, requirements and answer questions.

INNOVATIVE PROJECT DESCRIPTION

9. **Primary Purpose**

Select **one** of the following as the primary purpose of your project. (I.e. the overarching purpose that most closely aligns with the need or challenge described in Item 1 (above).

a) Increase access to mental health services to underserved groups
b) Increase the quality of mental health services, including measurable outcomes
c) Promote interagency collaboration related to mental health services, supports, or outcomes
d) Increase access to mental health services

10. **MHSA Innovative Project Category**

Which MHSA Innovation definition applies to your new Innovative Project (circle one):
a) Introduces a new mental health practice or approach
b) Makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community
c) Introduces a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting.

11. **Population (if applicable)**

a. Estimate number of clients expected to be served annually : **30 HAP-Y graduates**
b. Describe the population to be served, including relevant demographic information such as age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate:

The expectation is to recruit 30 diverse youth ages 16-25 to go through the HAP-Y curriculum and graduate. At least 30% of graduates should be youth with Lived Experience. The plan is to recruit youth from diverse cultural backgrounds (White, Latino, African American, Filipino, Pacific Islander, Native American), gender identity (LGBTQ) and geographic representation (North County, South County, Central and the Coastside, geographically isolated youth). Demographic data will be collected to ensure HAP-Y is reaching diverse youth.

12. **MHSA General Standards**

Using specific examples, briefly describe how your Innovative Project reflects and is consistent with all potentially applicable MHSA General Standards set forth in Title 9 California Code of Regulations, Section 3320. (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standard could not apply to your Innovative Project, please, for each, explain why.

a) Community Collaboration – Recruitment of youth, adaptation of the curriculum and courses will require a collaborative effort from BHRS staff, youth and community partners.
b) Cultural Competency – BHRS programs will be selected to serve a diverse San Mateo County population and provide equal access in terms of reaching geographic isolated, ethnic/racial, underserved and unserved communities. All BHRS staff and contractor staff are required to complete cultural humility training.
c) Client-Driven – Youth will be engaged in the adaptation of the curriculum, course selection and data collection, evaluation processes.
d) Family-Driven – where appropriate, families will also be engaged in the program components, including planning, course selection, implementation, and supporting the youth ambassadors
e) Wellness, Recovery, and Resilience-Focused – providing youth with lived experience the opportunity to graduate as youth ambassadors will aid in their wellness and recovery. All course options are based on these principles of wellness, recovery and resilience
f) Integrated Service Experience for Clients and Families – A referral process will be developed to ensure an youth ambassadors and participants in ambassador-led activities have access to a full range of service provided by BHRS and community agencies

13. **Continuity of Care for Individuals with Serious Mental Illness**

Will individuals with serious mental illness receive services from the proposed project? ☑ Yes ☐ No

If yes, describe how, if or when the Innovative Project ends, you plan to protect and provide continuity of care for these individuals.

SMI/SED transition age youth participating as ambassadors in the HAP-Y program will come from BHRS or network of care specific programs and will be connected to services. SMI/SED individuals that access ambassador-led activities will be referred to BHRS/contract providers and receive continuing care as medically necessary.

14. **INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement**.

a) Explain how you plan to ensure that the Project evaluation is **culturally competent**. *Note that this is not a required element of the initial Innovative Project description but is a mandatory component of the Final Report. We therefore advise considering a strategy for cultural competence early in the planning process. An example of cultural competence in an evaluation framework would be vetting evaluation methods and/or outcomes with any targeted ethnic/racial/linguistic minority groups.*

b) Explain how you plan to ensure **meaningful stakeholder participation** in the evaluation. *Note that the mere involvement of participants and/or stakeholders as participants (e.g. participants of the interview, focus group or survey component of an evaluation) is not sufficient. Participants and/or stakeholders must be involved in contributing to evaluation planning, implementation and analysis. Examples of stakeholder involvement include hiring peer/client evaluation support staff, or convening an evaluation advisory group composed of diverse community members that weighs in at different stages of the evaluation.*

The evaluation plan will be developed by a contractor and include meaningful and diverse stakeholder participation through the youth ambassador participants and the MHSA Steering Committee. The Steering Committee ensures that MHSA planning, implementation and evaluation reflects local diverse needs and priorities. It is made up of diverse stakeholders and cultural groups and is open to the public. There will be opportunity to vet, provide input and participate in evaluation planning and implementation activities.

15. **Deciding Whether and How to Continue the Project Without INN Funds**

Briefly describe how the County will decide whether and how to continue the INN Project, or elements of the Project, without Innovation Funds following Project completion. For example, if the evaluation does (or does not) indicate that the service or approach is effective, what are the next steps?

As described previously, the youth ambassadors will be engaged in the program planning, implementation and evaluation. In addition, the MHSA Steering Committee will be a venue for vetting next steps with diverse stakeholders. If the evaluation indicates that the HAP-Y is an effective process for youth capacity building and to increase access to mental health services, the youth can remain in the BHRS ambassador pool. Contractors will be asked to develop a sustainability plan as part of their project proposal.

If the evaluation indicates that the HAP-Y is not effective for youth ambassadors, BHRS and the MHSA Steering Committee would consider adaptations to the model and consider an alternative strategy/project.

16. **Communication and Dissemination Plan**.

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your Innovative Project.

a) How will you disseminate information to stakeholders within your county, and (if applicable) to other counties?
b) How will program participants or other stakeholders be involved in communication efforts?

MHSA implementation is very much a part of BHRS' day-to-day business. Information is shared and input collected with a diverse group of stakeholders on an ongoing basis. All the MHSA information is made available to stakeholders on the San Mateo County Behavioral Health and Recovery Services MHSA webpage, www.smchealth.org/bhrs/mhsa. The site includes a subscription feature to receive an email notification when the

website is updated with MHSA developments, meetings and opportunities for input. This is currently at over 800 subscribers, increased 300+ in the last year. Hard copies of materials are made available upon request.

The BHRS's e-journal, Wellness Matters is published the first Wednesday of every other month and distributed electronically to county wide partners and stakeholders, and serves as an information dissemination and educational tool, with a standing column written by the County's MHSA Manager. The BHRS Blog also provides a forum for sharing and disseminating information broadly. In addition, presentations and ongoing progress reports are provided by BHRS, and input is sought on an ongoing basis at the monthly Mental Health and Substance Abuse and Recovery Commission meeting at the MHSA Steering Committee meeting; at meetings with community partners and advocates; and internally with staff.

Opportunities to present at statewide conferences will be sought and the youth ambassadors can help present the information.

17. **Timeline**

A) Specify the total timeframe (duration) of the Innovative Project: **Proposed 3 Years, 0 Months**

B) Specify the expected start date and end date of your Innovative Project:

July 1, 2016 Start Date / June 30, 2019 End Date

Note: Please allow processing time for approval following official submission of the INN Project Description.

C) Include a timeline that specifies key activities and milestones and a brief explanation of how the project's timeframe will allow sufficient time for

- Development and refinement of the new or changed approach;
- Evaluation of the INN Project;
- Decision-making, including meaningful involvement of stakeholders, about whether and how to continue the Project;
- Communication of results and lessons learned.

The following is a rough timeline, this will be negotiated and finalized with the contracted partner agency:

July 1, 2016 – December 2016

- Startup activities – hiring program coordinator, adaptation of curriculum, selection and adaptation of courses, setting up infrastructure for implementation/evaluation
- Evaluator to meet with youth, partner agency and BHRS staff to discuss evaluation plan
- Evaluation plan brought to MHSA Steering Committee for input

January 2017 – December 2017

- Recruitment of youth and courses scheduled
- Courses commence
- Establish opportunities for engagement post-graduation from HAP-Y

January 2018 – December 2018

- 2nd round of recruitment and courses commence
- Support of youth ambassador graduates in liaison activities

January 2019 – June 2019

- 3rd round of recruitment and courses commence
- Support of youth ambassador graduates in liaison activities
- Complete evaluation analysis and report
- Engage MHSA Steering Committee on issue of continuation of the project
- Disseminate final findings and evaluation report

INN Project Budget and Source of Expenditures

Final budget and expenditures will be determined by the contracted agency. $250,000 is available for this project

INNOVATIVE PROJECT DESCRIPTION

County: San Mateo **Date: February 16,2016**

Project Name: LGBTQ Behavioral Health Coordinated Services Center

PLEASE NOTE: Using this template is **OPTIONAL**. It is being provided as a technical assistance tool to staff who wish to make use of it. Regulatory requirements for the Innovation (INN) Component of the Three-Year Program and Expenditure Plan, and Annual Report, can be found in Section 3930 of the Innovation Project Regulations. In some cases, the items contained in this **OPTIONAL** template are more specific or detailed than those required by the regulations.

Project Overview

1. **The Service Need**

Describe what led to the development of the idea for your INN project and the reasons that your project is a priority for your county. What primary problem or challenge are you trying to address?

The San Mateo County Health System, Behavioral Health and Recovery Services (BHRS) led a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan FY 2014-2017. During this CPP process, **the need for culturally specific programs, outreach and coordination of services for LGBTQ communities**, was prioritized in both the needs assessment process and strategy development sessions, which included generating ideas for potential MHSA Innovation projects. Over 300 individuals participated in 27 input sessions throughout the County.

The Innovation ideas were brought to the San Mateo County MHSA Steering Committee in March 2015 by stakeholders, MHSA Steering Committee members and BHRS staff and stakeholders in the form of potential projects. The Steering Committee made recommendations on which projects to move forward for further exploration. An LGBTQ Behavioral Health Coordinated Services Center was identified as a top priority by the Steering Committee as *a way to promote interagency and community collaboration and increase access to culturally appropriate services for the LGBTQ community in San Mateo County.*

LGBTQ individuals and families are considered one of the most vulnerable and marginalized communities in the United States. Many experience multiple levels of stress and risk for Serious Mental Illness (SMI) due to constant subtle or covert acts of homophobia, biphobia and transphobia against them. LGBTQ youth are especially vulnerable with higher rates of being victimized, of having a mental health disorder, higher rates of homelessness and suicide. LGBTQ adults are also at higher risk of depression and isolation from family and other social supports. Transgender persons and gender non-conforming/variant remain the most vulnerable, experiencing the highest rates of assaults, violence and discrimination compared to lesbians and gays. While there are LGBTQ services located in the San Francisco-Bay Area, there are very little services in San Mateo County and currently there is no model of coordination of psycho-educational, social services, peer-based and community support and clinical services.

2. **The Proposed Project**

*Describe the project you are proposing. Note that the "project" might consist of a process (e.g. figuring out how to bring stakeholders together), the **development of a new or adapted intervention or approach**, or the implementation and/or outcomes evaluation of a new or adapted intervention. Include sufficient details so that a reader without prior knowledge of the process can understand **what you're proposing to do**, **how you will implement the project**, **what participants will experience**, and **any other key activities associated with development and implementation**.*

The proposed projects aim is to develop a Coordinated Services Center, designed to provide a place for a wide range of services for the LGBTQ community in San Mateo County. Its overall purpose is to improve the quality of life and address the multiple barriers many LGBTQ individuals and families face in seeking behavioral health care. The LGBTQ Behavioral Health Coordinated Services Center will be operated through a collaboration of multiple agencies

that can provide a broad range of services (such as counseling and crisis intervention, case management, vocational and peer support services) to LGBTQ communities within San Mateo County. The project will include a location/space where groups, events and other LGBTQ-related activities will be held and feature the coordination of three (3) main components: (a) social and community, (b) clinical and (c) resource center including a social media and online presence.

1. *The social and community component* aims to engage, educate and provide support to LGBTQ individuals through peer-based models of wellness and recovery. The efforts will be led by an LGBTQ peer worker and collaboratively with other service providers both within and outside San Mateo County. The team would be leading community education, mentorship efforts, meet-ups, NA/AA and other social (i.e. Pride Initiative meetings, Transgender Day of Remembrance, Pride month celebrations, etc.) and educational activities.

2. *The clinical component* will be comprised of two areas:
    a) Behavioral health services focusing on communities at high risk or moderate to severe mentally ill (high risk for SMI include, queer youth of color, LGBTQ victims of bullying and/or trauma, etc.)
    b) A resource and training ground for healthcare providers to build competency working with the LGBTQ population especially with the transgender and gender non-conforming/variant community.

    The clinical component will consist of bilingual/bicultural licensed providers (including a part-time psychiatrist) that are able to provide appropriate mental health and substance use services specifically to LGBTQ individuals and families who are at high risk or moderate to severe mentally ill, including case management, counseling, medication assistance and support. Bilingual/bicultural peer workers who are critical members of the treatment team will also be able to provide some assistance and support.

3. *The resource component* is to become a hub for local, County and national LGBTQ resources including the creation of an online and social media presence, which will include the development of resource materials for the LGBTQ community. Online chats, texting, hotline and Facebook will be used to engage hard to reach populations including youth/young adults, geographically isolated individuals and older adults.

The services at the LGBTQ Behavioral Health Coordinated Services Center will be provided at times/days (including weekends) that would best meet the needs of the community including offering services to other parts of the County as needed. The LGBTQ Behavioral Health Coordinated Services Center will be staffed and supported by a diverse group of individuals including but not limited to licensed and certified behavioral health staff, individuals with lived experience as consumers or family members, interns and trainees and cultural brokers who have experience and knowledge on LGBTQ issues.

3. **Innovative Component**

Describe what about the project (potentially including project development, implementation or evaluation) is new, changed or adapted. What are you doing that distinguishes you project from similar projects other counties and/or providers have already piloted? What efforts have you made to investigate existing models or approaches close to what you're proposing? For example, literature reviews, internet searchers, or direct inquiries to/with other counties.

While it is not new to have an LGBTQ community center in the broader Bay Area and across the U.S. (i.e. the LGBT Center in San Francisco or the Billy de Frank Center in San Jose, The Center in New York) or to have a behavioral health program that focuses on the LGBTQ population (i.e. Alliance Health Project in San Francisco), it is innovative to have the combination of an LGBTQ behavioral health center that provides both behavioral health services, psycho-educational and community/social events and activities.

Individuals who enter the center in need of behavioral health help will have seamless access to treatment as well as to social and community groups that could further improve their mental health, enhance their sense of community and reduce their isolation. Similarly, those who visit the center to build social connections will have access to therapy/counseling to address any mental health and substance abuse issues they may have.

It is also new to have an LGBTQ Behavioral Health Coordinated Services Center that is primarily focused on outreach and treatment to marginalized communities within the LGBTQ community. The proposed LGBTQ Behavioral Health Coordinated Services Center would use aspects of a peer run model to engage multiple special populations and high risk for SMI populations including transgender and gender non-conforming/varaint community members, LGBTQ youth and seniors, as well as queer people of color in community activities as well as behavioral health services.

BHRS staff have reviewed and summarized previous MHSA Innovation Projects and vetted the ideas with the MHSOAC to ensure there is no duplication and that there is collaboration where appropriate.
direct inquiries with other counties San Francisco Transgender Pilot Project led to the conclusion that a coordinated system of care for high risk LGBTQ populations is innovative and worth the effort to learn whether this approach will improve service delivery, collaboration and access to mental health services.

4. **Learning Goals or Objectives**

Describe your learning goals or objectives. What is it that you want to learn or better understand over the course of the Innovative Project? (There is no minimum or maximum number of learning goals required, but we suggest at least two or three. Goals might revolve around understanding processes, testing hypotheses or achieving specific outcomes.)

During the BHRS comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan FY 2014-2017, **the need for culturally specific programs, outreach and coordination of services for LGBTQ communities**, was prioritized in both the needs assessment process and strategy development sessions. The Learning Goals of this project are intended to address these needs:

Learning Goal #1: Does the coordination of services improve service delivery and access to mental health services for LGBTQ marginalized and high risk for SMI communities?

Outcome objective:

- Determine baseline of collaboration, how do systems effectively collaborate currently to serve this population?
- Process measures: increase in communication, referrals, interaction
- Outcome measures: improved mental health indicators from pre/post scales or mental health patient questionnaires

Learning Goal #2: Does a focus on outreach for marginalized and high risk for SMI individuals improve access to mental health services?

Outcome objective:

- Positive likelihood/perceptions with regards to accessing mental health services from participants in peer-led outreach, support, etc.
- Increase in referral and linkages made

5. **Learning Plan (or Evaluation)**

For each of your learning goals or objectives, describe the approach you will take to achieving the goal or meeting the objective. We suggest including brief information across the following categories, as applicable:

1. Target participants (for example, who you plan to administer a survey to or interview);

Learning Goal #1: Does the coordination of services improve service delivery and access to mental health services for LGBTQ marginalized and high risk for SMI communities?

- Partner agency assessment to determine level of coordination

- LGBTQ visitors to the center at intake and closure and through client satisfaction

Learning Goal #2: Does a focus on outreach for marginalized and high risk for SMI individuals improve access to mental health services?

- Client intake and closure (pre/post) mental health scale/questionnaire
- Increase in clients accessing services within the system

2. Name and brief description of any specific measures, performance indicators or interview tools;
Tools may include but not limited to, pre/post mental health questionnaires, satisfaction surveys, and access data. Development of a thorough evaluation plan will be conducted by a contract evaluator.

3. Evaluation methods (e.g. interviews, focus groups, ethnographic observation, surveys, analysis of encounter data) Methods may include but not limited to, questionnaires/surveys, analysis of encounter data. Development of a thorough evaluation plan will be conducted by a contract evaluator.

4. *Preliminary* plan for evaluation administration, participant recruitment, data collection and cleaning, and analysis.
A contractor will be selected to conduct the administration, participant recruitment and data collection aspects of the evaluation plan. Development of a thorough evaluation plan, data cleaning, analysis and reporting will be conducted by a separate contract evaluator.

6. **Contracting**

If you plan to contract out the INN project and/or project evaluation, describe the County's relationship to the contractor(s) and how the County will ensure quality as well as regulatory compliance.

The County will conduct a Request for Proposal or "bidding" process to select a qualified evaluator. This process along with a contract negotiation and management process ensures that the selected contractor provides quality work. The contractor will be selected based on experience conducting community program evaluation, successful contract history, cultural competence and other metrics.

Additional Regulatory Requirements and Project Details

7. **Certifications**

Please attach documentation of all of the following:

i. Adoption by County Board of Supervisors
ii. Certification by the county mental health director which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act (MHSA)
iii. Certification by the county mental health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements, and that all expenditures are consistent with the requirements of the MHSA
iv. Documentation that the source of INN funds is 5 percent of the County's PEI allocation and 5 percent of the CSS allocation.

8. **Community Program Planning**

Please describe the County's Community Program Planning process for the INN Project, including inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community. Include a brief description of the training the county provided to community planning participants regarding the specific purposes and MHSA requirements for INN Projects.

INNOVATIVE PROJECT DESCRIPTION

BHRS led a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan FY 2014-2017, that included generating ideas for potential MHSA Innovations projects. Over 300 diverse stakeholders in close to 30 input sessions throughout the County to ensure that all stakeholder groups and demographics were represented. Details on the demographics, stakeholder group representation and engagement can be found in the Three-Year Plan.

As described above on question 1, the Innovation ideas were brought to the San Mateo County MHSA Steering Committee in March 2015 by stakeholders, MHSA Steering Committee members and BHRS staff and stakeholders in the form of potential projects. The Steering Committee made recommendations on which projects to move forward for further exploration. a Letter of Interest process further identified capacity and interest and a Request for Proposal (RFP) process is currently in selection phase for a project administration contractor.

A one-pager summary of Innovation Guidelines (based on the proposed new guidelines that were recently implemented) was provided at all sessions and a presentation to go over the purpose, requirements and answer questions.

9. **Primary Purpose**

Select **one** of the following as the primary purpose of your project. (I.e. the overarching purpose that most closely aligns with the need or challenge described in Item 1 (above).

a) Increase access to mental health services to underserved groups
b) Increase the quality of mental health services, including measurable outcomes
c) Promote interagency collaboration related to mental health services, supports, or outcomes
d) Increase access to mental health services

10. **MHSA Innovative Project Category**

Which MHSA Innovation definition applies to your new Innovative Project (circle one):

a) Introduces a new mental health practice or approach
b) Makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community
c) Introduces a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting.

11. **Population (if applicable)**

a. Estimate number of clients expected to be served annually : 30-50
b. Describe the population to be served, including relevant demographic information such as age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate:

The expectation is to reach out specifically to marginalized and high risk for SMI communities within LGBTQ including transgender and gender non-conforming/variant community members, LGBTQ youth and seniors, and queer people of color. Demographic data will be collected to ensure the Center is reaching diverse individuals from throughout San Mateo County.

12. **MHSA General Standards**

Using specific examples, briefly describe how your Innovative Project reflects and is consistent with all potentially applicable MHSA General Standards set forth in Title 9 California Code of Regulations, Section 3320. (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standard could not apply to your Innovative Project, please, for each, explain why.

a) Community Collaboration – the project is based on the principle of collaboration and coordination of

services from BHRS, community agencies and stakeholders.

b) Cultural Competency – The center will develop and maintain a diverse advisory group that can provide feedback and recommendations to the center's programming. Regular and consistent community and stakeholder involvement and engagement will be a necessary component to the center's operation. BHRS programs will be selected to serve a diverse San Mateo County population and provide equal access to all in terms of reaching geographic isolated, ethnic/racial, underserved and unserved communities. All BHRS staff and contractor staff are required to complete cultural humility training.

c) Client-Driven – involvement through the advisory group will be critical. All social and clinical services provided at the center will be based on the MHSA principles including client/family driven services.

d) Family-Driven – same as above

e) Wellness, Recovery, and Resilience-Focused –all social and clinical services will be based on these principles of wellness, recovery and resilience (peer based support, etc.)

f) Integrated Service Experience for Clients and Families – the coordination of services will ideally lead to an integrated service experience

13. **Continuity of Care for Individuals with Serious Mental Illness**

Will individuals with serious mental illness receive services from the proposed project? ☑ Yes ☐ No

If yes, describe how, if or when the Innovative Project ends, you plan to protect and provide continuity of care for these individuals.

SMI individuals will be referred to other BHRS and network of care programs, Full Service Partnership, PREP/BEAM, etc.

14. **INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement**.

a) Explain how you plan to ensure that the Project evaluation is **culturally competent**. *Note that this is not a required element of the initial Innovative Project description but is a mandatory component of the Final Report. We therefore advise considering a strategy for cultural competence early in the planning process. An example of cultural competence in an evaluation framework would be vetting evaluation methods and/or outcomes with any targeted ethnic/racial/linguistic minority groups.*

b) Explain how you plan to ensure **meaningful stakeholder participation** in the evaluation. *Note that the mere involvement of participants and/or stakeholders as participants (e.g. participants of the interview, focus group or survey component of an evaluation) is not sufficient. Participants and/or stakeholders must be involved in contributing to evaluation planning, implementation and analysis. Examples of stakeholder involvement include hiring peer/client evaluation support staff, or convening an evaluation advisory group composed of diverse community members that weighs in at different stages of the evaluation.*

The evaluation plan will be developed by a contractor and include meaningful and diverse stakeholder participation through the LGBTQ center advisory group and the MHSA Steering Committee. The Steering Committee ensures that MHSA planning, implementation and evaluation reflects local diverse needs and priorities. It is made up of diverse stakeholders and cultural groups and is open to the public. There will be opportunity to vet, provide input and participate in evaluation planning and implementation activities.

15. **Deciding Whether and How to Continue the Project Without INN Funds**

Briefly describe how the County will decide whether and how to continue the INN Project, or elements of the Project, without Innovation Funds following Project completion. For example, if the evaluation does (or does not) indicate that the service or approach is effective, what are the next steps?

As described previously, LGBTQ Behavioral Health Coordinated Services Center advisory group will be engaged in the program planning, implementation and evaluation. In addition, the MHSA Steering Committee will be a venue for vetting next steps with diverse stakeholders. If the evaluation indicates that the coordination of services for LGBTQ is an effective process for improved service delivery and access, the collaboration will continue. Contractors

will be asked to develop a sustainability plan as part of their project proposal.

If the evaluation indicates that it is not effective, the determination on next steps, further adaptation, lessons learned will be decided on.

16. **Communication and Dissemination Plan**.

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your Innovative Project.

a) How will you disseminate information to stakeholders within your county, and (if applicable) to other counties?
b) How will program participants or other stakeholders be involved in communication efforts?

MHSA implementation is very much a part of BHRS' day-to-day business. Information is shared and input collected with a diverse group of stakeholders on an ongoing basis. All the MHSA information is made available to stakeholders on the San Mateo County Behavioral Health and Recovery Services MHSA webpage, www.smchealth.org/bhrs/mhsa. The site includes a subscription feature to receive an email notification when the website is updated with MHSA developments, meetings and opportunities for input. This is currently at over 800 subscribers, increased 300+ in the last year. Hard copies of materials are made available upon request.

The BHRS's e-journal, Wellness Matters is published the first Wednesday of every other month and distributed electronically to county wide partners and stakeholders, and serves as an information dissemination and educational tool, with a standing column written by the County's MHSA Manager. The BHRS Blog also provides a forum for sharing and disseminating information broadly. In addition, presentations and ongoing progress reports are provided by BHRS, and input is sought on an ongoing basis at the monthly Mental Health and Substance Abuse and Recovery Commission meeting at the MHSA Steering Committee meeting; at meetings with community partners and advocates; and internally with staff.

Opportunities to present at statewide conferences will be sought and LGBTQ advisory group members or other stakeholders can help present the information.

17. **Timeline**

A) Specify the total timeframe (duration) of the Innovative Project: Proposed **3 Years, 0 Months**

B) Specify the expected start date and end date of your Innovative Project:

July 1, 2016 Start Date / June 30, 2019 End Date

Note: Please allow processing time for approval following official submission of the INN Project Description.

C) Include a timeline that specifies key activities and milestones and a brief explanation of how the project's timeframe will allow sufficient time for

- Development and refinement of the new or changed approach;
- Evaluation of the INN Project;
- Decision-making, including meaningful involvement of stakeholders, about whether and how to continue the Project;
- Communication of results and lessons learned.

The following is a rough timeline, this will be negotiated and finalized with the contracted partner agency and may change during implementation:

July 1, 2016 – December 2016

- Startup activities – secure space, establish advisory group hire staff, set up infrastructure for implementation/evaluation and referral system
- Evaluator to meet with advisory group, partner agency and BHRS staff to discuss evaluation plan
- Evaluation plan brought to MHSA Steering Committee for input

January 2017 – December 2017

- Targeted outreach and community education efforts begin
- Launch core services and resource center

- Begin planning for training component

January 2018 – December 2018

- Continue outreach, community education and core services
- Launch training program

January 2019 – June 2019

- Complete evaluation analysis and report
- Engage MHSA Steering Committee on issue of continuation of the project
- Disseminate final findings and evaluation report

- **INN Project Budget and Source of Expenditures**

Final budget and expenditures will be determined by the contracted agency. Currently, $700,000 is available for this project.

San Mateo County
Health System

April 29, 2015

Dear Colleagues and Community Partners,

In July 2013, The Behavioral Health and Recovery Services (BHRS) set out to evaluate its Mental Health Services Act (MHSA) Prevention & Early Intervention (PEI) programs to understand the impact these programs are having in terms of promoting mental health, reducing the risk of mental illness, and decreasing the severity and negative consequences associated with onset of mental illness. Gibson & Associates, was contracted to conduct the evaluation and provide data for two years of PEI implementation. The first year report, for services implemented in fiscal years 2013-14, is now available at our website www.smhealth.org/bhrs/mhsa.

The MHSA was approved by California voters in 2004 and provides funding to Counties for mental health services by imposing a 1% tax on personal income in excess of $1 million. The MHSA PEI component is intended to prevent mental illness from becoming severe and disabling by targeting individuals of all ages prior to the onset of mental illness, with the sole exception of programs focusing on early onset of psychotic disorders. PEI programs are designed and implemented to help create access and linkage to treatment, and improve timely access to services for individuals/families from underserved communities.

Eight San Mateo County PEI programs were evaluated:

- Project Grow
- Teaching Pro-Social Skills
- Project YES! & AC-OK, Seeking Safety Interventions
- Project SUCCESS
- Early Childhood Community Team (ECCT)
- Crisis Hotline and Youth Intervention Team (YIT)
- Prevention of Early Psychosis (PREP)

The full report provides excerpts on each program, including a project description, in the areas of productivity, effectiveness/ impact, satisfaction with services, responsiveness to target community and MHSA requirements, implementation success and lessons learned. Here are a few highlights from each program:

- Project Grow Pollicita students showed strong gains across levels of stress and negative emotions and ability to manage feelings.
- Over 80% of Project YES! Participants surveyed learned to recognize important skills related to setting boundaries and seeking help when facing challenges or stressors.
- Significant decrease in AC-OK client-reported need for alcohol and drug treatment and reductions in their experience of stress and need for treatment for stress.
- All Teaching Pro-Social sites exceeded an increase of 10% in positive social skills.

Behavioral Health and Recovery Services
225 37th Avenue, Room 320, San Mateo, CA 94403
Phone (650) 573-2541 • **Fax** (650) 573-2841 • **CA Relay** 711 • **Website** www.smhealth.org
Health System Chief • Jean S. Fraser

- Project SUCCESS students demonstrated gains in self--esteem and view of their future.
- ECCT teachers and families increased capacity to understand child's behaviors and respond effectively.
- Over 75% of Crisis Hotline callers surveyed, felt connected to the counselor and found the call helpful.
- PREP clients demonstrated reduction in symptoms and hospitalizations with the strongest and most valid gains in reductions in anxiety and depression.

While there was considerable difference in the quality, quantity and validity of data available for each program this first year, there was sufficient evidence that each project was having a positive impact. In the cases where data was weaker, program managers were able to make commitments to strengthen data collection in the next fiscal year, 2014-15. The following highlights overall evaluation process findings and areas where BHRS has taken action to make improvements in data collection and reporting:

Overall Process Findings and Outcomes
✓ Every project evaluation validated client satisfaction and/or positive client impact.
✓ Areas for improvement for each project were identified.
✓ Staff attrition impacted services and data collection efforts.
✓ Most PEI projects lacked capacity for participating in an external evaluation.
✓ All PEI programs now have a consistent evaluation plan currently being implemented
✓ PEI program reports will now include impact and satisfaction data, along with the usual service dosage, demographics , successes and challenges
✓ The evaluation plan has been incorporated into the Request for Proposal, released this month and will be incorporated into the new contracts.

We anticipate this report will provide additional impetus to our ongoing dialogue with consumers/clients, family members, service providers and other key community stakeholders about PEI programs and services. We welcome your comments and suggestions after you have had a chance to read through this report by emailing Doris Estremera, MHSA Manager at mhsa@smcgov.org.

Thank you for your continued support.

Stephen Kaplan, LCSW
Director
Behavioral Health and Recovery Services

San Mateo County Behavioral Health & Recovery Services
Mental Health Services Act
Prevention & Early Intervention Evaluation 2013-14

Evaluation Conducted by Gibson & Associates

December 19, 2014

Introduction

The Evaluation Report is comprised of a brief description of the evaluation planning process and the agencies and projects evaluated, followed by an analysis of the evaluation process and the BHRS monitoring system, including a series of options for ensuring that the work done through this evaluation leads to sustained improvement in the collection, reporting and use of data by both PEI-funded agencies and the County managers who are overseeing these operations. Following this analysis is a short summary for each project evaluated with that summary comprised of a project summary, summary of findings, and list of recommendations for project improvement for each agency. Full evaluation reports for each project are then included after the conclusion of the Executive Summary.

Evaluation Process

In May 2013, SMC BHRS contracted with Gibson & Associates (G&A) to conduct a two-year evaluation of ten Prevention & Early Intervention projects being funded through the Mental Health Services Act. The evaluation was designed to produce evaluation reports for the 2013-14 and 2014-15 program years. The goals of the PEI evaluation were:

- To move beyond what is provided to the County by way of monitoring reports to produce evaluation reports that captured project productivity, client impact, client and stakeholder satisfaction and recommendations for improvement in project areas and data collection procedures;
- To analyze how BHRS currently monitors PEI-funded projects including an assessment of the contracting and reporting processes;
- To identify ways to improve reporting to the County once the two-year evaluation cycle is complete;
- To help funded-agencies develop a better appreciation for the benefits of using data for their own internal quality improvement efforts and a greater capacity to do so; and
- To develop a transition plan or road map to help the county build upon what has been learned from this process and construct a sustainable approach to the use of data by County managers and the PEI projects they oversee.

The following projects were evaluated as part of this process.

Asian American Recovery Services, North County Outreach Collaborative NCOC) conducted outreach to engage under-served populations, educate them about health and behavioral health services, encourage their enrollment in the County health plan and to access appropriate mental health services.

Asian American Recovery Services' Project Grow, a project that provides school-based, Evidence-Based Practice Trauma-Focused Cognitive Behavioral Therapy that focuses upon building student resiliency skills necessary to be successful at school. Project Grow explicitly nurtures Search Institute's Forty-One Developmental Assets and directly incorporates their development into each child's individual treatment goals.

Caminar Project YES!. Caminar delivers thirteen Seeking Safety groups at six discrete locations serving transition age youth. Seeking Safety is an approach to help people attain safety from trauma/PTSD and substance abuse. Caminar's YES! Caminar collaborates with the Youth Center and an array of residential, transitional, and crisis intervention centers who serve TAY and delivers its groups at these facilities.

El Centro AC-OK. El Centro's AC-OK Seeking Safety project targets Transition Age Youth and young adults, the vast majority of whom were referred by the Department of Probation. El Centro named its Seeking Safety project the AC-OK Project as it conveyed a more positive image than Seeking Safety. During 2013-14 AC-OK served 40 transition-age youth involved in the juvenile or adult justice systems.

Human Services Agency Teaching Pro-social Skills. HSA delivers Teaching Pro-social Skills (TPS) groups in San Mateo County public elementary schools where HSA Family Resource Centers are located. These schools generally receive referrals from teachers for students with classroom behavioral issues. TPS addresses the social skill needs of students who display aggression, immaturity, withdrawal, or other problem behaviors. Students are at risk due to issues such as growing up in a low-income household and community; peer rejection; low quality child care and preschool experiences; afterschool care with poor supervision; school failure, among others.

Prevention & Recovery in Early Psychosis (PREP), was developed by a partnership led by Family Services Agency of San Francisco, now Felton Institute and the University of California, San Francisco. It is now operating in five Northern California counties. While delivered somewhat differently in each county, in San Mateo County PREP is comprised of the following five evidence-based practice components: Early, rigorous diagnosis: Cognitive Behavioral Therapy for Early Psychosis (CBTp); Algorithm guided Medication Management: Multifamily Psycho-education Groups (MFG): and Education and Employment Support.

One East Palo Alto, Community Outreach Partnership. A partnership, much like AARS' NCOC partnership, the Community Outreach Partnership conducted outreach and engagement to increase appropriate, timely use of mental health services and to enroll under-served populations in the County health plan.

Puente. Project SUCCESS. Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students), is considered a SAMHSA model project that prevents and reduces substance use and abuse and associated behavioral issues among high risk, multi-problem adolescents. PROJECT SUCCESS places highly trained professionals (Project SUCCESS counselors) in four Southcoast schools to provide a full range of prevention and early intervention services.

StarVista-Early Childhood Community Team. Early Childhood Community Team (ECCT) incorporates three service components that build on current models already operative in San Mateo County. The three service modalities are: 1) Clinical Services, 2) Case management services, and 3) Mental health consultations with childcare and early child development project staff and parents served by these centers. In addition, the ECCT team conducts extensive outreach in the community to build a more collaborative, interdisciplinary system of services for infants, toddlers and families. The ECCT is designed to support the healthy social emotional development of young children. ECCT is comprised of a community outreach worker, an early childhood mental health consultant, and a licensed clinician. BHRS PEI funding is supporting one Coastside team located in Half Moon Bay and providing funding for the clinical treatment component of a North Coast ECCT (First 5 and private funding support the other components).

StarVista Crisis Intervention and Suicide Prevention Center, is a project comprised of a 24 hour phone Hotline and a Youth Intervention Team that works primarily through schools countywide offering crisis intervention services when a student is in crisis, training for school personnel and prevention education for thousands of middle and high school students.

G&A developed a plan to collaborate in a participatory evaluation process working with project managers from the ten projects to be evaluated. The evaluations were organized around seven evaluation questions.

> ***Evaluation Question # 1***: Has the intervention/ project been implemented efficiently and according to the contract funding the project?
> ***Evaluation Question # 2***: Has the project implemented effective project strategies? i.e. Is the project well-designed and achieving a desired impact?
> ***Evaluation Question # 3***: Have clients, families, partners, and/or communities been satisfied with services?
> ***Evaluation Question # 4***: Have project services been responsive to the population targeted by the contract?
> ***Evaluation Question # 5***: To what degree has the project advanced the vision, mission and objectives of the MHSA PEI plan?
> ***Evaluation Question # 6***: What factors have impeded or contributed to successful implementation? How?
> ***Evaluation Question # 7***: What steps can be taken in the future to improve project services and what data could verify that these improvements had occurred?

During the spring and summer 2013 began the evaluation by reviewing contracts for each agency that was operating a PEI-project. This process was exceedingly complex as County contracts incorporate into one contract all projects being operated by a program. Most agencies had at least four projects included in the contract and many had as many as eight. None of the projects in the contracts were clearly identify as being PEI-funded, so there was initially some confusion as to which projects within a contract were to be evaluated. Making this more challenging, the description of project activities, anticipated outcomes and staffing were not described in one location, but were presented in different sections of the contract. The process of weeding through these contracts was illuminating as it clarified why many PEI-funded project managers were not aware of outcomes or service levels that were to be reported for their project. Most project managers had never even seen their agency contract or the portions of it that included reporting requirements for the project they managed. Lastly, the level of detail in terms of the productivity levels, client outcomes, and satisfaction surveys varied considerably, making it difficult to construct evaluation plans that emerged from the contract.

In addition to reviewing contracts, the evaluator reviewed all project monitoring reports submitted to the County, in some cases going back one or two years before the time period to be evaluated.

Once a review of the contracts was complete, discussions were held between the evaluator and project managers for each of the projects described above. During these conferences, plans were developed for agencies to collect data that would be used to answer the evaluation questions above. Plans were developed to capture productivity at a client-level, with an effort to distinguish participation from among a variety of modalities delivered, where appropriate. To assess project impact, the evaluator tried to minimize the level of effort involved for project staff by using pre-post

assessment tools that the project was already using, but in some instances the evaluator either searched for and secured existing assessment tools or created others based upon existing validated tools. The latter was done more often, as many of the validated tools identified would have required an inordinate commitment of time and resources to administer. Finally, all agencies identified satisfaction surveys to be used to assess satisfaction with services from clients, family, and/or stakeholders or, again, the evaluator developed surveys for this purpose.

Along the way, challenges to the evaluation were identified that either required adjusting the evaluation scope of work, adjustments that also have informed recommendations for an improved reporting and monitoring system. The goal of the evaluation had never been to establish a framework for ongoing evaluation of PEI programs, but rather to use the evaluation as a process through which a sustainable and meaningful reporting and monitoring system could emerge. Another aspect of BHRS' continuing effort to build systems that foster quality service delivery and reporting and monitoring systems that support it, is its partnership with the American Institute of Research, a partnership focused upon BHRS-wide reporting systems.

In the winter of 2013-14, follow-up meetings were held between project managers and the evaluator. In many instances, there were changes in project managers or other staffing that had limited project compliance with the data collection plan. This was especially the case when there was a change in project manager, as in most cases information about the evaluation was not conveyed from the exiting manager to the new one. This often resulted in the need to make adjustments in the evaluation plan. At this time, it became clear to the evaluator that two of the projects, the two outreach projects operated by AARS and OEPA were simply not the type of projects that achieved easily documented outcomes or impacts on 'clients.' Indeed these projects did not really serve clients, they identified and referred them to BHRS and reported that data to the County monthly. The evaluator recommended to County leadership that these projects not be evaluated as part of this evaluation scope of work and this recommendation was approved.

For the other eight projects, the plan had been for the evaluator to work with the project managers in July to compile and share the data so that evaluation reports could be completed. When this process was initiated in July 2013, still more staff transition was encountered and the need for more adjustments in evaluation plans as most projects had encountered challenges in implementing data collection agreed to in earlier meetings. The evaluator worked with each project manager to develop alternative plans to allow for robust answers to the evaluation questions, while trying to avoid too much extra work on the part of the agencies. Finalizing data collection was delayed by the County's unexpected requirement of an end-of-year report from PEI-funded projects. With these reports being due August 1, project managers asked for a delay to starting work on the evaluation until their County reports were complete. The evaluation was then further delayed, as the evaluator had scheduled other work for August and September, requiring him to balance multiple projects. The evaluator worked with each project manager to assemble the data, make adjustments where data collection was not as available as planned, and prepared reports that were then reviewed by the project managers and discussed with the evaluator in a series of structured interviews. While the process took far longer than anticipated, by the first week of December all reports were completed. Excerpts of each project's evaluation are provided after analysis of the County contracting, monitoring, and evaluation processes.

General Findings about PEI-Funded Projects

Every project produced data validating either client satisfaction or positive client impact. While there was considerable difference in the quality, quantity and validity of data provided, even with the leanest evaluation, there was sufficient evidence that the project was having a positive impact. In the cases where evidence was weaker than in other projects, project managers were able to make commitments to strengthen data collection in 2014-15. ***Section V, includes excerpts from every individual project evaluation that includes a project description, general findings, and the recommendations for improvement for each project.***

Collaboration between project managers and the evaluator resulted in identification of significant areas for improvement that could only have occurred as a result of an evaluation. In every one of the eight PEI evaluations areas where projects were under-performing were identified and in most instances resulting changes identified through the process should significantly improve services for clients. As project managers from PEI-funded agencies will attest, these findings were only possible because of persistent efforts to push far beyond what agencies typically produce in monitoring reports. Indeed, it is highly unusual to see monitoring reports describing areas where projects were under-performing, where there were areas where improvement was possible, or where additional data collection could provide better insight into project operations.

Staff attrition impacted services and data collection efforts. In all but one PEI project that was evaluated, at least one key staff person left the project during the evaluation and in several agencies several staff members left the project. Only two agencies being evaluated had the same project manager in place when evaluation discussions began in Spring 2013 and at the end of the process in December 2014. This impacted the evaluation significantly as in some instances the absence of a key staff meant that important data collection processes were inconsistently implemented or were not implemented at all for periods of time. ***More importantly, the absence of key staff also resulted in important project functions not being delivered, at least for a time.*** This is a well-documented challenge throughout the public mental health system, with numerous SAMHSA studies describing the impact high staff turnover has on project services. In many instances, staff moved to county positions or positions with private providers.

Recommendation I. While each agency manages these transitions differently, it may be worthwhile exploring a more systemic solution to how these transitions are addressed. One possibility might involve the use of a flexible pool of MHSA Workforce Education & Training funding to enable agencies that operate projects that multiple evidence-based practices that require significant training to implement practices to fidelity to provide training promptly when new staff are hired.

Monitoring reports to the county were very uneven in content. The evaluator reviewed most all of the reports submitted to the County. In most every instance the reports included little, if any, detail, certainly nothing that could be used to effectively monitor project operations. In some instances, reports stated that satisfaction surveys were administered, but no results were provided. In others, data on the number of groups offered was provided, but without any data describing the number of clients that participated. Even in the best County monitoring reports, where assertions were made about the percent of clients improving in one area or another, there was never actual data provided, information about the N used was absent, and the basic assertions were not really supported. ***This issue is discussed in more depth in Section III.***

Recommendation II. In addition to producing reports such as those developed in 2013-14, the 2014-15 evaluation, this process should be used either to create a more specific project

monitoring process that asks providers to produce data similar to that produced for the evaluation OR extend the evaluation one more year to ensure that providers become still more accustomed to collecting and using data AND to ensure that the County monitoring process is strengthened to a point where meaningful reports are routinely produced by funded agencies. Specific ideas about strengthening the contracting and monitoring processes are provided under Section III, Findings Related to BHRS Contracting, Monitoring and Evaluation Processes below.

Most Funded PEI Project Personnel Lack Experience, Resources and Capacity for Participating in an External Evaluation. A number of challenges emerged in attempting to secure sufficient data to create robust, valid evaluation reports.

> ***Most agencies are simply not accustomed to collecting and using data***. In most every agency, some level of attendance/participation, assessment and satisfaction data is collected, however, in most every instance agencies either failed to collect this data consistently or missed opportunities to gather data that could better validate the impact of their projects. The likely reason for this is that agencies do not appear to use most of the data they collect, except to inform specific and individual clinical decisions. Virtually every agency had to compile pre-post assessment, attendance and/or satisfaction data in July and apparently only because it was being sought by the evaluator. If data is not organized into a database system that allows some level of manipulation and disaggregation, it is of limited value. Ideally, a database would allow project managers to examine results of pre-post test assessments at a client-level within a spreadsheet or database that allows analysis of the relationship between positive outcomes and participation levels or differences in outcomes between sites, groups, different populations or conditions. ***For managers to be able to do this, the data system must be simple, intuitive, and easy to operated. Once data is entered, it should easily create reports that are immediately useful to the manager. Only when managers see the value in data reports will there be motivation for gathering and compiling data. In the absence of this, data reports to an evaluator or the county will only feel like jumping through hoops.***
>
> ***Lack of sufficient administrative staffing***. On several occasions data to be provided for the evaluation was entered into spreadsheets by clinical directors and project managers. If this is the only option a project has, it may go to this effort for a required evaluation or monitoring report, but will not do so for ongoing internal project improvement efforts. While there may have been administrative assistants or research assistants operating in large agencies, in most instances projects had to secure their time on a temporary basis. Even essential project management was often under-funded. For example one agency operating a complex, multi-component serving a large geographic community had only four hours a week of project management support.
>
> ***Lack of funding.*** Budgets for all projects were not reviewed, but in the budgets that were reviewed and in interviews with project managers, it is clear that the County does not directly fund staffing for data collection or funding for software that would make use of data easier. While project managers understood why the County would want an evaluation of project activities, the lack of personnel to support this activity compromised the evaluation.

Recommendation III—If the County is committed to promoting the use of data in ongoing project planning, quality improvement efforts, or evaluations, funding should be provided to support the required work. It would also be good to offer training in how to interpret and use data. A number of other options are described in Section III (follows) where options for building upon this evaluation are discussed.

Section I Agency & Program Description

I.A. Description of Program Services

Project Grow provides school-based, Evidence-Based Practice Trauma-Focused Cognitive Behavioral Therapy that focuses upon helping students develop resiliency skills necessary to be successful at school. Project Grow explicitly incorporates the development of Search Institute's Forty-One Developmental Assets directly into each child's individual treatment goals. Students targeted for services are determined to be at risk of serious emotional disturbance but are not eligible for an IEP. Project Grow offers strength-based individual counseling services as well as collateral services that include consulting with teachers and parents to support student success at home and in the classroom. In addition to mental health services, Project Grow provides case management services designed to connect students and their families to educational, medical, social, prevocational, rehabilitative and, as necessary, for out of home placement options. The program works not only with the students, but with parents and teachers, providing technical assistance to the teachers, and support and education to the parents. Additionally the therapist provides a high level of collateral services to both teachers and parents. Collateral services most often include consultation with the parent or teachers about behavior issues with the child. Project Grow operates throughout the school year with caseloads of at least 14 adolescents at each site although the summer program tends to be more recreational and socializing than clinical. Some families do elect to continue family therapy throughout the year. A noteworthy characteristic of this program is that many students refer their peers to the program, which indicates a high level of buy-in on the part of the clients.

I.B. Research Basis for Approach

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents. Initially developed to address the psychological trauma associated with child sexual abuse, the model has been adapted for use with children who have a wide array of traumatic experiences, including domestic violence, traumatic loss, and the often multiple psychological traumas experienced by children prior to foster care placement. The treatment model is designed to be delivered by trained therapists who initially provide parallel individual sessions with children and their parents (or guardians), with conjoint parent-child sessions increasingly incorporated over the course of treatment. The acronym PRACTICE reflects the components of the treatment model:

- Psycho-education and parenting skills,
- Relaxation skills,
- Affect expression and regulation skills,
- Cognitive coping skills and processing,
- Trauma narrative,
- In vivo exposure (when needed),
- Conjoint parent-child sessions, and
- Enhancing safety and future development.

Although TF-CBT is generally delivered in 12-16 sessions of individual and parent-child therapy, it also may be provided in the context of a longer-term treatment process or in a group therapy format. AARS has incorporated many of the elements of the PRACTICE model but has been

challenged in trying to engage parents sufficiently to incorporate parent psycho-education and conjoint sessions consistently.

I.C. Target Population, Number Served and Sites

Project Grow is a school-based behavioral health project operated by Asian American Recovery Services (AARS) at two San Mateo County middle schools, Parkway Heights Middle School in South San Francisco and Thomas R. Pollicita Middle School in Daly City. Parkway Middle School serves a student population that is 78% Latino with almost 70% of students low-income, as reflected by their eligibility for Free & Reduced Lunch. Pollicita serves a more diverse population with 47% Asian and 43% Latino with 58% of students eligible for Free & Reduced Lunch. The schools are but 3 miles distant from each other with both schools located near the San Bruno Mountain State Park.

Project Grow was contracted to maintain a caseload of 14 students delivering 20 hours per week per site of mental health services that include individual, group and family therapy, as well as collateral services like parent and teacher conferences. The contract stipulates that services should be delivered throughout the year, even when school is not in session. While weekly treatment services are not delivered during the summer, an array of low-intensity recreational, social, a movie with discussion, a games day with discussion and a field trip to the San Francisco zoo, and other activities are delivered throughout the summer. In addition, three families continued in their family therapy throughout the summer. A barrier to sustaining a full clinical program during the summer is that many families return to visit families in Mexico. Treatment is driven by a comprehensive assessment conducted at intake and then formalized in a Treatment Plan that is submitted to the county. Case management services include working with the student and family to identify needs and facilitate access to health, social services, transportation, housing and placement in higher-levels of care, as indicated. Finally, the contract calls for Project Grow staff to provide education and training to teachers and other personnel at the two sites being served.

Section II Evaluation Process

The evaluation plan was developed in June-July 2013 through a series of participatory meetings that included the evaluator and Fran George AARS Clinical Supervisor for AARS. A second series of meetings was held in December 2013 to assess and adapt the evaluation process and still more adjustments were made in July 2014 to secure the data. Finally, an interview was held with Fran George to review findings and make plans for this year's evaluation

Service Dosage. Project Grow maintained a database on student participation in individual treatment sessions, and extracted case management contacts, and family therapy sessions from case notes. This enabled the evaluator to answer EQ # 1.

Service Impact. Project Grow administered a pre-post test of students upon entry to the project and upon completion of each school year. The pre-post test asks students to self report on the frequency with which they experience a variety of symptoms common to trauma exposure: (loneliness, anxiety, anger, sadness, irritability, worries) as well asking them how well they are managing these symptoms. The survey also asks students to describe the frequency with which they get into trouble at school and have conflict at home, as well as a general question asking how they are doing in school. Together, these questions provide a good snapshot of student perceptions as to how well they are doing managing stress and succeeding in school. Pre-Post tests were

collected on 20 students at Policita and 12 students at Parkway and were used to evaluate the impact of the program.

Satisfaction Data. While plans were made to administer satisfaction surveys with teachers and parents, this did not occur due to staff turnover at the end of the school year. However, there are satisfaction survey results from 2012-13 and these are reported to assess how the program is viewed by school personnel. The Clinical Supervisor has assured the evaluator that she will personally oversee administration of satisfaction surveys with both parents and teachers for the 14-15 evaluation.

Section III Evaluation Findings

There are seven evaluation questions that frame the evaluation of the Prevention & Early Intervention programs supported with Mental Health Services Act funds.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to the contract funding the program?
Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?
Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?
Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?
Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?
Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?
Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

Each evaluation question is discussed separately below, but in general evaluation findings were positive. Participation levels in individual counseling were very high and satisfaction with the program among faculty was also high. Pollicita students showed strong gains across almost all domains on an 18-item pre-post test assessing levels of stress and negative emotions and student self-report of their ability to manage those feelings. Both sites provided high levels of case management services and Parkway also had very strong family counseling component. In addition, to expand the scope of services to students at both schools and to create a kind of outreach and promotion component, Project Grow offers voluntary, drop-in lunchtime psycho-educational sessions on a range of topics. What's more AARS sought and received Kaiser Permanente funding to expand services at both sites. Through this funding, AARS provides ongoing psycho-education sessions for the faculty at Pollicita. In 2014-15, Parkway determined that site renovations and teacher focus on adopting the new Common Core were enough extra-instructional activity and is deferring on these added services for now.

While there is abundant evidence of the value and quality of Project Grow, there were some clear areas for improvement identified through the evaluation at each site.

- Pollicitas had almost no family therapy sessions—only seven sessions the entire year.
- Parkway's enrollment in the program could be increased significantly (12 enrolled while Pollicita had 20).

- What was initially very puzzling were the pre-post test results at Parkway Heights, results showing significant increases in the level of sadness, madness, anxiety, irritability and loneliness with a parallel decrease in student ability to manage these emotions. In an interview, the Clinical Supervisor indicated that Parkway had been a school in significant crisis throughout the year with many marriage disruptions, extra-marital affairs, immigration issues, CPS reports, high suicidal ideation and hospitalizations. At Monday weekly meetings, the common refrain was: 'Okay, what is the crisis this week at Parkway.' Further underscoring the scope of family stress at Parkway is the high level of family counseling conducted.
- While the results on the post-test may be more of a reflection of a school community in crisis than a program that was deficient, they do not explain why in a school in crisis, there were just over half of the students in Project Grow at Parkway as at Pollicita, so more aggressive outreach to teachers at Parkway is recommended.
- Since satisfaction surveys were not administered this year, the evaluator is recommending the use of surveys with teachers and parents involved in counseling or collateral services.
- Lastly, it is recommended that Project Grow utilize a valid assessment tool like the Parental Stress Index, to capture the specific kinds of stress that participating families are undergoing. This would both inform the family counseling as well as help the therapist better understand the family environment in which the child is living.

In the teacher satisfaction survey—which had uniformly high scores at both sites on most every item—there were other suggestions as to how to improve the program. While also providing consistent praise for the therapists at each site and their positive impact at the school, faculty at both schools felt the program staff could do a better job of communicating with teachers about the program and about students enrolled in the program. These findings are discussed in greater detail below.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to its contract?

Evaluation Question 1 was answered through an analysis of data on service utilization provided by the Clinical Supervisor. Table I below summarizes the number of students served, the

Table I: Summary of Services Delivered

Service Type	Tot for Year	Ave. Per Stud.	Comments
Parkway N= 12 students			
Student 1-1 therapy	298	24.75	At Parkway, all students received at least 20 sessions except for one who exited the program in January and who still received 14 1-1 sessions prior to moving. Services were consistent throughout the year with the level of services each month about 2.75 sessions per student every month except June when the school year's end abbreviated service delivery
Case Management	154	12.90	Only 2 students received no case management services with the lowest # being 7 and the most being 27.
Family Therapy	38	3.17	One family received 12 sessions, two had seven and two had five sessions. It will be helpful to get parent satisfaction surveys in 14-15 to assess the impact.
Policita N = 20 students			
Student 1-1	495	24.83	Students tended to receive at least 3-4 sessions each month. The only

therapy			students who didn't receive over 20 sessions during the year were students who either entered mid-year or exited mid-year, almost always due to changes in school attendance.
Case Management	354	17.65	Only one student did not receive any case management services and all but three had more than 10 and six received 20 or more contacts, the most being 42.
Family Therapy	7	.35	From interviews with the Clinical Supervisor, it is clear that the composition and experience base of staff plays a critical role in how engaged families become. This is very evident when comparing Pollicita's unacceptably low level of family counseling with that evident at Parkway.

number of therapy sessions held and the number of case management contacts and family counseling sessions. No specified number of sessions was delineated in the contract, but it is clear that a consistent level of services was delivered during the school year, that this level of services was maintained throughout the year and that this level of services was consistently sustained with all students. The single, and significant exception is that family engagement simply did not happen at Pollicita. While case management and collateral services were delivered to Pollicita families, almost no family therapy occurred. The Clinical Supervisor has indicated that she will make certain that the therapist understands the importance of family counseling and reviews data on family participation in therapy on a monthly basis.

In addition to the services captured in Table I, the therapist at each site held school wide meetings with all faculty to introduce the program, to provide an introduction to stigma, mental health issues, and how they can manifest in classroom behavior. In addition, the site therapist met often with referring teachers, the school resource teacher and parents to discuss specific children, to provide information about how to address specific kinds of behaviors at home or in the classroom and to obtain feedback as to how a child is progressing at home or in class. At Pollicita, with funding from Kaiser, the Clinical Supervisor conducted a series of psycho-educational sessions with teachers about emerging trends in child-adolescent mental health. Lastly, at both sites voluntary student groups were held during lunch with a rotating topic designed to educate students about stigma, signs of mental health issues, and both how stress and trauma can impact you and to introduce coping skills to help students learn how they can better manage their stresses. The lunch groups are intended to serve as a gateway to the counseling program and indeed many students then self-refer to Project Grow.

Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?

To assess the degree to which Project Grow is having a positive impact upon student participants, a pre-post test survey was used to assess student self-reported attitudes and behaviors. Table II presents results for Pollicita students and Table III presents results for Parkway Heights students. Pre and post-test score responses are provided for each of 18 items with the change in pre-post test results and with item-specific analysis provided throughout. The survey uses scales that vary from question to question with some scales calibrated so that an increase in post-test scores indicates progress and in others where a higher score on the post-test indicates regression. In all cases, responses are those of adolescents self report. So, for example, responses related to grades are not a report on grades from the school, but rather each student's response as is the case in relation to getting along with peers and families. In dialog with the Project Grow Clinical Supervisor, the evaluator has suggested getting the schools to provide more objective student level data on attendance, discipline referrals, suspensions and GPA as more valid measures of student growth. As the Tables II and III reveal, there are some items in which change is minimal

and others where they are substantial. The column at right is used to comment on where trends are significant. It must be kept in mind that this survey was asked of teenagers and their responses may have as much to do with events of the day as with an overall view of their lives. Remember being a teenager?

Generally speaking, Pollicita students demonstrated consistent improvements across the spectrum of issues addressed in the assessment, with 9 of 18 items showing significant improvement and only one of 18 items showing a significant negative change. The one area where there was significant regression between the pre and post-test was in relation to the amount of stress or worry experienced by the student. While students also indicated a slight increase in their ability to manage stress, this increase was not significant. The other eight items show little or no significant change. ***In both charts, items indicating significant and highly positive significant change are presented in bold and items showing significant negative change are reported in bold and italics.***

Table II: Pollicita Pre-Post Results				
Item	**Pre**	**Post**	**Change**	**Discussion**
How I feel about school.	2.26	2.32	+.06	Based on a 3-point scale from I don't like to I like my school. While an increase is indicated, it is of marginal importance.
Grades	2.54	3.05	+1.05	A four-point scale where an increased score shows student report of improvement in grades. **Highly significant increase in student report of GPA.** In the future, it would be good to affirm this with actual grades from the school.
Getting along with family	7.11	7.53	+.42	Ten point scale on this and the next item. **Significant improvement in family relations indicated**. Generally respondents had very positive relations with family to begin with.
Getting along with peers	7.47	7.26	-.19	A statistically insignificant decrease in peer relations. Generally respondents had very positive relations with peers to begin with.
Use of drugs	1.39	1.21	-.18	Five point scale on this and the next item. Results indicate a reduction in drug use.
Remaining items are on a 4 point scale.				
Getting in trouble at school	3.67	3.06	-.61	**Results indicate a highly significant reduction in student reports of problems at school.** It would be good to affirm this report with data from the school on discipline referrals and suspensions.
How often do you feel sad?	2.33	1.84	-.49	**Highly significant reduction in experienced sadness.**
How often do you feel mad?	2.65	2.11	-.54	**Highly significant reduction in experienced anger.**
How often do you feel worried?	1.88	2.32	+.44	***Significant increase in being worried.***
How often do you feel anxious?	1.76	1.74	-.02	No significant change.
How often do you feel lonely?	1.89	1.68	-.31	**Significant improvement in the degree of experienced loneliness.**

Table II: Pollicita Pre-Post Results				
Item	**Pre**	**Post**	**Change**	**Discussion**
How often do you feel irritable?	1.88	2.00	+.12	Statistically insignificant increase in student level of irritability.
How well do you handle sadness?	**3.00**	**3.26**	**+.26**	**Significant increase in capacity to deal with sadness.**
How well do you handle anger?	**2.28**	**3.05**	**+.77**	**Very significant increase in capacity to deal with anger.**
How well do you handle worries?	3.29	3.21	-.08	Insignificant change.
How well do you handle anxiety?	3.24	3.32	+.08	Insignificant change.
How well do you handle loneliness?	3.47	3.42	-.05	Insignificant change.
How well do you handle irritability?	**3.06**	**3.32**	**+.26**	**Significant increase in capacity to deal with irritability.**

While Pollicita showed consistently positive results, survey results at Parkway Heights showed a very different story. Students reported significant improvement in how they feel about school and a significant reduction in getting into trouble at school, however in relation to every item describing the level of negative moods or feelings and their ability to manage them, students reported increases in the degree to which they experience negative feelings like sadness, anxiety, anger, worry, and irritability and a decrease in their capacity to manage these same feelings. While the increases in sadness and madness were not significant, changes in the other emotions and ability to manage them all showed significant increases in experiencing the negative feelings and decreases in student ability to manage them. When these findings were discussed with the Clinical Supervisor, she indicated that Parkway had been a school in significant crisis throughout the year with many marriage disruptions, extra-marital affairs, immigration issues, CPS reports, high suicidal ideation and hospitalizations. At Monday weekly meetings, the common refrain was: 'Ok what is the crisis this week at Parkway.' Another indicator of the scope of family crisis is the significantly higher level of family counseling delivered at Parkway and the comments from teachers indicating that the therapist at Parkway worked well with families and was especially effective with difficult students. So while the results on the post-test may be more of a reflection of a school community in crisis than a program that was deficient, they do not explain why in a school in crisis, there were just over half of the students in Project Grow at Parkway as at Pollicita.

Table III: Parkway Heights Pre-Post Test Results				
Item	**Pre**	**Post**	**Change**	**Discussion**
How I feel about school.	2.27	2.67	+.40	3-point scale**. Highly significant increase in how students feel about school.**
Grades	2.89	2.75	-.14	Four point scale. Not statistically significant.
Getting along with family	7.45	7.33	-.12	Ten point scale on this and the next item. Not statistically significant. But with most students feeling that they have good relations with their

Table III: Parkway Heights Pre-Post Test Results				
Item	**Pre**	**Post**	**Change**	**Discussion**
				family to begin with.
Getting along with peers	8.00	7.92	-.08	Not statistically significant. But with most students feeling that they have good relations with peers to begin with.
Use of drugs	1.00	1.17	+.17	Five point scale on this and the next item. Not statistically significant.
Getting in trouble at school	3.22	2.82	-.40	**Highly significant reduction in this item.**
Four point scale on remaining items.				
How often do you feel sad?	2.18	2.25	+.07	Not statistically significant.
How often do you feel mad?	2.09	2.17	+.08	Not statistically significant.
How often do you feel worried?	1.60	2.17	+.57	***Highly significant increase in the degree to which students feel worried.***
How often do you feel anxious?	1.45	1.83	+.38	***Significant increase in the degree to which students feel anxious.***
How often do you feel lonely?	1.27	1.67	+.40	***Significant increase in the degree to which students feel lonely.***
How often do you feel irritable?	1.82	2.33	+.51	***Highly significant increase in the degree to which students feel irritable.***
How well do you handle sadness?	3.45	3.25	-.20	Statistically insignificant reduction in ability to handle sadness.
How well do you handle anger?	3.27	3.00	-.27	Statistically insignificant reduction in ability to handle anger.
How well do you handle worries?	3.45	3.00	-.45	***Highly statistically significant reduction in ability to handle worries.***
How well do you handle anxiety?	3.36	3.00	-.36	***Statistically significant reduction in ability to handle anxiety.***
How well do you handle loneliness?	3.82	3.17	-.55	***Highly statistically significant reduction in ability to handle loneliness.***
How well do you handle irritability?	3.18	3.00	-.18	Statistically insignificant reduction in ability to handle irritability.

Another means of assessing program impact would be for each school to provide student level data on Project Grow participants on student discipline referrals, grades (GPA), suspensions and attendance. With data on these measures from the semester before enrollment in Grow, throughout the period students are in Grow and, if possible, the year after Grow, there would be an extremely valid measure of student behavior change. What's more, with attendance data, the evaluation could project the total revenue increase generated from State Average Daily Attendance (ADA) by virtue of Project Grow students' increase in attendance. This could be a powerful incentive for the school and AARS to seek additional funding to expand the program. What's more, this data is relatively easy for a district to generate, doesn't place an added burden on teachers or

Project Grow staff, and would also provide more concrete evidence of impact to the County, site faculty and the community.

Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?

While clearly it would be preferable to have faculty satisfaction data for the 2013-14 and family satisfaction results from families participating in family counseling, 2012-13 data is what was available and it does shed some light on the degree to which each school values Project Grow. Clearly at Pollicita the faculty rated the program very highly with a 'needs improvement' identified by only one faculty member on a single item (outreach and promotion of the program). Even on this item over half of respondents indicated that outreach was either excellent or very good.

Table IV: Faculty Satisfaction Pollicita 2012-13 N = 16 Item	Excellent	Very Good	Satisfactory	Needs Imp.	Not Applicable
1. Overall services to the school.	7	5	2	0	2
2. Therapist services to the students.	6	6	1	0	3
3. Therapist relationship with the administration.	5	3	2	0	5
4. Therapist relationship with teaching faculty	6	7	1	0	2
5. Therapist relationship with counseling staff.	4	3	2	0	6
6. Therapist's outreach to students, teachers & parents to promote Project Success services	5	3	3	1	3
7. Therapist presence and participation in school activities and meetings.	4	3	4	0	4
Totals	37	30	15	1	25

When asked what the faculty liked about the program, Pollicita faculty indicated:

- Kids who know about and use the service benefit –
- Saori was a great support to many of my students. She is consistent and flexible and communicates well.
- The availability and consistency of counselors at our school.
- Offering a much needed resource.
- The services provided by Asian American – we really appreciate what you do for our school
- Having this service available to our students is wonderful.
- The counseling part with severely disturbed students.
- Flexibility, sharing, support, extra time given during crisis periods.
- Never used it, but would be interested in learning more about the services.
- It allowed for more much-needed services for many of our students who desperately need it!
- The availability of Saori, knowing when a crisis arises we have help for our students.
- Everything positive.

When asked how the program could be improved, faculty had a list of very specific suggestions that should be taken within the context of being helpful suggestions as the ratings above show clear satisfaction with the program. Items in bold italics are very specific suggestions that could perhaps be considered. Interestingly, while teachers seemed to clearly value the

program, only six of the eighteen teachers completing the survey indicated that they had referred any students to the program, a suggestion that more intense outreach would be beneficial. There are several specific examples of the kind of outreach and scheduling changes that might be effective below.

- ***Communication with all teachers could be improved.***
- It seemed like counselors didn't have many students – perhaps more referrals needed/pursued. [*Evaluator comment: Pollicita had 20 students enrolled in the program, well over the target of 14 and is implementing a group program* in the second semester of 2014-15.]
- ***Would like more communication with Asian American staff about our students.***
- More hours available for our needy student population.
- Need more therapist to help the kids.
- I don't think most kids know about this option, ***so more outreach would be nice.***
- We need more counselors like Saori!
- Let teachers know who is working with students.
- ***Let us know schedule and drop-in availability if possible.***
- Get more funding to be able to provide more services for our students.
- Even more counselors/staff.
- ***Perhaps students could meet with you during P.E. – several of them can't afford to miss English/Reading.***
- My only contact has been the yellow passes. Other than that I don't have any relationship with the program.
- ***I would have liked to have more "outreach" – reminder of hours, services – maybe through homeroom, PR and report card envelopes, posters/pamphlets in hall/by lunch counter/in a central place. Reminders in announcements or homeroom***.
- ***Expand the visibility on campus; more hours, large size bulletin board highlighting services in your resource guide. On a regular basis, hand out recreation fun throughout the bay area.***

It is interesting how many comments suggest the need for more outreach and promotion of the program with students and teachers. Grow conducts a psycho-educational orientation to Grow, student eligibility criteria, referral process, and range of services available. In addition, at both schools there is a monthly voluntary lunch group for students with each session focused on different topics like 'managing stress or loneliness' to 'controlling anger.' Finally, at Pollicita, with Kaiser funding, throughout the year, AARS is providing psycho-education sessions for teachers on a range of mental health topics and reference to Grow is typically a part of these presentations. So while it would seem that quite a bit of outreach and promotion is occurring, the teachers obviously feel that more promotion is needed and with groups beginning in 2015, an expanded outreach effort is called for.

While the proportion of Parkway faculty rating Project Grow's performance as excellent is even higher than at Pollicita, there were also far more 'needs improvement' with at least one faculty member indicating improvement needed in four of the seven items. Neither faculty identified a need for improvement in therapy services and this was the highest rated item at both schools and the general level of Pollicita and Parkway faculty satisfaction is very high.

Table V: Parkway Faculty Satisfaction N=12 Item	Excellent	Very Good	Satisfactory	Needs Imp.	Not Applicable
1. Overall services to the school.	7	3		1	
2. Therapist services to the students.	7	2	1		
3. Therapist relationship with the administration.	4	3	1		1
4. Therapist relationship with teaching faculty	6	2	2	1	
5. Therapist relationship with counseling staff.	6	2			2
6. Therapist's outreach to students, teachers & parents to promote Project Success services	5	2	1	2	
7. Therapists presence and participation in school activities and meetings.	7	1	1	1	1
Totals	42	15	6	5	4

A sampling of comments from the faculty include:

- Blancaluz was well liked by the students. They wanted me to speak with her! Also, I think she spent time with their families as well.
- Having the therapist available at our when students need to talk to her. She was able to answer questions we had.
- Therapist's willingness and enthusiasm to help our students and their families.
- Having Ms. Blancaluz in the school worked best. She's able to work with students.
- Project Grow is a healthy program to have at our school, beneficial for our community and students!
- It seemed that students enjoyed the counseling sessions.
- Project Grow was able to provide our school the additional resource we need to add to the school's intervention programs.
- Ms. Blancaluz has done a great job of working with our students, especially some of the more difficult students.
- Ms. Blancaluz-Hansen was very approachable and open to work with teachers and students. The attention to details and close bond formed by Janette with the students and families.

However, not all comments were favorable and may point to ways in which the program could be improved.

- Increase the number of students it is available to.
- She needs to attend meetings with staff – particularly grade level and staff to communicate.
- Not too sure. If I worked closely with Project Grow I could have an answer.
- I think it would be helpful to know which students are part of this program and why.
- A little more contact with teachers.

In particular, it appears that more contact with the faculty at staff and grade level meetings might improve the program's impact and presence. Given that Parkway had only slightly more than half the number of students as served at Pollicita, that only six of twelve teachers made any referrals at all and that in 2015 groups will begin to be offered, it would also seem that this level of contact would increase the number of students served.

While levels of satisfaction at both schools is quite high among the faculty, the data is a year old and given the poor results on the Parkway pre-post test, a deeper exploration of the cause of

any level of dissatisfaction is warranted. What's more, it is critical that satisfaction surveys be administered this year at both schools with faculty and parents.

Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?

Project Grow is clearly serving demographic populations that are historically identified as being under-served. Parkway Middle School serves a student population that is 78% Latino with almost 70% of students low-income, as reflected by their eligibility for Free & Reduced Lunch. Pollicita serves a more diverse population with 47% Asian and 43% Latino with 58% of students eligible for Free & Reduced Lunch. That students are referred because of teacher concerns about student behavior and their capacity to function effectively in the classroom suggests that students are at high risk of school failure. Pollicita served six more students than the contract threshold of 14 and while Parkway missed this level by two, both provided intensive case management support to address a myriad of student needs. While the evaluation found areas where the scope and intensity of services could be enhanced, Project Grow is clearly serving the high-risk population identified in the contract. The fact that only six of eighteen Pollicita teachers and six of twelve Parkway teachers made a referral all year suggests that there are likely many under-served students in need who are not receiving services. The plan by Project Grow to implement groups in 2014-15's second semester may enable the program to serve more students in need and the provision of lunchtime drop-in groups for students is also an added effort to engage underserved students.

Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?

The vision, mission and values of San Mateo County Behavioral Health & Recovery Services stress empowering individuals to direct their own recovery process. BHRS stresses the adoption of culturally competent treatment approaches and through its MHSA planning processes, a further focus has been placed upon implementing evidence-based practices that have demonstrated the capacity to support client wellness and recovery. From the perspective of prevention, BHRS has also described the journey towards a transformed system requiring that programs:

- move "upstream" to primary prevention strategies;
- partner with other health prevention efforts to focus on wellness and recovery;
- achieve desired outcomes; and
- integrate efforts to support sustainability;

What's more, San Mateo's MHSA plan clearly described the priority of intervening early and identified stress, PTSD, and use of alcohol and drugs as factors where early intervention were most important, particularly in relation to individuals from historically underserved populations.

Project Grow addresses a number of key priorities identified in the San Mateo County MHSA plan. Project Grow is an early intervention program that serves cultural populations that are historically under-served and hence is increasing access to treatment among populations that have been challenged accessing these services. The Clinical Supervisor indicated that when high schools sought to have Project Grow implemented at their site, the County responded that their resources were prioritizing intervention at an early age, another indication of the program being aligned with County priorities for earlier intervention. The program intervenes early, providing coping skills for youth while screening for more serious conditions with early access and screening for other

conditions both being priorities of the MHSA plan. Finally, Project Grow focuses on helping students cope with stress, developing coping skills and in doing so, reduce risk of school failure. Project Grow works closely with teachers at both sites, using teacher referrals as a means of identifying students at risk of academic failure. Addressing conditions triggered by trauma is an expressed priority of the MHSA plan, as is serving students at risk of school failure.

Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?

The evaluation identified a number of factors that have impeded Project Grow's success. Specifically, insufficient communication with staff at both school, impedes coordination, information sharing and referral of students in need of services. Another factor that impedes success, identified from an interview with the Clinical Supervisor, is staff turnover, a factor that has impacted both Project Grow and many of the other PEI projects. At Project Grow turnover has been the result of highly skilled Family Partners being hired by the County where higher pay and better benefits are available. While there is not much a CBO can do about this commonly experienced phenomenon, it is something that certainly is a factor that can impede developing and sustaining relationships with schools, communities, students and parents.

But aside from the significantly poor scores on the pre-post test at Parkway Heights and the need to significantly increase parent engagement at Pollicita, Project Grow demonstrated very high satisfaction expressed by both faculties, sustained high-levels of student engagement and at Pollicita showed strong gains on the pre-post test almost across the board.

Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

Despite high satisfaction, significant improvement in pre-post tests at Pollicita, and strong student commitment and consistent attendance in the program, the evaluation identified some very clear areas for improvement:

Stronger Outreach & Communication with Faculty. While only identified as a "needs to improve" by 3 out of 28 teachers across sites, in both surveys' open-ended comments, teachers noted the need for improvement in communication in a variety of forms: increased signage and posting of program information; increased communication with teachers about students in the program; and increased participation in faculty and grade-level meetings, being the primary areas sited. At Parkway there were only 12 students enrolled in the program, with 20 at Pollicita. Clearly more communication with Parkway faculty could improve those numbers and with groups being offered in 2015 aggressive outreach will be necessary to fill those groups quickly. Clearly teachers feel the need for these services.

Expanded outreach to families at Pollicita. Family counseling was barely evident at Pollicita and a significant effort to engage families, perhaps learning from the successes at Parkway, should occur in 2014-15.

Use of a validated assessment of parental stress. Given the anecdotal evidence of extremely high stress among the parents at Parkway in 2013-14 and reported high levels of stress at Pollicita in 2012-13, administration of a validated stress assessment like the Parental Stress Index could both validate conditions impacting student stress levels, as well as inform the focus of family and individual child counseling.

Parkway Pre-Post-test scores. Given the high marks by teachers at Parkway and their open-ended comments praising the therapist's work, the high-level of family counseling services, and the Clinical Supervisors view that the therapist at Parkway was skilled in implementing the program, it is likely that the stress and inability to manage emotions experienced by students at Parkway had more to do with family and community trauma than with shortcomings in how the program was delivered. Indeed, it could be argued that without the program, student stress would have been far higher, as the impact of the program on students at Pollicita was pronounced. Furthermore, the provision of vastly more family counseling at Parkway likely also helped mitigate some of the family trauma that was noted by the Clinical Supervisor. Nonetheless the Project Grow Clinical Supervisor should monitor the Parkway program more closely this year to ensure a high quality program and to encourage even higher provision of family counseling.

Satisfaction Surveys at both Sites. Faculty and family satisfaction surveys should be administered in the spring and perhaps also at the end of the first semester to affirm satisfaction and/or to identify areas for improvement.

Section V Demographic Summary

The data below will be used in reports to the MHSOAC.

Table I: Demographic Summary					**Source of Data**
Total Unduplicated Served					
Gender		**Clients**	**Program Staff**		
	#	%	#	%	
Male	14	43.75%			
Female	18	56.25%	4	100	
Other					
Age	#		%		
Children 0-15	32-100%				
Transition Age Youth 16-24					
Adult (25-59)			100%		
Older Adults 60+					
Families (can include families with children or TAY)					
Ethnicity	**Clients**		**Program Staff**		
	#	%	#	%	
Caucasian	0	0			
Latino	15	47	3	75%	
African American	1	3			
Asian	9	28	1	25%	
Pacific Islander	3	10			
Native American	0	0			
Multi-Ethnic	2	6			
Other	2	6			
Total	**30**	**100**			
Home Language	**#**	**%**	**#**	**%**	
English	15	47%	4	100%	
Spanish	12	37.5%	3	75%	

Table I: Demographic Summary					Source of Data
Tagalog	1	3%			
Other	4	12.5%	1	25%	
Total	**30**	**100%**			
Underserved Pops Served	**#**	**%**	**#**	**%**	No identifiable groups among middle school children.
LGBT					
Blind/Vision Impaired					
Deaf/Hearing Impaired					
Veterans					
Homeless					

Program Components Table and discussion are on the next page.

Section VI Program Components:

The information in Table II will be used to report to MHSA as part of the statewide evaluation. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator.

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.		
	Yes	**No**
II-1) Access for Underserved Populations	**X**	
Details: 100% of clients served were children of color and all met County criteria for eligibility for Medi-Cal funded children.		
II-2) Outreach for Early Recognition of Need	**X**	
Details: Program targets youth at an age when mental health conditions just begin to emerge		
II-3) Access or Linkages to Care	**X**	
Details: In addition to treatment, case management links students and families for other services.		
II-4) Reduction of Stigma	**X**	
Details: Psycho-education for teachers and monthly drop-in voluntary groups for students explicitly discuss stigma and its implications.		
II-5) Screening for Needs	**X**	
Details: Assessments are conducted prior to enrollment in accord with County need to approve placement. In 2014-15 parents will undergo assessment for trauma upon entry in the program.		
Program Activities	**Yes**	**No**
II-6) Addressing Trauma	**X**	
Details: Project Grow explicitly addresses disorders related to trauma and substance use, educating TAYs to recognize triggers and to use coping skills.		
II-7) Specific Risk Factors	X	
Details: Students have been identified as being at risk of school failure by referral by teachers.		
	Provide specific details very briefly. 1-3 sentences per line.	
II-7) Indicate the location where program activities occur (identify places where services occur	Pollicita and Parkway middle schools	

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.	
II-8) Specify the roles for Peers (mentors Outreach, Peer education, other)…Please specify.	Family Partners engage families.
II-9) Specify the sectors with which you collaborate on this program (housing, criminal justice, public health, education, child welfare)	CPS, hospitals, education and a range of housing, public health and social welfare agencies depending upon the child and family needs.

Section VII Program Alignment with SMC MHSA PEI Priorities:

Providers will mark Y for Yes for any community need or priority population addressed. In the space provided, please explain how these needs or populations were served. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator during which time a discussion will occur to amplify and provide details or examples.

Table III: Alignment with SMC MHSA PEI PRIORITIES				
	Children & Youth	**TAY**	**Adult**	**Older Adult**
1-PEI Key Community Needs				
1-A) Disparities in Access to Mental Health Services	X			
Details: 100% of students served are of color and treatment services are implemented early.				
1-B) Psycho-Social Impact of Trauma	X			
Details: Staff are trained in trauma-informed CBT and most students are exposed to significant levels of community and family trauma.				
1-C) At-Risk Children, Youth and Young Adult Populations	X			
Details: Students at risk as confirmed by assessment forwarded to County and by teacher referral.				
1-D) Stigma and Discrimination	X			
Details: Psycho-educational groups for teachers and students address stigma and its implications.				
1-E) Suicide Risk	X			
Details: Suicidal ideation has been identified in students at both schools.				
2- PEI Priority Populations				
2-A) Trauma Exposed Individuals	X			
Details: Family trauma has been identified in many, if not most students.				
2-B) Individuals Experiencing Onset of Serious Psychiatric Illness	perhaps			
Details: Older students in the program (15) are at an age when early onset of of serious psychiatric conditions can begin to emerge.				
2-C) Children and Youth in Stressed Families	X			
Details: Family trauma is common.				
2-D) Children and Youth at Risk for School Failure	X			
Details: Teachers have identified students as being at risk of school failure.				
2-E) Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	X			
Details: Data was not collected on juvenile justice involvement, however it is likely that students with significant classroom behavioral issues are at high-risk of juvenile justice involvement.				

Section I Agency & Program Description

I.A. Description of Program Services

Caminar was established in 1964 as a non-profit corporation located in San Mateo, California. Initially envisioned to provide community-based rehabilitation support services for adults in mental health recovery, the agency's introduction of services began with the opening of El Camino House. Since the opening of its first program, El Camino House, Caminar recovery, treatment, and support services have expanded dramatically. With services delivered in San Mateo, Solano, and Butte, California, the number of people Caminar serves yearly has grown from 41 individuals to more than 3,600. Caminar's San Mateo mental health services focus on health & wellness, recovery, and community integration.

Since 2011 Caminar has utilized San Mateo County Behavioral Health & Recovery Services' Prevention & Early Intervention funding to implement the YES! Program through which Caminar delivers thirteen Seeking Safety groups at six discrete locations serving transition age youth. Seeking Safety is an approach to help people attain safety from trauma/PTSD and substance abuse. Caminar's YES! Program targets Transition Age Youth through its contacts with community-based organizations. Seeking Safety is a manualized intervention (also available in Spanish), providing both client handouts and guidance for clinicians. It is conducted in group and individual format; with diverse populations; for women, men, and mixed-gender groups; using all topics or fewer topics; in a variety of settings; and for both substance abuse and dependence.

The key principles of Seeking Safety are:

1. Safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions);
2. Integrated treatment (working on both PTSD and substance abuse at the same time);
3. A focus on ideals to counteract the loss of ideals in both PTSD and substance abuse;
4. Four content areas: cognitive, behavioral, interpersonal, case management; and
5. Attention to clinician processes (helping clinicians work on countertransference, self-care, and other issues).

Since 1992, Seeking Safety has been implemented in more than 3,000 clinical settings and as part of statewide initiatives in Connecticut, Hawaii, Oregon, Texas, and Wyoming. It has been implemented in programs for substance abuse, mental health, domestic violence, homelessness, women and children, and veterans and in correctional, medical, and school settings in the United States and internationally, including in Argentina, Australia, Canada, France, Germany, Italy, Japan, the Netherlands, New Zealand, Scotland, and Sweden.

I.B. Research Basis for Approach

For programs utilizing MHSA funding, San Mateo Behavioral Health & Recovery Services has prioritized the adoption of evidence-based practices and so as part of the evaluation of PEI programs, the evaluator has conducted a brief review of the literature related to Seeking Safety. A recent comprehensive review of the literature on treatment for Post Traumatic Stress Disorder (PTSD) and Substance Use Disorder (SUD) identified Seeking Safety as the most rigorously studied treatment thus far for PTSD/SUD with 13 pilot studies, three controlled studies, and six Random Controlled Trials (*Helping Vulnerable Populations: A Comprehensive Review of the Treatment Outcome Literature on Substance Use Disorder and PTSD, Najavits and Hien, 2013)*. Clients in Seeking Safety studies were challenged by complex trauma/PTSD, with comorbidity, high severity

and chronicity, and multiple life problems. Many of the studies examined by Najavits and Hien included significant minority representation.

Six of the studies were partial-dose studies, where the programs used 24% to 48% of the model, including the largest investigation of SS to date, the National Institute on Drug Abuse Clinical Trials Network (CTN) study, which used 48% of the model in 6 weeks (#21). "Partial-dose" refers to the number of SS topics used. Even in these partial dose studies, Seeking Safety has shown positive outcomes across studies generally. Across studies SS has had numerous positive outcomes on PTSD, SUD, and other conditions. In the controlled trials and RCTs, Seeking Safety outperformed the control on PTSD but not SUD in four studies; on SUD but not PTSD in another study; and in three studies, Seeking Safety outperformed the controls on both PTSD and SUD and on both PTSD, including one study of more severe SUD patients. Most also found SS outperformed the control on other variables, such as psychopathology, cognitions, and coping. Finally, Seeking Safety is listed as having strong research support by various professional entities, based on their criteria sets, including Level A by the International Society for Traumatic Stress Studies, and "strong research support" by Divisions 12 and 50 of the American Psychological Association.

Partial dose approach is consistent with how Caminar is implementing Seeking Safety, as .the population served by Caminar is challenged to attend groups with the consistency necessary to enable YES! to adhere to the full Seeking Safety model.

I.C. Target Population, Number Served and Sites

Caminar's Seeking Safety Program serves transition age youth ages 16 to 27 at six different locations with the vast majority of participants 25 or under. The addition of 26 and 27 year-olds is mainly to accommodate Cordilleras participants who are more comfortable in a TAY group than in an adult group. Sites for YES! are listed below:

- Cordilleras Mental Health Center, located in Redwood City (3 groups)
- Redwood House, located in Redwood City and operated by Caminar (2 groups);
- South County BHRS Clinic, located in Redwood City (1 group);
- Eucalyptus House, located in Daly City and also operated by Caminar (1 group);
- Edgewood Drop-In Center, located in San Bruno; and
- Youth Services Center, located in the city of San Mateo where Caminar offers four separate groups with five groups being offered in 2014-15.

A total of 147 unduplicated clients were served in the 2013-14 fiscal year. The ethnic breakdown of participants is provided below.

Table I: Distribution of Client Ethnicity

Ethnicity	Caucasian	Afr. Am.	Asian	Latino	Pac. Isl.	Nat. Am.	Multi	Other
147	31/21%	17/12%	2/1.4%	76/52%	11/7.5%	2/1.4%	6/4.1%	2/1.4%

I.C. Budget Amount

Funding supporting the YES! Program totaled $120,000 for the year. Funds were used to:

- 1.0 FTE case manager-facilitator;
- .25 FTE assistant case manager;

- snacks and beverages for groups;
- local transportation;
- office space and supplies; and
- Supervision from the Program Director.

No funding is in the contract to cover the cost of collecting and compiling assessment and attendance data for reporting to the county or for working with the independent evaluator. While Caminar is a large agency with significant resources, Project YES! is a very small program with a small staff, six sites and thirteen groups on which to report. Nonetheless, the YES! Program Director was extremely cooperative in working with the evaluator to develop this report.

Section II Evaluation Process

The evaluation plan was developed in June-July 2013 through a series of participatory meetings that included the evaluator and Caminar's YES! Program Director Katie Scherrman. A second series of meetings was held in December 2013 with the new Program Director Rick Ralphson to assess and adapt the evaluation process and still more adjustments were made in July 2014 to respond to challenges Caminar incurred in collecting data. Despite encountering challenges unique to the YES! program and its targeted population, an array of data has been collected to assess the degree to which the YES! Program met its contract deliverables and had a positive impact upon the targeted population.

- Client-level data was collected on attendance in all groups from February 2014 through the end of June 2014;
- A survey was administered seeking client self-report of knowledge obtained in groups related to coping skills and triggers and related to their satisfaction with the groups;
- The evaluator and Caminar Program Manager collaborated in developing a customized pre-post test survey that sought more specific information about client use of coping skills, recognition of triggers and the degree to which stress, alcohol and/or drug use were impacting work, family or peer relationships; and
- A survey was created and administered to stakeholders at Redwood, Eucalyptus, Edgewood, South County, Cordilleras, and Youth Service Center with questions seeking validation of the program's value and impact.

Section III Evaluation Findings

There are seven evaluation questions that frame the evaluation of the Prevention & Early Intervention programs supported with Mental Health Services Act funds.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to the contract funding the program?
Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?
Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?
Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?

Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?
Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?
Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

YES! serves a population that is highly inconsistent in group attendance due to court dates (YSC), changes in schedule in the residential programs (YSC, Cordilleras, Eucalyptus and Redwood House), the small size of the population served at Eucalyptus (12 clients) and Redwood House (16) and the informal structure at the drop-in-centers in San Bruno and South County Clinic. Inconsistency in participation levels made it difficult to administer pre and post test assessments to determine the degree to which the program was contributing to clients being better able to manage symptoms, identify triggers, and adopt the use of coping skills. For example, a pre-post test given to all the groups at a six-week interval elicited only 4 matches where those clients taking the post-test had also taken the pre-test. The Program Director acknowledged that while the contract called for a 20% reduction in symptoms and that the only way to verify this impact would be through pre and post tests, he wanted to insert his view that because YES! does not customize groups to individual symptoms or provide individual counseling that could be informed by a pre-test, he saw no clinical value to the pre-post test. He did acknowledge its potential value in guiding future program improvement as he would be better able to see where the program was having an impact. However, even here, wondered to what degree a pre-post test focused on coping skill development could be attributed to the project when most of the clients were engaged in significantly more intensive treatment in the program from which they were referred. The evaluator, BHRS and the Caminar Project Director met to discuss these challenge and concluded that for the 2013-14 evaluation effort to achieve sufficient matched pre-post tests would be an undue burden on program operations and likely would never yield the level of matched surveys necessary to produce valid results. The YES! Program's intent to target TAY who by the nature of their program placements, were not going to be able to be evaluated via pre and post test surveys led BHRS to determine that the evaluation should shift focus and use client and stakeholder surveys to assess the quality of services. However, as will be discussed in the Evaluation Findings that follow, based upon a closer review of the attendance data, the evaluator has developed some recommendations that might lead to collection of pre-post test data that would enrich the evaluation for 2014-15. However, these strategies, while producing some level of evaluation outcome data, would not provide any real clinical value and may be of questionable value for evaluation given the level of confounding services clients will be receiving independent of YES!. The evaluator, Program Director and BHRS leadership will discuss this upon review of the report.

Inconsistent participation patterns not only impeded administration of evaluation tools, but also challenged YES! staff in delivering a structured sequencing of topics that build upon prior work. So while YES! delivered all 25 Seeking Safety topics over the year, it was exceedingly difficult to go from week to week and sustain conversations with the same participants about patterns in triggers and the use of coping skills or the consequences from failure to do so. Only two program sites ever achieved a consistent group of participants over more than two or three weeks . As a result, Caminar adapted the program to make it responsive to those in attendance at that day with case managers coming to the group with a planned topic, but adapting it to perceived or expressed client needs that day. From a review of the client self-assessment surveys it seems clear that this client-centered approach was appreciated and that participants valued the opportunity to speak with others about the issues challenging them in the moment rather than have the topic for the group foisted on them because it was time for Topic # 12.

Despite these challenges, evaluation findings below describe a program that is responsive to the needs of the targeted population, exceeded contract deliverables, and was resourceful in adapting the Seeking Safety model to overcome the barriers outlined above. Analysis of the data also identified areas where improvement in specific groups occurring at specific sites might elicit a greater impact. In addition, changes in data collection practices were identified as a way to more easily generate attendance data and administer pre-post test surveys to obtain more robust data to assess the impact of the program on participants.
Each evaluation question is discussed separately below.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to its contract?

Table II			
Month	**Groups Delivered**	**Cumulative Total**	**Contract Target**
July	52	52	40
August	46	98	80
September	48	146	120
October	48	194	160
November	33	227	200
December	34	261	240
January	44	305	280
February	45	350	320
March	48	398	360
April	51	449	400
May	39	488	440
June	37	525	480

YES staff included a Program Director, a full-time Case Manager who facilitated the groups, and a part-time Assistant Case Manager who co-facilitates 5 groups per week. While program was without a full-time case manager during the final two weeks of June, the Program Director and Assistant Case Manager continued the majority of groups each week. As can be seen, despite the loss of this case manager, Caminar exceeded the contract requirement to provide 480 groups over the course of the 2013-14 with the contract not specifying the total number of unduplicated clients to participate in these groups.

Table II at left summarizes the number of groups Caminar delivered during the year. As can be seen, Caminar exceeded contract specifications by delivering 525 groups, 45 more than required by the contract.

On a typical week, YES staff held the following number of one-hour groups at the following locations:

- 2 groups at Redwood House (Monday & Friday at 10:30 am),
- 3 groups at Cordilleras (Monday, Wednesday & Friday at 12:30 pm),
- 1 group at South County BHRS, (Monday at 2 pm),
- 5 groups serving 3 different units at the Youth Services Center (Tuesday & Thursday at 2 and 3:15 pm; Wednesday at 2 pm),
- 1 group at Eucalyptus House (Wednesday at 4 pm), and
- 1 group at the Edgewood Drop-In Center (Wednesday [Jan-Feb] then Monday [Mar-June] at 6:30 pm).

Group size ranges from 1-6 members per group. Through these groups Caminar served 147 unduplicated Transition Age Youth (TAY) between January – June 2014 and a significant number of 'guest' participants, many of whom wound up enrolling in the program. Caminar's contract also stipulated that the program should target Asian Pacific Islander, African American and Latino TAY. During the program year, as presented in Table I, almost 80% of the unduplicated clients identified their ethnicity as either Asian/Pacific Islander, Filipino, Latino/a, African American, Israeli, or

Multi-ethnic. Staff again utilized all 25 Seeking Safety topics at least once, often much more frequently, during the reporting period.

Caminar partnered with program staff at most of the sites from which clients were drawn, engaging site-based program staff as co-facilitators of groups, especially important when one or more clients is symptomatic or were in distress and needed individual support. For example, the South County BHRS site offers a co-facilitator for its weekly group, and Youth Services Center provides a co-facilitator for the 3:15 pm groups on Tuesday and Thursday. In addition, the assistant case manager co-facilitates at Cordilleras two days a week, and at Redwood, Eucalyptus and YSC one day a week.

As noted above, the Caminar contract called for Caminar to deliver 480 Seeking Safety groups during the program year and from July 1, 2013-June 30, 2014, Caminar YES staff provided 525 Seeking-Safety groups at 6 different sites--Redwood House, Eucalyptus House, Edgewood's San Bruno Drop-In Center, South County Behavioral Health & Recovery Services, the Youth Services Center, and Cordilleras Mental Health Center.

To dig beneath the data above and to determine how well attended each group was, how many unduplicated clients were served at each group, and very importantly, how many clients attended groups consistently enough to achieve at least 6 sessions (the minimum dosage that has been evaluated and deemed impactful), the evaluator analyzed client-level attendance data for February 2014-June 2014, the only period for which Caminar compiled the data at a client-level into a spreadsheet format. Prior to February, Caminar had collected the data in paper format without inputting it into a spreadsheet. While a laborious task, the evaluator was able to extract the client level attendance data and prepare the tables below for each group. The labor involved was well worth it as the tables below illuminate a number of important observations that could have implications for changes in the program going forward.

As described above, the YES! Program was offered from 1-3 times per week at 6 different locations. Each month, providers held a slightly different number of sessions, depending upon how many weeks were in each month. In the Tables III-XII that follow, columns 2-6 contain the number of clients attending each session during the months of Feb-June. In the row where Totals are recorded, the total number of ***duplicated*** clients attending sessions each month are recorded in Columns 2-6 and then in Column 7, the average number of ***duplicated*** clients attending each month. Counting the number of duplicated clients allows assessing the average number of participants in each group. Again in the Totals column, in Column 8 is presented the total number of unduplicated clients served over the five months for which data is available and in Row 10 is presented the total number of clients who attended six or more sessions over the course of the five months. In the Average Row, Columns 2-6 show the average number of clients who participated in each group held that month with Column 7 showing the average number in attendance over the full five months for which data was available. Column 9 in the Average Row shows the average number sessions attended by each participant. The value of this data will be clearer as we analyze each sites performance. See the following page for Table III.

Redwood House.

As can be seen, Redwood House served a total of 11 clients throughout the year, but of those eleven, nine attended at least six sessions, by far the site with the highest proportion of clients to achieve this threshold. So while the total number of clients served was among the lowest of group sites, it also might possibly be among the most impactful, as participants were very consistent in attending. However, in an interview, the Program Director pointed out that clients referred from Redwood House would be among the most symptomatic and may often be limited in the degree to which they can assimilate group content. He felt that more likely the impact would be two-fold: more immediately to help ground or distract clients from their symptoms, and perhaps longer term to plant seeds that bear fruit later when clients were less impacted by symptoms. The average number of sessions per client was 8.64 the second highest of all sites. The average number of clients participating in each group was 2.45. On three occasions over the five months, groups were cancelled due to conflicts in schedules between clients and the case manager.

Table III

Redwood House: A crisis residential program serving up to sixteens at a time with a widely varying number of those clients being TAY.

1	2	3	4	5	6	7	8	9	10
Session #	Feb	Mar	Apr	May	June	Ave	5 Mo. Tot Undup	Ave # of sessions for each partic.	# clients w/6+ sessions
1.00	2.00	2.00	2.00	4.00	4.00				
2.00	3.00	0.00	2.00	3.00	1.00				
3.00	3.00	2.00	2.00	5.00	2.00				
4.00	3.00	2.00	2.00	4.00	2.00				
5.00	Holiday	1.00	3.00	5.00	2.00				
6.00	1.00	3.00	3.00	4.00	0.00				
7.00	2.00	1.00	6.00	Holiday	1.00				
8.00	3.00	1.00	5.00	4.00	0.00				
Total Duplicated Client Totals	17.00	12.00	25.00	29.00	12.00	19.00	11.00		9.00
Average Participants Per Group	2.13	1.33	3.13	4.14	1.50	2.45		8.64	

Cordilleras

Cordilleras served thirteen unduplicated clients over the five months. Cordilleras had among the lowest average attendance with an average of only 1.09 participants per group, and while the average number of sessions attended per client was relatively high (4.92), this average is skewed by two clients, one of whom attended 25 times and another who attended 16 times. Indeed, none of the other 11 clients attended more than four times with four only attending once, one attending twice, four attending three times and one attending four. Being a 68-bed Mental Health Rehabilitation Center with clients with acute psychiatric histories, it is easy to understand how sustaining consistent attendance would be difficult. While it is likely that the two clients who attended consistently benefited from the program, aside from possibly planting seeds in the minds

of participants, it is hard to see how the program could provide significant benefit to the eleven clients who attended only a few times. An indicator of the challenge of sustaining consistent attendance, fifteen sessions (in red) were cancelled mostly due to the failure of any client to appear for group. This represents over 25% of the total number of sessions held. In addition, another 26 sessions included only one person. Seeking Safety has been implemented as both a group and an individual treatment. Sessions that were scheduled but not held were ***not*** reported as 'groups' as part of the total 525 group total.

Table IV

Cordilleras a 68-bed Mental Health Rehabilitation Center serving consumers with a serious mental illness. As with Redwood House the proportion of TAY clients varies, but is not a substantial proportion, usually no more than 5-10.

Session #	Feb	Mar	Apr	May	June	Ave	5 Mo. Tot Undup	Ave # of sessions for each partic.	# clients w/6+ sessions
1	1.00	1.00	1.00	0.00	2.00				
2	2.00	1.00	1.00	0.00	2.00				
3	1.00	1.00	1.00	1.00	1.00				
4	1.00	0.00	2.00	0.00	1.00				
5	0.00	0.00	1.00	3.00	2.00				
6	0.00	2.00	1.00	2.00	1.00				
7	Holiday	2.00	0.00	0.00	0.00				
8	0.00	1.00	1.00	0.00	0.00				
9	1.00	1.00	1.00	1.00	2.00				
10	2.00	1.00	2.00	2.00	0.00				
11	1.00	2.00	1.00	0.00	3.00				
12	3.00	1.00	1.00	1.00	0.00				
13		1							
Total Duplicated Client Totals	12.00	14.00	13.00	10.00	14.00	12.80	13.00		2.00
Average Participants Per Group	1.09	1.08	1.18	0.77	1.27	1.09		4.92	
Comments:									

South County Clinic

South County had 12 unduplicated clients and only two clients who achieved a threshold of six sessions. Six of the twelve participants attended only once with four others attending less than five times. One attended twelve times and another seven. Only one session was cancelled. As with Cordilleras, it is difficult to project a way in which more than 2-3 of the South County participants could benefit from the program without increased and more consistent attendance. When the Program Director was asked if there might be more that could be done to 'market' to South County clients, he noted that Caminar has done an open house, outdoor groups, fliers, communication with clinical staff at South County, pizza nights, and other outreach strategies to engage larger numbers of clients. In addition, Caminar provides transportation to YAIL clients to and from YAIL to participate in the group. Unfortunately, given the unstructured nature of the drop-in setting clients

must plan to be at South County on Tuesday at 2pm to participate and given this, consistency is difficult to sustain.

Table V
South County Clinic Behavioral Health Services an outpatient behavioral health clinic

Session #	Feb	Mar	Apr	May	June	Ave	5 Mo. Tot Undup	Ave # of sessions for each partic.	# clients w/6+ sessions
1.00	4.00	3.00	5.00	2.00	1.00				
2.00	1.00	1.00	2.00	3.00	2.00				
3.00	Holiday	1.00	3.00	1.00	0.00				
4.00	2.00	2.00	0.00	Holiday	2.00				
		3.00			2.00				
Total Duplicated Client Totals	7.00	10.00	10.00	6.00	7.00	8.00	12.00	3.33	2
Average Participants Per Group	2.33	2.00	2.50	2.00	1.40	2.05			

Youth Services Center-F2.

Comments: Youth Services Center F-2 is a very unusual story. With only three unduplicated clients, one of whom attended but once, the program really served two clients. But these clients attended with almost perfect attendance, with one client attending 28 times and the other 39 times. The persistence with which these two individuals attended suggests that they felt they were obtaining significant benefit from the program. And indeed, to a significant degree as the result of their participation in YES!, one client was able to obtain an early release from custody and the other was able to avoid deportation. If a few more clients could be drawn to the group, this would make for a more diverse and effective group. The potential of the YES! program and the Seeking Safety approach is reflected in the persistence with which these two clients participated.

Table VI
Youth Services Center-F2: This unit serves only male 'direct-file' clients who are being tried as adults and as a result there is a very small pool to draw from. In 2014-15, F2 will have both direct file clients and general population clients, significantly increasing the pool to draw from.

Session #	Feb	Mar	Apr	May	June	Ave	5 Mo. Tot Undup	Ave # of sessions per partic.	# clients w/6+ sessions
1	2.00	2.00	2.00	2.00	1.00				
2	2.00	2.00	2.00	2.00	1.00				
3	2.00	2.00	2.00	2.00	1.00				
4	2.00	1.00	2.00	1.00	1.00				
5	2.00	2.00	2.00	1.00	1.00				
6	2.00	2.00	2.00	1.00	0.00				
7	2.00	2.00	2.00	1.00	1.00				
8	2.00	2.00	2.00	1.00	1.00				

Table VI Youth Services Center-F2: This unit serves only male 'direct-file' clients who are being tried as adults and as a result there is a very small pool to draw from. In 2014-15, F2 will have both direct file clients and general population clients, significantly increasing the pool to draw from.									
Session #	**Feb**	**Mar**	**Apr**	**May**	**June**	**Ave**	**5 Mo. Tot Undup**	**Ave # of sessions per partic.**	**# clients w/6+ sessions**
9			2.00						
Total Dupl. Client Tot.	16.00	15.00	18.00	11.00	7.00	13.40	3.00		2.00
Ave.Participants Per Group	2.00	1.88	2.00	1.38	0.88	1.63		22.33	

Youth Services Center P4.

YSC-P4 served the highest number of unduplicated clients (tied with YSC-7-Th), had the second highest number of clients attending each month and had five clients who attended at least six sessions. What's more, on average there were 4.7 clients in attendance, creating a more authentic group experience.

Table VII Youth Services Center-P4: This is a general population unit serving girls.									
Session #	**Feb**	**Mar**	**Apr**	**May**	**June**	**Ave**	**5 Mo. Tot Undup**	**Ave # of sessions for each partic.**	**# clients w/6+ sessions**
1	3.00	6.00	6.00	5.00	4.00				
2	4.00	5.00	6.00	4.00	2.00				
3	4.00	6.00	6.00	5.00	3.00				
4	4.00	3.00	6.00	5.00	3.00				
5			4.00						
Total Duplicated Client Totals	15	20	28	19	12	18.80	20	4.7	5
Ave Participants Per Group	3.75	5	5.6	4.75	3	4.42			

Youth Services Center E7

YSC E7 Wednesday, engaged 13 unduplicated clients and with almost half (6) of participants achieving the six-session threshold and with 3.3 participants at each group. This percentage was lowered due to a precipitous drop in program attendance in June resulting in three consecutive group cancellations. Unit lockdown, a staff illness and a mandatory Caminar training resulted in three cancellations during June. Table VIII follows on the next page.

Table VIII Youth Services Center E7 Wednesday: General population boys unit.									
Session #	Feb	Mar	Apr	May	June	Ave	5 Mo. Tot Undup	Ave # of sessions for each partic.	# clients w/6+ sessions
1	1	4	4	6	4				
2	2	0	4	4	0				
3	3	4	5	5	0				
4	5	4	6	5	0				
Total Duplicated Client Totals	11	12	19	20	4	13.20	13	5.08	6
Average Participants Per Group	2.75	3	4.75	5	1	3.30			

Youth Services Center E7 (Thursday)

YSC E-7 Thursday attracted the most unduplicated clients (20), but only two of them achieved the threshold number of six sessions. Nonetheless, the group had consistently well-attended groups with an average attendance of 3.7 participants per group and with the average number of sessions attended by participants being almost four (3.7), there is likelihood of good benefit from this group. Most all of the Thursday session participants attended very consistently until they were released from custody and then no longer attended.

Table IX Youth Services Center E7 Thursday: General population male unit. The E7 is quite large, warranting two groups, especially to enable separation of rival gang members. On rare occasions, YES! staff work with YSC staff to create interaction between gang members, but only after careful consideration.									
Session #	Feb	Mar	Apr	May	June	Ave	5 Mo. Tot Undup	Ave # of sessions for each partic.	# clients w/6+ sessions
1	4	3	3	5	4				
2	4	4	5	5	2				
3	3	0	4	6	0				
4	3	3	5	6	5				
Total Duplicated Client Totals	14	10	17	22	11	14.80	20		2
Average Participants Per Group	3.5	2.5	4.25	5.5	2.75	3.7		3.7	

Eucalyptus

Clearly some adjustments need to be made to the Eucalyptus partnership if it is to be sustained at all. With only five total clients and an average attendance of just over. .5 clients per session.

Eucalyptus only had two sessions in five months with more than one participant and 12 sessions were cancelled for lack of clients, representing over half of the groups offered. No client attended six sessions, indeed only one attended four times and two of the five clients only attended once. It is likely that the poor attendance levels is the small number of residents (12) at Eucalyptus and its being a transitional program with clients typically remaining no longer than a few weeks.

Table X

Eucalyptus: Six month 12-bed transitional residential program that until this year had very few TAY clients, but this has been changed to become a TAY –focused program. This should increase the proportion of TAY residents. As a non-residential program, Eucalyptus clients are not required to be on site, attend school, have jobs and have other options than attending YES! groups.

Session #	Feb	Mar	Apr	May	June	Ave	5 Mo. Tot Undup	Ave # of sessions for each partic.	# clients w/6+ sessions
1	2.00	2.00	2.00	0.00	0.00				
2	1.00	0.00	0.00	0.00	0.00				
3	0.00	1.00	1.00	0.00	0.00				
4	1.00	1.00	0.00	0.00	0.00				
Total Duplicated Client Totals	4.00	4.00	3.00	0.00	0.00	2.20	5.00	2.20	0.00
Average Participants Per Group	1.00	1.00	0.75	0.00	0.00	0.55			

San Bruno Drop-In Center

While one participant attended ten times, ten of the 15 participants attended no more than one or two times. The nature of the program, a drop-in center, is such that consistent attendance would be difficult to achieve since it is a voluntary program. To work with probation and the mental health system to either encourage and mandate participation in the group would require more Caminar staffing to work with probation officers and clinicians and compromise the voluntary nature of the program.

Table XI

San Bruno Drop In Center: A drop-in center in San Bruno operated by Edgewood.

Session #	Feb	Mar	Apr	May	June	Ave	5 Mo. Tot Undup	Ave # of sessions for each partic.	# clients w/6+ sessions
1	3.00	2.00	3.00	0.00	1.00				
2	2.00	2.00	3.00	0.00	2.00				
3	1.00	2.00	2.00	1.00	2.00				
4	1.00	4.00	1.00	0.00	0.00				
5		3.00			1.00				
Total Duplicated Client Totals	7.00	13.00	9.00	1.00	6.00	7.20	15.00		1

Table XI San Bruno Drop In Center: A drop-in center in San Bruno operated by Edgewood.									
Session #	**Feb**	**Mar**	**Apr**	**May**	**June**	**Ave**	**5 Mo. Tot Undup**	**Ave # of sessions for each partic.**	**# clients w/6+ sessions**
Average Participants Per Group	1.75	3.25	2.25	0.25	1.20	1.74		2.40	

The table below aggregates the above data to facilitate comparisons across sites. Some observations:

- Redwood was a highly effective site with the largest proportion of clients attending at least six sessions and the second highest average sessions attended by each participant. This would suggest that Redwood participants are more likely to benefit from the group due to there being a relatively low number of total participants, but high attendance rates among that group. Hence each group was held with more familiar faces and this familiarity among participants was likely to engender a high level of trust.
- Averages can be deceiving, as Cordilleras had a relatively high average number of sessions per participant, with an average of almost 5, however this was skewed by two participants who attended 16 and 25 times each. As noted above, attendance among the other eleven participants was very low.
- South County had very inconsistent attendance with only two clients achieving a threshold of six sessions attended with half of the 12 unduplicated clients attending only once;
- While YSC-P4 only served two clients all year, other YSC groups were generally well attended by consistent groups of participants;
- Eucalyptus was by far the most challenged site in terms of engaging and sustaining participants, with only 5, over half of all groups cancelled, most often for lack of clients, and with only one client attending as many as four sessions;
- At the Drop-In Center, while 15 unduplicated clients attended a group, ten of those fifteen only attended once or twice and only one achieved the six-session threshold; and
- While there are certainly benefits to have a group dynamic that is only possible with a group of at least three or four, as the Program Director pointed out, there is significant benefit derived from very small groups, as those highly symptomatic participants are more able to express their views in the smaller groups.

Across all sites:

- 25% of the unduplicated participants attended at least 6 sessions, a surprisingly high percentage buoyed by three sites, Redwood (9), YSC-E7W (6) and YSC-P4 (5) and a total of 28 clients did achieve the threshold six sessions and at several sites attendance was consistent for weeks at a time;
- No other site had more than two clients achieving the six session threshold;
- The three programs who had among the highest average number of participants per group and the highest attendance per session.
- Due to the transitory nature of the population, only one client participated in groups continuously from February through June and very few attended more than two months. Since protocols for site staff communicating with YES staff prior to clients being discharged,

it is difficult to schedule an exit post-test with these clients and as noted elsewhere, any such additional communication coordinated from Caminar would further stretch an already over-extended program.

Table XII, below, summarizes the five-month totals on variables discussed by site above. While in Caminar's reports to the County, it reported as 'served' only participants who formally enrolled in the program while also allowing 'guests' to attend. The evaluator noted that many guests ultimately wound up enrolling in the program and so guests have been included in the analysis throughout the tables above and below as they were indeed 'participants.' Further, the practice of allowing guests served as an effective outreach strategy that allowed potential clients to sample the groups prior to committing.

Table XII:

Site	Ave. Monthly Total of Duplicated Clients	Total Unduplicated Participants (includes guests)	Ave. # of Participants in Each Group	Average number of sessions attended by a participant	# of participants who participated in at least six groups
Redwood	19	11	2.45	8.64	9
Cordilleras	12.80	13	1.09	4.92	2
South County	8.00	12	2.05	3.33	2
YSC-F2	13.40	3	1.63	22.33	2
YSC-P4	18.8	20	4.42	4.7	5
YSC-E7 Weds.	13.2	13	3.30	5.08	6
YSC-E7 Thur.	14.8	20	3.7	3.7	1
Eucalyptus	2.20	5	.55	2.2	0
San Bruno DIC	7.20	15	1.74	2.4	1
Total	109.4	112	2.48	4.87	28

In summation, Caminar's YES! Program met both objectives related to clients served that are stipulated in the contract, exceeding the total number of groups held and targeting underserved populations effectively. Indeed, while the contract stipulated under-served as ethnic minorities, Caminar went beyond this targeting higher-risk clients in RMHC's, crisis residential programs and in juvenile hall. However, as Table XII indicates, serving these populations made it difficult to sustain consistent attendance in many of the program sites. The sporadic attendance also made it difficult to collect pre-post data to assess the impact of the program. Both issues will be discussed in more detail under EQ 6 and 7.

Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?

The YES! Program utilizes an evidence-based practice that has been intensively researched and found to have a significant positive impact serving individuals suffering from trauma and/or substance use disorders. Given the difficulty of sustaining ongoing participation of clients, Caminar has been resourceful in restructuring the SS model to accommodate client attendance patterns. It has also impeded administration of pre and post tests that might help to assess the degree to which the program is meeting the client outcome measure referenced in the contract: "Reduce co-occurring substance abuse and trauma-related symptoms by twenty percent (20%) in TAY participants that have completed the Seeking Safety program." A pre-post test was developed to attempt to assess change in symptoms related to trauma and substance use, but attendance

patterns resulted in only 4 pre-post test matches. A thorough examination of those patterns has revealed a possible solution to this problem as 29 YES! clients actually attended at least six sessions and the evaluator has developed a strategy for 2014-15 whereby Caminar can obtain pre-post test surveys on most clients who meet this threshold. See EQ 7 for a discussion of this strategy.

A client satisfaction and coping skill survey was used to determine both the level of client satisfaction (See EQ 3) and client perceptions of the coping skills they were developing through the program. In the same client survey, participants were asked to identify which coping skills they now were aware of. As the table at left reveals, it would appear that a very high percentage of the participants are learning to recognize important skills related to coping with trauma and anger and seeking help appropriately when facing challenges or stressors. For next year's evaluation, the evaluator and Caminar Program Director will work together to create a pre-post test that will seek more refined information about how the clients are knowledgeable of specific skills and are using those skills. This will likely be a much better method for seeing the program's impact and for responding to one of the contract outcomes related to reduction in stress-related symptoms.

Table XIII	
Skill	Percent
Asking for Help	82.4%
Coping with my Triggers	71%
Creating Meaning out of my experiences	53%
Respecting my time	76.5%
Using Community Resources	71%
Being able to identify Red and Green Flags	53%
Healthy Relationships (or getting rid of unhealthy ones)	71%
Taking Good Care of Myself	71%
Self-Nurturing	76.5%
Setting Boundaries	82.4%
Honesty	71%
Grounding	59%

Also in this client self-assessment survey, participants were asked to describe any other skills that they had learned. Only five clients declined to identify any additional skills learned. Among the skills identified: communicating more clearly (3); analyzing my own experience and relating to others; discussing issues with staff and peers; relaxation; taking walks; plan for your future (2); set and stick to goals (2); and not to procrastinate; and being myself. The responses suggested that the participants were actually thinking through their responses, an indication of their taking the question seriously.

Caminar also administered surveys with the staff from the programs that housed the clients or the case managers/clinicians who worked with the clients who were not in residential programs. As Table XIV illustrates, of the eight partner site manager's queried all but one respondent strongly agreed with every statement in the questionnaire below, with but one response indicating 'agree' and no one disagreeing with statements asserting the value of the program.

Table XIV-Responses to Stakeholder Survey					
Question	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
1. The YES groups have a positive impact on participants.	100%				
2. YES group participants speak highly of the benefit they derive from the groups.	87.5%	12.5%			
3. Caminar's YES groups are responsive to the schedules of its clients.	100%				
4. Caminar YES staff maintains good communication with our program staff.	100%				
5. I would recommend Caminar's YES groups to other youth and young adult serving programs.	100%				

The open-ended comments made by case managers and clinicians gave a clear expression of the perceived value of the program. For example, one counselor noted that, "Young adults have shared their positive experience in the Yes groups…. The Yes group is benefiting our young adults and helping them interact better with peers." Another therapist stated that, "YES has provided a safe environment for my clients to share their struggles and get positive feedback from peers. Having a targeted age group and small group size has been helpful and beneficial." Another counselor mentioned how communication from the YES staff helped Eucalyptus staff better support a client around self-harm issues and informed their de-escalation plan and interventions. When asked how the program could improve there was only one suggestion: increase communication with our staff about client treatment goals. That aside, the question asking for how the program could improve only got responses like "none," "you are awesome" and "more groups" or "three times a week."

While the data is not as robust as desired, the data that was collected provides reasonable evidence of the YES! groups having a positive impact upon participants. As noted above, in the 2014-15 evaluation, a plan has been developed to ensure that additional data is being collected to provide a more complete understanding of the scope of that impact. The additional data will provide the kind of information needed to respond to another contract objective: Project Yes! clients will demonstrate a 20% reduction in symptoms, something that can not be asserted based on the data available in 2013-14.

Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?

The same client self-assessment survey described above also asked clients four questions about their experience in the YES! groups. As you can see, a significant majority of respondents strongly agreed that staff treated them with respect, listened to their views, and believed that the participants could sustain recovery. Oddly, given these responses, the lowest level of approval was in relation to whether participants felt that the group was actually helpful, with just over 70% strongly agreeing and 11.8% disagreeing, the only item where clients disagreed. Nonetheless, the survey demonstrates that participants highly valued the group. See below.

Table XV: Client Satisfaction Survey Responses

Overall I feel that …. N= 17	Strongly Agree	Agree	Disagree	Strongly Disagree
The YES staff treats me with respect.	88.2%	11.8%		
YES staff really listens to what I have to say about things.	94.1%	5.9%		
I feel that staff believes I can recover and create a meaningful life.	76.5%	23.5%		
I found this group helpful.	70.6%	17.6%	11.8%	

Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?

Caminar's contract stipulated that it should target "at-risk" transition-age youth with a focus on Asian, Pacific Islander, African American and Latino/a populations. Demographic data on clients' served demonstrates that during the program year, 80% of the 147 unduplicated clients identified their ethnicity as either Asian/Pacific Islander, Filipino, Latino/a, African American, Israeli, or Multi-ethnic, so clearly the YES! groups were reaching the demographic population identified in the contract. Table I provides a breakdown of the total ethnicity of clients enrolled in YES! and shows clearly that YES! worked with a diverse client base that is historically under-served.

A clear demonstration of the degree to which Caminar's Seeking Safety Program serves 'at-risk' transition age youth ages 16 to 27 is evident from a review of the populations served by the six different locations from which Caminar drew clients:

- Cordilleras, located in Redwood City, Cordilleras is a locked mental health rehabilitation center for adults with chronic mental illness housing 68 clients many of whom have serious mental health conditions;
- Redwood House, located in Redwood City and operated by Caminar, Redwood House is a crisis residential program that offers an alternative to hospitalization for individuals in the recovery process;
- South County BHRS Clinic, located in Redwood City, South County Clinic is part of the BHRS mental health system offering a wide range of outpatient treatment services;
- Eucalyptus House, located in Daly City, Eucalyptus House is 12-bed transitional residential program that helps people prepare for independent living;
- Edgewood Drop-In Center, located in San Bruno, the Drop-In Center is a voluntary, peer-driven program that provides interpersonal, educational, vocational, wellness, and recreational opportunities for San Mateo County young adults between the ages of 18-25 to expand the skills necessary for a successful transition into adulthood.; and
- Youth Services Center, located in the city of San Mateo, YSC provides the Juvenile Probation charges with a range of mental health services and supports for adolescents and their families needing more than routine probation. At this location, Caminar offers four separate groups, as described below.

By definition, clients served at the above locations are at extremely high-risk. Additional evidence of client risk was identified through another survey developed by the evaluator. The 17-item survey included questions about the level of stress experienced and the frequency with which clients used coping skills to address stressful situations. With some revisions, this is the tool that will be used in a pre-post test format to assess the impact the program is having on clients. For this evaluation, the tool shows clearly the extent to which Caminar has engaged clients experiencing significant levels of stress. Survey results showed that:

- 37% of respondents indicated that they often or almost always found that anxiety interfered with their personal relationships;
- 50% of respondents indicated that they often or always used drugs or alcohol when stressed with 25% of respondents indicating always;
- 43% of respondents indicated that they rarely or never got the sleep they need with 32% indicating that they never do;
- 48% of respondents indicated that they often or always were very stressed with 32% indicating that they were always very stressed;
- 43% of respondents indicated that they never or rarely were able to use relaxation techniques to calm themselves when stressed with 32% indicating never; and
- 44% of respondents indicated that they never or rarely were able to ask someone for help when stressed, with 31% indicating never.

Taken together, these results present a client base that experiences significant levels of stress; where that stress has a negative impact upon their relationships; and where they are not able to access help appropriately, calm themselves or get the sleep needed that might help prevent the stress. The data above provides ample evidence that the client-base served by YES! groups is 'at

high-risk.' In sum, Caminar has partnered with referring agencies whose population are by definition at high risk, has successfully engaged demographic populations that are historically under-served and were identified to be targeted in the contract; and has presented data that shows that clients have experienced high levels of stress and lack coping skills to manage that stress effectively.

Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?

The vision, mission and values of San Mateo County Behavioral Health & Recovery Services stress empowering individuals to direct their own recovery process. BHRS stresses the adoption of culturally competent treatment approaches and through its MHSA planning processes, a further focus has been placed upon implementing evidence-based practices that have demonstrated the capacity to support client wellness and recovery. From the perspective of prevention, BHRS has also described the journey towards a transformed system requiring that programs:

- move "upstream" to primary prevention strategies;
- partner with other health prevention efforts to focus on wellness and recovery;
- achieve desired outcomes; and
- integrate efforts to support sustainability;

What's more, San Mateo's MHSA plan clearly described the priority of intervening early and identified stress, PTSD, and use of alcohol and drugs as factors where early intervention were most important, particularly in relation to individuals from historically underserved populations.

Caminar's YES! Project clearly responds to the vast majority of these expressed priorities. The treatment approach, Seeking Safety, is perhaps the most studied evidence-based practice in mental health and it was explicitly designed to build the competence of participants, to help them develop coping skills, identify stress-triggers and learn to manage their stress rather than be managed by it. Caminar partnered with referring agencies that serve populations experiencing extreme levels of stress and Caminar successfully engaged clients from historically under-served populations. Caminar also partnered with six different treatment centers, incorporating their clinicians at YSC and South County into the framework of the Seeking Safety groups with clinicians and case managers from these sites serving as co-facilitators. In addition, YES staff work intensively with staff at all sites to coordinate and schedule services, to select clients to ensure that the groups will be cohesive (e.g. no rival gang members without careful deliberation).

Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?

Caminar faced significant challenges in delivering the Seeking Safety model to a consistent client base and in collecting data to validate the impact of the program. The greatest challenge was in relation to inconsistent client attendance at some sites and last-minute site-specific schedule changes. Clients participate voluntarily and enjoy their experiences. But they are not always at the group location at the time of the group (e.g., a client(s) just may not be at South County or Edgewood on a given Monday afternoon or evening. Also, Youth Services Center clients are routinely in and out of custody). The other, though much less frequent, obstacle to effective groups is site-specific. Groups can be cancelled at the last minute. For instance, if there is a "code" or emergency lock-down at the Youth Services Center, then groups may be cancelled or shortened (or "groups" are held individually through client jail cell doors). The inconsistency of attendance

makes it challenging for Caminar to deliver the Seeking Safety model to fidelity. While all 25 topics were delivered over the course of the year, Caminar staff flexibility and creativity have allowed the program to navigate the challenges. From the evaluator's perspective, the population served by Caminar's YES! program is at extreme high risk of future incarceration and/or hospitalization. The clientele requires a highly skilled staff that would benefit from additional staffing to support the scheduling functions, to expand coordination with referring partners and to be able to better respond to clients who come to groups highly symptomatic.

Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

In order to improve the quality of the YES! program and enhance its ability to demonstrate clear client benefit, the following recommendations are made:

- Examine ways to incorporate the YES groups more integrally within Eucalyptus, Cordilleras, and Redwood so as to foster greater, more consistent participation;
- Develop a protocol with partner agencies through which YES staff are notified in advance of pending discharges whenever possible so that YES could more easily schedule post-test surveys needed to document program impact upon clients; and
- Implement a protocol to administer a pre-post test to all clients attending their first group and then track client participation more consistently throughout the year to better enable administering a post-test whenever a client completes a sixth session.

The last two recommendations above are made to respond to Caminar's contract that stipulates that it must demonstrate a 20% reduction in client symptoms. An acceptable alternative recommendation would be to ask the county to remove from the contract the need for Caminar to administer pre and post-test surveys. As noted above, there is little if any clinical value to these assessments as Caminar doesn't provide individual treatment that could be informed by these results and given that most all YES participants are also engaged in far more intensive treatment and supervision services from their host/referring agency, attributing changes in coping skill development to the YES! program may be specious. Indeed, given the degree to which the program is over-extended and under-staffed and the clear evidence of perceived benefit from referring stakeholders who are very familiar with both the program and its clients, this may well be the better recommendation.

Section V Demographic Summary

The data below will be reported has been culled from data provided by Caminar. It will be used in reports to the MHSOAC.

Table I: Demographic Summary					**Source of Data**
Total Unduplicated Served					
Gender		**Clients**	**Program Staff**		
	#	%	#	%	
Male	97	67	2	40	
Female	50	33	3	60	
Other					
Age	#		%		
Children 0-15					

Table I: Demographic Summary					Source of Data
Transition Age Youth 16-24		147		100%	
Adult (25-59)					
Older Adults 60+					
Families (can include families with children or TAY)					
Ethnicity		**Clients**		**Program Staff**	
	#	%	#	%	
Caucasian	31	21	3	60	
Latino	76	52			
African American	17	12	1	20	
Asian	2	1.4			
Pacific Islander	11	7.5			
Native American	2	1.4			
Multi-Ethnic	6	4.1			
Other	2	1.4	1	20	Caribbean
Language	**#**	**%**	**#**	**%**	
English	129	88	5	100%	All staff spoke English but two are bilingual.
Spanish	16	10.8	2	40%	All clients were bilingual and since family work was not part of model, Spanish skills were not essential. Staff had Spanish language capacity and used this to better engage clients, but groups were in English.
Cantonese					
Mandarin	1	< 1			
Hindi	1	< 1			
Underserved Pops Served	**#**	**%**	**#**	**%**	
LGBT					
Blind/Vision Impaired					
Deaf/Hearing Impaired					
Veterans					
Homeless					

Program Components Table and discussion are on the next page.

Section VI Program Components:

The information in Table II will be used to report to MHSA as part of the statewide evaluation. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator.

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.		
	Yes	**No**
II-1) Access for Underserved Populations	**X**	
Details:		
II-2) Outreach for Early Recognition of Need		**X**
Details: Outreach is to referring agency staff not directly to potential clients.		
II-3) Access or Linkages to Care		**X**
Details: Group leaders do not typically make referrals, but if an unmet client need were identified would communicate this to staff from the referring agency who has primary responsibility for treatment and supervision. Referral functions would be outside the scope of the program.		
II-4) Reduction of Stigma	**X**	
Details: Group psycho-education addresses source of trauma, demystifying and destigmatizing clients understanding of the source of their stress and anxiety.		
II-5) Screening for Needs	**X**	
Details: Limited screening is conducted upon enrolment in the program.		
Program Activities	**Yes**	**No**
II-6) Addressing Trauma	Seeking Safety explicitly addresses disorders related to trauma and substance use, educating TAYs to recognize triggers and to use coping skills.	
Details:		
II-7) Specific Risk Factors	Risk factors include: exposure to trauma, juvenile and criminal justice involvement.	
Details:		
	Provide specific details very briefly. 1-3 sentences per line.	
II-7) Indicate the location where program activities occur (identify places where services occur	Six locations in San Mateo County: Redwood House, Cordilleras, San Bruno Drop-In Center, Eucalyptus House, South County BHRS Clinic, and Youth Services Center.	
II-8) Specify the roles for Peers (mentors Outreach, Peer education, other)…Please specify.	Veteran attendees make recommendations for group topics and two such clients created a revised check-in/check-out ritual that has been implemented across all groups.	
II-9) Specify the sectors with which you collaborate on this program (housing, criminal justice, public health, education, child welfare)	Criminal justice with close ties with the Youth Services Center who provide co-facilitators for most groups. YES! Is also BHRS and its South County clinic, as well as with Cordilleras and Edgewood's Drop in Center, offering groups at both sites.	

Section VII Program Alignment with SMC MHSA PEI Priorities:

Providers will mark Y for Yes for any community need or priority population addressed. In the space provided, please explain how these needs or populations were served. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator during which time a discussion will occur to amplify and provide details or examples.

Table III: Alignment with SMC MHSA PEI PRIORITIES				
	Children & Youth	**TAY**	**Adult**	**Older Adult**
1-PEI Key Community Needs				
1-A) Disparities in Access to Mental Health Services		X		
Details: Clients served by YES! are primarily (80%) from historically under-served or poorly served demographic populations.				
1-B) Psycho-Social Impact of Trauma		X		
Details: YES! targets TAY who have been subjected to high levels of trauma including those residing in crisis residential, residential treatment programs, transitional housing, and juvenile justice settings.				
1-C) At-Risk Children, Youth and Young Adult Populations		X		
Details: **See 1-B.**				
1-D) Stigma and Discrimination		X		
Details: **See 1-A.**				
1-E) Suicide Risk		X		
Details: Those subjected to high levels of stress are at higher risk of suicide. Learning coping skills to address stress and trauma have been shown to reduce incidents of suicide.				
2- PEI Priority Populations				
2-A) Trauma Exposed Individuals		X		
Details: See above				
2-B) Individuals Experiencing Onset of Serious Psychiatric Illness		X		
Details:				
2-C) Children and Youth in Stressed Families		X		
Details: See above1-B				
2-D) Children and Youth at Risk for School Failure		X		
Details: Youth (TAY) in juvenile justice system or in crisis mental health programs are at high risk of school failure.				
2-E) Children and Youth at Risk of or Experiencing Juvenile Justice Involvement		X		
Details: Multiple groups offered at YSC.				

Section I Agency & Program Description

I.A. Description of Program Services

Since 2011 El Centro has utilized San Mateo County Behavioral Health & Recovery Services' Prevention & Early Intervention funding to implement the Seeking Safety through which El Centro delivers weekly Seeking Safety group sessions at El Centro's Redwood City clinic and in Half Mood Bay. Seeking Safety is an approach to help people attain safety from trauma/PTSD and substance abuse. Seeking Safety is a manualized intervention (also available in Spanish), providing both client handouts and guidance for clinicians. It is conducted in group and individual format; with diverse populations; for women, men, and mixed-gender groups; using all topics or fewer topics; in a variety of settings; and for both substance abuse and dependence.

El Centro's AC-OK Seeking Safety program targeted Transition Age Youth and young adults, the vast majority of whom were referred by the Department of Probation. El Centro named its Seeking Safety program the AC-OK Program as it conveyed a more positive image than Seeking Safety. AC-OK served 40 transition-age youth involved in the juvenile or adult justice systems. Between the two sites, a total of ninety-six groups were contracted to be conducted, however as will be described in the body of the report, El Centro was unable to engage sufficient numbers of Half Moon Bay residents to sustain attendance for groups in that Coastside community, however El Centro offered 130 individual counseling sessions to 18 Coastside residents and conducted outreach to promote the program via participation in community events, networking with other providers in the area, communicating with probation officers. As a result, El Centro plans to initiate groups in Half Moon Bay in 2015.

The key principles of Seeking Safety are:

1. Safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions);
2. Integrated treatment (working on both PTSD and substance abuse at the same time);
3. A focus on ideals to counteract the loss of ideals in both PTSD and substance abuse;
4. Four content areas: cognitive, behavioral, interpersonal, case management; and
5. Attention to clinician processes (helping clinicians work on countertransference, self-care, and other issues).

Since 1992, Seeking Safety has been implemented in more than 3,000 clinical settings and as part of statewide initiatives in Connecticut, Hawaii, Oregon, Texas, and Wyoming. It has been implemented in programs for substance abuse, mental health, domestic violence, homelessness, women and children, and veterans and in correctional, medical, and school settings in the United States and internationally, including in Argentina, Australia, Canada, France, Germany, Italy, Japan, the Netherlands, New Zealand, Scotland, and Sweden.

I.B. Research Basis for Approach

For programs utilizing MHSA funding, San Mateo Behavioral Health & Recovery Services has prioritized the adoption of evidence-based practices and so as part of the evaluation of PEI programs, the evaluator has conducted a brief review of the literature related to Seeking Safety. A recent comprehensive review of the literature on treatment for Post Traumatic Stress Disorder (PTSD) and Substance Use Disorder (SUD) identified Seeking Safety as the most rigorously studied treatment thus far for PTSD/SUD with 13 pilot studies, three controlled studies, and six Random Controlled Trials (*Helping Vulnerable Populations: A Comprehensive Review of the Treatment*

Outcome Literature on Substance Use Disorder and PTSD, Najavits and Hien, 2013). Clients in Seeking Safety studies were challenged by complex trauma/PTSD, with comorbidity, high severity and chronicity, and multiple life problems. Many of the studies examined by Najavits and Hien included significant minority representation.

Six of the studies were partial-dose studies, where the programs used 24% to 48% of the model, including the largest investigation of SS to date, the National Institute on Drug Abuse Clinical Trials Network (CTN) study, which used 48% of the model in 6 weeks (#21). "Partial-dose" refers to the number of SS topics used. Even in these partial dose studies, Seeking Safety has shown positive outcomes across studies generally, an important finding since both SMC BHRS PEI agencies (Caminar and El Centro) implementing Seeking Safety had difficulty sustaining sufficient client engagement to have clients achieve the six-session threshold. Across studies SS has had numerous positive outcomes on PTSD, SUD, and other conditions. In the controlled trials and RCTs, Seeking Safety outperformed the control on PTSD but not SUD in four studies; on SUD but not PTSD in another study; and in three studies, Seeking Safety outperformed the controls on both PTSD and SUD and on both PTSD, including one study of more severe SUD patients. Most also found SS outperformed the control on other variables, such as psychopathology, cognitions, and coping. Finally, Seeking Safety is listed as having strong research support by various professional entities, based on their criteria sets, including Level A by the International Society for Traumatic Stress Studies, and "strong research support" by Divisions 12 and 50 of the APA.

I.C. Target Population, Number Served and Sites

El Centro's AC-OK Program served a population of youth and young adults identified as being at high risk primarily by virtue of client involvement in the juvenile or adult justice system. The table at left captures the age, ethnicity, and referral source of the forty clients served by El Centro's Seeking Safety Program.

Table I: Client Demographic Summary

Characteristic	#	%
Ethnicity		
Caucasian	13	39.4%
African American	2	6.1%
Asian	0	0
Latino	17	51.5%
Multi	0	0
Native Amer.	0	0
Pacific Islander	2	6.1%
Other	6	18.2%
Age at Intake		
18-20	15	37.5%
21-23	15	37.5%
23+	10	25%
Gender		
Male	28	70%
Female	12	30%
Referral Source		
Probation	33	82.5%
Family		
Self	2	5%
Another Agency	3	7.5%
Other	2	5%

The contract stipulated that El Centro target Latino, Asian, Pacific Islander, and African American populations as these are historically unders-served populations who, aside from Asian youth, are also historically over-represented in the justice system. The table shows that while El Centro was successful in serving over 60% clients of color, only four clients were served from the Pacific Islander and African American population and no Asians were served. In an interview with the Program Manager and agency CFO, they explained that El Centro has a specific service niche in the community with a focus upon delivering culturally relevant services to the Latino/a community. This is reflected in the high percentage of Latino participants. While El Centro conducts extensive outreach to identify potential clients, the community has come to view El Centro more as a provider for the Latino community, a view shared by probation officers who make over 80% of the referrals to the program.

The contract did not stipulate how many clients should be served or with what frequency clients should participate, instead only stipulating that 96 groups be offered. Weekly open-enrollment groups were delivered at El Centro's clinic in Redwood City and while the Redwood City site conducted 51 groups in 2013-14 (3 above its goal), no groups were conducted in Half Moon Bay. As El Centro leadership recognized that groups were simply not engaging consistent attendance, it shifted service delivery to offering individual counseling services while continuing outreach to community providers to promote group participation. During 2013-14, El Centro served a total of 18 clients with 130 individual counseling sessions an indication that services are in demand, but that more work must be done to engage a sufficient threshold level of participation in the group model. The challenges engaging clients in Half Moon Bay are discussed under EQ # 1 and in EQ # 6 and 7.

Section II Evaluation Process

The evaluation plan was developed in June-July 2013 through a series of participatory meetings that included the evaluator and El Centro's Program Manager Joe Macedo. A second series of meetings was held in December 2013 to assess and adapt the evaluation process and still more adjustments were made in July and August 2014 to respond to challenges El Centro incurred in collecting data. As with the other Seeking Safety program supported by PEI funding (Caminar), a pre-post test was developed to measure change in the use of coping skills to mitigate the degree to which trauma, stress, and drug and/or alcohol use were impacting social functioning. However, for different reasons both agencies failed to utilize this pre-post test tool. El Centro did utilize a tool that included questions selected from the Addiction Severity Index (ASI). However, even when using this tool, El Centro was only able to produce pre-post- test results for ten clients served in 2013-14. In addition to the pre-post test data, El Centro also collected and provided client-level data was collected on attendance in all groups from July 1, 2013 through the end of June 2014. In addition, El Centro administered a series of satisfaction surveys with 34 clients providing responses to 11 items related to various aspects of client satisfaction. Throughout the process, staff at El Centro was very responsive, acknowledging that their data collection fell short of what had been planned. To address this staff re-engaged clients who had completed the program to take the post-test to increase the number of clients with pre and post tests. Even still, as Section III describes, the lack of sufficient data limited the scope of the evaluation.

Section III Evaluation Findings

There are seven evaluation questions that frame the evaluation of the Prevention & Early Intervention programs supported with Mental Health Services Act funds.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to the contract funding the program?
Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?
Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?
Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?
Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?
Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?

Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

In brief, the El Centro contract did not have many specific deliverables outlined in its contract. Goals included that El Centro should conduct 96 groups, to reduce trauma and alcohol and drug related symptoms, to increase the use of coping skills, and to reduce psychiatric hospitalizations. No goals were included specifying the numbers to be served or client participation levels (frequency of participation in groups). The contract did not specify how El Centro could document reductions in hospitalizations and as noted above the tool developed to capture symptoms and use of coping skills was never administered by El Centro. As a result, findings were limited to analysis of attendance data, satisfaction surveys and an ASI pre-post test administered with just ten clients. Based upon this data, it is clear that while El Centro met the contract goal for providing groups in Redwood City (goal = 48; actual = 51), it did not meet the goal for number of groups in Half Moon Bay, indeed no groups were held in this Coastside community although as noted above 130 individual sessions were proved to 18 Coastside residents. As described in EQ-1, due to the inability to engage sufficient numbers of clients for group work, El Centro delivered individual counseling services to meet the needs of clients who could not attend groups. While the contract did not outline goals for the number of clients who participated in groups, the evaluation examined client level data that revealed that while almost 60% of clients participated in 6 or more sessions, over 40% attended fewer than 6.

In discussions with the Program Manager and CFO, El Centro disclosed plans to address these shortcomings. Specifically, it has begun holding monthly program planning meetings with the program manager, two group facilitators, administrative assistant and the CFO. These meetings focus on a review of data related to attendance/participation, retention, and quality of data being collected. They have also initiated a practice of entering data as assessments are completed so that results can be used for program improvement purposes. Data collection now includes administration of the pre-post test developed by the evaluator which will provide better data on client use of coping skills and the impact of alcohol, drugs and stress on social, family and work relations. To improve attendance, in Redwood City and increase the number of sessions attended by clients, El Centro is initiating a second group in Redwood City on another day to provide more options for participation. Lastly, El Centro is building upon its outreach efforts and individual client work in Half Moon Bay and will begin offering a Coastside group in 2015.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to its contract?

El Centro's contract stipulates only that El Centro deliver 96 groups during the year, not indicating the number of clients served or the frequency with which these clients attend. Their plan was to offer weekly groups in Redwood City (48) and in Half Mood Bay (48). El Centro was successful in Redwood City exceeding their target by 3 (51), but in Half Moon Bay, despite significant outreach, they were unable to engage enough clients to hold any groups. The Program Manager indicated that while they did provide a significant level of individual work (not

Table II: N= 40

Tot # of Sessions Attended	***0-5***		***6-10***		***11-15***		***16+***	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**
All Clients	17	42.5%	12	30%	8	20%	3	7.5%
Clients minus those enrolled in May-June 2014	12	34%	12	34%	8	24%	3	9%

reported in this evaluation), they never generated sufficient clients to sustain a group. Whatever the cause, El Centro clearly under-performed in relation to the number of groups to be held.

The contract did not specify either how many clients should participate in the program or the level of participation expected but the relatively high number of clients participating in fewer than six groups is a concern, however another way of looking at meeting productivity objectives and effectively implementing the model is to examine participation levels of those who did take part in the program. The literature points to participation in six sessions as a threshold below which there is no evidence that a positive impact can be expected. AC-OK program served forty clients over the course of the 2013-14 program year. As Table II above depicts, under 60% of the forty program participants achieved this six-session threshold with 42.5% of clients attending five or less sessions. A closer look at client-level data revealed that five of the 17 clients with less than 6 sessions had just enrolled in May or June and had been consistently attending. The second row in Table II provides data that omits these five clients. This boosts the proportion of those attending groups six or more times to 66%.

As relates to Coastside, despite an inability to engage a consistent group program in Coastside, El Centro did provide individual counseling to 18 individuals providing 130 sessions. In examining client level data it is clear that El Centro is engaging an under-served population as 75% of the clients are Latino/a and from participation patterns it is clear from that the vast majority of these clients remain in the program for six months or more than half have attended at least 9 sessions. This represents a good springboard for launching the weekly AC-OK groups that El Centro plans to initiate in 2015.

In the structured interview with the CFO and Program manager, reasons cited for clients leaving the program include re-incarceration, relapse, moving out of the area, job scheduling or movement to a higher level of care. El Centro captures this data in exit interviews, but until now had not entered the reasons into a database. Whatever the reasons for clients leaving the program, clearly there is room for improvement in participation levels in Redwood City and in Half Moon Bay. Adjustments planned by El Centro are discussed under EQ # 7.

Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?

To determine the degree to which clients benefited from the AC-OK groups or, put another way, experienced reductions in stress, depression, anxiety, and problems with family and peers, El Centro administered the Addiction Severity Index (ASI), with El Centro extracting key items from the survey for the purpose of evaluating impact. Of the forty clients served only 10 completed both a pre- and post-test and so the table below reflects the data for only these ten clients. The ASI is not designed to measure the use of coping skills and so the evaluation does not include an assessment of the degree to which coping skills have been introduced or adopted. This was the reason that the evaluator and Caminar developed another pre-post tool to capture changes in symptoms and changes in use of coping skills (a tool that will be used in 2014-15).

Due to limitations in El Centro's capacity to enter all data elements from the ASI, a selection of items focusing on the impact of drug and alcohol use on functioning, and the impact of stress on family and social relations was compiled. The ASI employs different scales throughout the assessment instrument with the first seven items captured in the table below (D32-F36) all using a four point scale with zero representing no expressed needs or severity of problem and then extending from 1 (slight) through 4 (extreme). The next four items analyzed (PfA-P5B) were yes

or no questions as to whether the client had experienced depression or stress in the past 30 days or over a lifetime, with yes indicated with a 1. The last three items (P13-P21) are again a four-point scale like the first four items. The table captures the average pre and post-test scores and the change experienced by the ten clients with a – change indicating a reduction in symptoms or problems and a + indicating an increase.

Table III: Pre-Post Test Results Addiction Severity Index				
Item	Pre	Post	Change	Discussion
D32-Client need for alcohol tx.	1.6	1.3	-.3	This represents a significant decline in client expressed need for alcohol treatment. Interestingly, three clients scored themselves a 3 or a 4 indicating a high need for treatment. The scores for these 3 did not change, so the entire improvement was among those with moderate treatment needs. This makes sense, as a low-intensity intervention like Seeking Safety is not likely to result in major change in treatment needs for individuals with a severe addiction. However, fully half of the clients (5) experienced significant reductions with two remaining the same.
D33-Client need for drug tx.	1.8	1.2	-.6	This represents an even more significant drop in perceived severity of need for drug treatment as indicated above for alcohol. Here four clients had a four or three score in the pre-test (with all three of the high scoring clients for alcohol indicating high scores for drugs, also). But in post-test only two of the four indicated any need for drug treatment at all. Again half the group made progress with two showing no change and three showing slight increases.
F32-How troubled by family problems (Last 30 days)	.5	.3	-.2	The post-test showed a slight reduction in family problems in the last 30 days. What is more interesting is the exceedingly low overall score with only three clients identifying any family problems and two clients indicating only a slight level of problem and one indicating a considerable level (see results of AC-OK assessment below, which gives a significantly different picture on the severity of client problems and symptoms.) In the post-test, only one person indicated problem with family, that being the same person who had indicated a considerable problem on the pre-test.
F33-How troubled by social problems (Last 30 days)	.3	.6	+.3	Clients identified an even lower level of social problems with only three clients indicating a slight level of problem in the pre-test. Their reported level of problems remained unchanged in the post-test with the increase being entirely the result of one client who registered no problems in the pre and considerable problems in the post-test. Overall, however, the scores across the board were so low that the level of increase is not really significant
F34-How important to you would be tx or counseling for family problems?	.5	.8	+.3	Here again, the average scores on both the pre and post are below 1 with only 3 of ten clients indicating any need for treatment with two indicating a slight need and one indicating a considerable need. The client who indicated considerable need in the pre-test felt an extreme need for treatment in the post-test. One client reduced their perceived level of need from slight to none. But the same person who suddenly had considerable social problems in F33 went from having no need for treatment in the pre-test, to considerable need in the post-test.

Table III: Pre-Post Test Results Addiction Severity Index				
Item	Pre	Post	Change	Discussion
F35- How important to you would be tx or counseling for social problems?	.6	.9	+.3	Three of ten clients indicated the need for counseling for social problems on the pre-test with only one indicating more than a slight need. But this client indicated an extreme need. Three clients reported no change in the post-test. The same individual who went from no need to an urgent need for treatment in F34, had the same trajectory in relation to F35. In short, the increases in severity of need for treatment to address social and family problems was entirely due to one client.
F36-How would you rate the client's need for social or family counseling.	.8	1.3	+.5	Interestingly, on the pre-test, the clinician's view of client need for counseling almost exactly matches up with the clients' perceptions, except that the clinician identified one additional client with need for counseling. While the increase in clinician-perceived need is significant, the overall level of need remains very low. The primary cause for the increase is that in the post-test, the clinician identified one client who was not identified as needing treatment in the pre-test but was identified as having an extreme need in the post-test, resulting in almost the entire gain. Still, a relatively insignificant level of need overall.
P4A-Experience of depression. (last 30 days)	.1	.1	NC	Only one client indicated an experience with depression and that same client expressed that in both the pre and post test.
P4B-Experience of depression. (lifetime)	.1	.2	+.1	Here the same client for P4A indicated that s/he had experienced depression in their lifetime, but one other client did also. Since that client did not indicate experiencing depression in the last 30 days, the change is really not reflective of the group experience.
P5A- Experience anxiety or stress. (last 30 days)	.3	.2	-.1	A higher number of clients experienced bouts with anxiety in the past month (3) than with depression, with a decrease of one reported in the post-test.
P5B-Experience anxiety or stress. (lifetime)	.3	.4	+.1	Two additional individuals reported having had stress in their lifetime, but as per above, with depression, neither expressed experiencing it in the last 30 days
P13-Psychological or Emotional Stress (last 30 days)	.5	0	-.5	Significant reduction in psychological or emotional stress in the past 30 days.
P14-Need for psychiatric tx.	.5	0	-.5	Significant reduction in perceived need for treatment for psychological or emotional stress in the past 30 days.
P21- Clinician assessment of client need for psychiatric tx.	.8	.6	-.2	Insignificant reduction in clinician perception of need for client treatment.

Despite significant efforts on behalf of El Centro staff to re-engage clients who had graduated to obtain more post-tests, an N of 10 for the pre-post test limits the validity of findings significantly. However, based upon the results summarized above, some conclusions can be advanced.

- Data from the ASI overall discloses a relatively low level of severity of self-reported symptoms and problems, with only 2-3 clients identifying that their challenges were considerable or extreme, although this result is countered significantly by results from the AC-OK Adolescent Screening Assessment (see below);
- There was a consistent and significant decrease in client-reported need for treatment for either alcohol or drug treatment, an indicator that the contract goal related to reducing symptoms is being addressed;

- While the level of problems experienced was so low that there was very limited room for further reductions, there was also a reduction in client-reported conflict with family and peers;
- Levels of depression and anxiety, as with the levels of family-peer conflict, were extremely low making small change in either direction statistically insignificant;
- The clinician identified a significantly higher need for treatment services to address the family and/or social problems as well as the need for psychiatric treatment than did clients; and
- Clients reported significant reductions in their experience of stress and need for treatment for stress, possibly an indication that use of coping skills introduced in AC-OK groups was impacting client functioning within family and social settings.

As noted in the first bullet, clients did not self-identify high levels of stress, drug and alcohol use or problems with family and social settings in the ASI pre-post test. However, the AC-OK Adolescent Screening tool provided a very different story. This 14-item Yes-No response screening tool showed far more indications of client challenges, especially with alcohol and/or drugs. Only seven of the 34 clients taking the AC-OK did not screen as needing further assessment in relation to alcohol or drug addiction with fifteen of the 34 indicating yes to at least four of the six items in the alcohol subscale. Only one yes response indicates the need for further assessment. Twenty-three of the 34 clients screened by the AC-OK also screened positively for needing further mental health assessment. While only 12 of 34 screened positively for trauma exposure, this still represents over a third of the group. The results from this screening tool suggests strongly that clients in the group may have had more issues with alcohol and drugs and/or with mental health challenges than might be evident from the self-assessment.

Taken together, it would appear that the AC-OK groups have a positive impact upon clients managing significant levels of alcohol and drug use and family and peer conflict. Given the relatively low participation levels in groups, this is an encouraging finding and points to the critical need to increase participation to ensure that clients maximize the benefit from this program. This finding is reinforced by a close examination of client level participation rates and changes in the pre-post-test. Six of the ten pre-post test clients experienced 8 or more sessions with two having attended 12 times. These clients showed more consistent gains than did the remaining clients who had fewer sessions. What's more, the only clients who experienced significant declines in outcomes were the two clients who participated in fewer than six sessions. Clearly, boosting consistent attendance rates is important to AC-OK having the positive impact desired upon clients.

Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?

Satisfaction with AC-OK services was measured through analysis of responses from 33 clients responding to an eleven-item satisfaction survey using a five-point Likkert scale with responses ranging from 1= Strongly Agree; 2 = Somewhat Agree; 3 = Not Sure; 4 = Disagree; and 5 = Strongly Disagree. The average response is provided in the table below.

Table IV: Satisfaction Survey Statement	Strongly Agree	Some what Agree	Not Sure	Disagree	Strongly Disagree	Ave Score
Staff treats me with respect and are courteous to me.	28	3	0	0	0	1.1

Table IV: Satisfaction Survey Statement	Strongly Agree	Some what Agree	Not Sure	Disagree	Strongly Disagree	Ave Score
Treatment services are easy to get to.	23	8	0	0	0	1.26
Facilities are clean.	25	6	0	0	0	1.19
The initial assessment process was sensitive to gender, racial, and ethnic issues.	24	6	1	0	0	1.26
I was able to participate in planning my treatment goals.	24	3	2	1		1.32
My counselor is helpful and speaks to me in a way that I can understand.	30	0	0	0	0	1.00
Other Staff are helpful and speak to me in a way that I can understand.	26	5	0	0	0	1.16
Staff take time to explain to me what will happen next in treatment.	23	7	1	0	0	1.29
Staff are sensitive to gender, racial, and ethnic issues.	26	5	0	0	0	1.16
Overall, I feel that treatment is helping me.	20	4	2	0	0	1.23
I would recommend this program to my friends and family members who also need help.	26	3	1	1	0	1.26

Clearly, clients were extremely satisfied with services across all items with only two 'disagrees' and no 'strongly disagree' responses from all clients combined. Moreover, on every item over two-thirds of respondents strongly agreed. The highest rated item was a perfect score (all strongly agreed) in terms of how helpful the counselor had been. The lowest score was in relation to clients' being able to participate in care planning, but even here only one person disagreed with the statement. The other statement where there was one respondent who disagreed had to do with overall recommendation of the program, a curious response given that this respondent had given all but one of the other items a 1 score.

The survey also included two open-ended questions, one seeking ways in which the program had been particularly helpful and the other in relation to areas where the program could improve. In relation to areas for improvement, one respondent indicated that not enough people consistently attended and another commented that the required number of 12-step meetings was a barrier that he/she didn't like. Otherwise, even the comments about areas for improvement were quite positive, e.g. "Nothing. All is great" or "Nothing, I have learned a lot."

As to the positive elements of the program, all but six clients identified at least one thing that they liked about the group with quotes including:

- "Groups and one-on-one sessions are very helpful;"
- "My one-on-one counseling has made this a great experience for me and my recovery;"
- "I like that the groups are girls only;"
- "Counselor is amazing and gets me. She has been through it and understands my addictions. Angelina is also amazing non-judgmental offers perfect advice and genuinely cares for her clients;"
- "People really care here about helping. I feel comfortable discussing my problems whereas I've had trouble in the past being open;" and

- "I like everything about service especially the people that are in need of the Service & help I also like that there are resources available if you want it. Counselors are there for me, & I want my Recovery & I am accepting the help & I love it."

The comments point to program elements that spoke to the clients and should be sustained: gender-specific groups; the importance of 1-1 sessions; and the value of counselors with lived-experience. However, the overarching client view is that the program is very valuable, the staff is responsive and acute, and that they feel they get tremendous value from the program.

Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?

The contract indicated that it should target high-risk clients and specified under-served populations. Over 80% of clients were referred by the Probation Department and over 60% of those served came from demographic populations who have been historically underserved. While the low number of African American clients (6.1%) is surprising, by all other criteria, El Centro has met this criteria. El Centro leadership indicated that the likely reason for low numbers of African Americans in the program is that the agency is viewed by the community and by referring agencies as primarily a Latino-serving agency, an assertion supported by even lower levels of African Americans in other El Centro programs.

Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?

The vision, mission and values of San Mateo County Behavioral Health & Recovery Services stress empowering individuals to direct their own recovery process. BHRS stresses the adoption of culturally competent treatment approaches and through its MHSA planning processes, a further focus has been placed upon implementing evidence-based practices that have demonstrated the capacity to support client wellness and recovery. From the perspective of prevention, BHRS has also described the journey towards a transformed system requiring that programs:

- move "upstream" to primary prevention strategies;
- partner with other health prevention efforts to focus on wellness and recovery;
- achieve desired outcomes; and
- integrate efforts to support sustainability;

What's more, San Mateo's MHSA plan clearly described the priority of intervening early and identified stress, PTSD, and use of alcohol and drugs as factors where early intervention were most important, particularly in relation to individuals from historically underserved populations. By serving clients involved in the juvenile-adult justice system (over 80% of clients) and by using evidence-based intervention to help these clients develop coping skills that prevent alcohol and drug addiction or trauma from impeding in functioning, the AC-OK program is clearly meeting this priority.

Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?

The AC-OK program successfully implemented Seeking Safety groups in Redwood City, clients there were entirely satisfied with the program, pointing to many specific program elements that were responsive to their needs, and pre-post test data provides evidence that the groups had a positive

impact upon client symptoms related to alcohol, drugs, and family/social relations. However, data also points to several areas where improvement is needed:

Coastside. AC-OK failed entirely in delivering groups in the Coastside community. In conversation with the Program Manager, it was indicated that the program encountered challenges in engaging sufficient numbers of Coastside clients to sustain groups in this community despite ongoing outreach to Coastside agencies and participation in community events. The Manager indicated that often a facilitator would go to HMB finding that no one had come to the scheduled group. As a result, El Centro provided 130 individual counseling sessions to 18 Coastside clients. However, Coastside is consistently identified as an 'under-served' community in a large number of county needs assessments (something underscored by the number of clients seeking individual counseling services). Either some means of increasing client engagement and sustaining participation in groups is needed or a program focusing upon individual counseling needs to be further developed. See EQ # 7 below for a discussion of this challenge.

Participation Levels. Even in Redwood City, the number of participants who failed to achieve even the threshold level of six sessions is too high. Improvement in the use of coping skills and reduction of symptoms would be more prevalent and sustainable with more consistent attendance levels.

Data Collection. The use of the ASI pre-post test was not ideal. It is not designed to be used as a pre-post test and does not capture use of coping skills. It was used only because pre-test assessments were in place and so re-administration of the assessment provided two point-in-time data sets. A tool developed by the evaluator based upon validated tools, should be used in the future with all clients. An N of ten is simply too small to draw valid conclusions about the impact of services. Another limitation in data collection is the lack of an easy way to document reductions in hospitalizations among El Centro clients and while this may be possible to do with County leadership, the evaluator questions if this is an appropriate performance measure for such a low-level intervention.

As described below, El Centro leadership has committed to making program and data collection adjustments to respond to the above challenges.

Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

There is significant evidence of client satisfaction with the program, data supporting improvement in clients' ability to cope with drugs, alcohol and social/family stresses, and client comments pointing to specific program strengths. But several challenges encountered by El Centro have limited the AC-OK's impact in Redwood City and prevented the program from making any inroads in the Coastside community. El Centro leadership has been remarkably responsive to considering the challenges faced by the program and thinking deeply about how best to use the evaluation to craft strategies that improve future program operations. Key improvements identified by El Centro as important to 2014-15 operations include:

Use of Data. Data provided for this evaluation was not representative of the full population served and clearly has not been entered within a timeframe where it could be used by program staff to analyze ongoing operations and plan for ongoing program improvement, a key objective stipulated in all BHRS contract. El Centro has committed to improving data collection processes in a number of ways. First, it will expedite data entry of client intake, and client pre- and post-test assessments,

ensuring that a far higher proportion of clients complete pre and post tests, and capturing the reasons for program exit in their database. In addition, a monthly Program Planning meeting has been instituted where the Program Manager, Group Facilitators, Administrative Assistant and CFO will review data, specifically looking for the impact of recruitment efforts, group participation levels, client retention, and quality and completeness of data being collected. In addition, with data entered as clients complete assessments, impact data will also be reviewed in these meetings, allowing for the opportunity to identify specific areas where clients are showing gains and where they are not.

The satisfaction surveys with clients provided important insights into the program and a reassuring view of how clients felt the program was benefiting them. Administration of a satisfaction survey with probation officers referring clients might also provide valuable insights into their perception of the programs impact or areas where it might be improved.

Participation Levels. Less than half of clients participated in over six groups, a level of involvement that is indicated by the literature as being essential to achieving significant client impact. El Centro needs to work with the Department of Probation to seek ways to encourage or require participation in groups at a level sufficient to achieving the kinds of outcomes sought by both systems. El Centro is making these adjustments, adding a group in Redwood City, offering clients more flexibility in days that they can attend the group. The routine review of participation data and reasons for program exit will also enable El Centro to make data-informed mid-course corrections in service delivery.

Half Moon Bay. While El Centro provided a range of individual counseling services in HMB, if the Seeking Safety model is to be implemented in Coastside, either relationships with other Coastside agencies or with the Department of Probation need to be strengthened to create sufficient referrals to sustain groups operating in this under-served community. El Centro has committed itself to this outreach and to instituting a AC-OK group in Half Moon Bay in 2015. What's more, El Centro leadership indicated that the Half Moon Bay group would be sustained even if the group size is small in size. Given the current level of engagement of clients in individual counseling sessions and their commitment to conducting the groups no matter the size, there is reason to hope that groups will become established in Coastside.

In short, while the program has demonstrated considerable strengths and has largely met its contract obligations in Redwood City, even in Redwood City improvement in client participation would lead to a greater impact. More importantly, there is a critical need to re-think how services are promoted and/or delivered in Half Moon Bay. Improvements in data collection are a far easier fix and El Centro staff has been very responsive improving data collection practices. Taken together, changes in data collection practices agreed to by El Centro, creating an additional group in Redwood City and sustaining outreach and initiating a group schedule in Half Moon Bay will address all concerns identified in this evaluation.

Section V Demographic Summary

The data below will be reported with different programs having customized reports if their programs have unique features that would benefit from separate reporting. For example, if a program:

- Offered its programs in different communities; or
- Offered the same program at a school to different students in the first semester than the second; or

- Delivered two or more very different program components, e.g. consultation to school professionals and direct service to children and/or families.

Table I: Demographic Summary					**Source of Data**
Total Unduplicated Served					
Gender		**Clients**	**Program Staff**		
	#	%	#	%	
Male	28	70%	1	25%	
Female	12	30%	3	75%	
Other					
Age	#		%		
Children 0-15	30	75%			
Transition Age Youth 16-24	10	25%			
Adult (25-59)					
Older Adults 60+					
Families (can include families with children or TAY)					
Ethnicity		**Clients**		**Program Staff**	
	#	%	#	%	
Caucasian	13	39.4%	3	75%	
Latino	17	51.5%	1	25%	
African American	2	6.1%			
Asian	0	0			
Pacific Islander	2	6.1%			
Native American					
Multi-Ethnic					
Other	6	18.2			
Home Language	**#**	**%**	**#**	**%**	
English	40	100%			While many clients indicated that the "home" language was Spanish, none of the clients were monolingual Spanish and the program scope of work did not include family work.
Spanish					
Cantonese					
Mandarin					
Underserved Pops Served	**#**	**%**	**#**	**%**	Intake process asks clients about each of the under-served client populations.
LGBT	0				
Blind/Vision Impaired	0				
Deaf/Hearing Impaired	0				
Veterans	0				
Homeless	3				

Program Components Table and discussion are on the next page.

Section VI Program Components:

The information in Table II will be used to report to MHSA as part of the statewide evaluation. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator.

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.		
	Yes	**No**
II-1) Access for Underserved Populations	**X**	
Details: Program served demographic groups that are historically under-served, i.e. over 60% of clients are from ethnic groups that are historically under-served. While well-over a majority, the 60% level is significantly lower than the proportion of clients served in other PEI funded projects.		
II-2) Outreach for Early Recognition of Need	**X**	
Details: While serving clients already immersed in the justice system, most AC-OK clients are young, have limited histories in the public health system but are at high-risk of involvement in both the justice and behavioral health systems.		
II-3) Access or Linkages to Care		**X**
Details: While group leaders do help clients access services from other systems, this is not a function of groups but rather an added benefit from them.		
II-4) Reduction of Stigma	**X**	
Details: Discussions of stigma is a part of the Seeking Safety curriculum.		
II-5) Screening for Needs	**X**	
Details: All clients entering the program are screened using the AC-OK Adolescent Screening Tool, a validated tool developed explicitly to identify adolescents who would benefit from additional assessments in relation to alcohol or drug use, mental health, or exposure to trauma.		
Program Activities	**Yes**	**No**
II-6) Addressing Trauma	X	
Details: Seeking Safety explicitly addresses disorders related to trauma and substance use, educating TAYs to recognize triggers and to use coping skills.		
II-7) Specific Risk Factors	X	
Details: Risk factors include: exposure to trauma, juvenile and criminal justice involvement.		
II-7) Indicate the location where program activities occur (identify places where services occur	One location in Redwood City and one in Half Moon Bay. The failure to engage clients in Half Moon Bay needs to be addressed.	
II-8) Specify the roles for Peers (mentors Outreach, Peer education, other)…Please specify.	Peers participate in all groups with the shared experience of clients is only reinforced by El Centro's use of group facilitators who also have lived experience. Clients expressed satisfaction with having counselors who had a shared experience base.	
II-9) Specify the sectors with which you collaborate on this program (housing, criminal justice, public health, education, child welfare)	Criminal justice with close ties with the Youth Services Center who provide co-facilitators for most groups. YES! Is also BHRS and its South County clinic, as well as with Cordilleras and Edgewood's Drop in Center, offering groups at both sites.	

Section VII Program Alignment with SMC MHSA PEI Priorities:

Providers will mark Y for Yes for any community need or priority population addressed. In the space provided, please explain how these needs or populations were served. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator during which time a discussion will occur to amplify and provide details or examples.

Table III: Alignment with SMC MHSA PEI PRIORITIES				
	Children & Youth	**TAY**	**Adult**	**Older Adult**
1-PEI Key Community Needs				
1-A) Disparities in Access to Mental Health Services		X		
Details: Program serves clients in the juvenile justice and demographic populations that have been historically under-served.				
1-B) Psycho-Social Impact of Trauma		X		
Details: 60% of screened as requiring additional assessment in relation to their exposure to trauma.				
1-C) At-Risk Children, Youth and Young Adult Populations		X		
Details: Over 85% of clients are already involved in the juvenile justice system with the vast majority of clients screening as being at risk of problems of with alcohol, drug or mental health problems, suggesting the need for further assessment.				
1-D) Stigma and Discrimination		X		
Details: Issues of stigma and discrimination are woven through all Seeking Safety groups.				
1-E) Suicide Risk				
Details:				
2- PEI Priority Populations				
2-A) Trauma Exposed Individuals		X		
Details: Details: 60% of screened as requiring additional assessment in relation to their exposure to trauma.				
2-B) Individuals Experiencing Onset of Serious Psychiatric Illness				
Details:				
2-C) Children and Youth in Stressed Families				
Details:				
2-D) Children and Youth at Risk for School Failure				
Details:				
2-E) Children and Youth at Risk of or Experiencing Juvenile Justice Involvement		X		
Details: Over 80% of clients are involved in the juvenile justice system.				

Section I Agency & Program Description

I.A. Description of Program Services

San Mateo County Human Services Agency, Children & Family Services Division is a division of San Mateo County that operates:

- Children & Family Services
- Child Abuse and Neglect Hotline
- Child Protective Services
- Family Resource Centers
- Foster Care Program
- Adoptions
- Child care
- Kinship Support Services
- Youth Services
- Safe Surrender Baby Info
- Children and Family Services Resources

The vision of the Children's Division is: Healthy, thriving children, youth and families with a mission of protecting the welfare of children; improving the lifelong stability of children and youth; and improving the health and strength of families. HSA achieves these goals by helping families understand and solve the issues that lead to child neglect, abuse or exploitation. In those cases when a child must be removed from the home for safety reasons, HSA helps families resolve their issues as soon as possible so that the child can be returned to a safe and loving home. When a child cannot be reunited with the biological family, HSA helps identify a suitable adoptive home or other safe and permanent living arrangement.

Since 2007, HSA has operated Teaching Pro-social Skills (TPS) groups in San Mateo County public elementary schools where HSA Family Resource Centers are located. These schools generally receive referrals from teachers for students with classroom behavioral issues. TPS addresses the social skill needs of students who display aggression, immaturity, withdrawal, or other problem behaviors. Students are at risk due to issues such as growing up poor; peer rejection; low quality child care and preschool experiences; afterschool care with poor supervision; school failure, among others. Teaching Pro-social Skills is based on Aggression Replacement Training (ART). ART was developed by Arnold P. Goldstein, Barry Glick and John C. Gibbs, and takes concepts from a number of other theories for working with youth, and incorporates them into a comprehensive system. Peer learning and repetition are elements of the model. ART is an evidence-based program broadly utilized. Social skills training, anger control, and moral reasoning are the main components of both ART and TPS. While originally designed for older youth with juvenile justice involvement, TPS and ART have been utilized in dozens of health and human service contexts including with: nurses, home attendant care providers, undergraduate students, military personnel, counselors, teachers, and with youth beginning as early as Kindergarten. TPS training is provided by the California Institute of Mental Health using the TPS curriculum develop by Skillstreaming. Skillstreaming for Elementary School children employs a four-part training approach—modeling, role-playing, performance feedback, and generalization—to teach essential prosocial skills to elementary school students.

I.B. Research Basis for Approach

The vast majority of studies of the efficacy of TPS have been focused upon older youth, principally youth involved in the juvenile justice system. However, as noted above TPS has also

been adapted to support elementary school students experiencing challenges conforming with classroom expectations and behavior norms. Brief summaries of a number of appropriate studies are provided below.

Choi, H. S., & Heckenlaible-Gotto, M. J. (1998). Classroom-based social skills training: Impact on peer acceptance of first-grade students. Journal of Educational Research, 91(4), 209–214.
Trainees: First-grade general education students (n=13), two 30-minute groups per week for four weeks. Included control group (n=12).
Skills: Problem-solving, using self-control, accepting consequences, avoiding trouble
Experimental design: Peer ratings (work with, play with); pretesting and posttesting
Results: T-test showed significant increase from pretest to posttest on "work with" peer rating for treatment group; no increase in control group. No significant differences on "play with."

Cobb, F. M. (1973). Acquisition and retention of cooperative behavior in young boys through instructions, modeling, and structured learning. Unpublished doctoral dissertation, Syracuse University.
Trainees: First-grade boys (N = 80)
Skill(s): Cooperation
Experimental design: (1) Skillstreaming for cooperation, (2) instructions plus modeling of cooperation, (3) instructions for cooperation, (4) attention control, (5) no-treatment control
Results: Skillstreaming significantly increased all other conditions on both immediate and delayed tests of cooperative behavior.

Leonardi, R., Roberts, J., & Wasoka, D. (2001). Skillstreaming: A report to the Vermont State Department of Education. Montpelier: Vermont State Department of Education.
Trainees: Elementary students (grades 2–6) with either emotional-behavioral disorders or high incidences of school disciplinary problems (N = 12).
Skills: Variety of Skillstreaming skills
Results: Students demonstrated a substantial reduction in discipline referrals.

Sarmento, P., Almeida, K., Rauktis, M. E., & Bernardo, S. (2008). Promoting social competence and inclusion: Taking alternative paths. Reclaiming Children and Youth, 16(4), 47–54.
Trainees: Elementary-age youth with oppositional behaviors attending public school
Skills: Combined Skillstreaming instruction with positive reinforcement for participation, following rules, and practicing skills
Experimental design: Correlations among group attendance, motivation points, and social skills
Results: The greater the number of group sessions attended, the greater degree of advanced social skills demonstrated by the end of training.

Swanstrom, C. R. (1978). An examination of Structured Learning Therapy and the helper therapy principle in teaching a self-control strategy to school children with conduct problems. Unpublished doctoral dissertation, Syracuse University.
Trainees: Elementary school children with acting-out problems (30 boys, 11 girls; N = 41)
Skill(s): Self-control
Experimental design: Skillstreaming versus structured discussion by helper experience versus helper structuring versus no helper role plus brief instructions control
Results: Skillstreaming and structured discussion significantly increase in self-control acquisition. No significant transfer or helper role effects.

Wight, M., & Chapparo, C. (2008). Social competence and learning difficulties: Teacher perceptions.

Australian Occupational Therapy Journal, 55, 256–265.
Subjects: A total of 21 elementary-aged (ages 5–11) boys with learning difficulties; 21 elementary-aged boys as comparison
Experimental design: Point bi-serial analysis on Teacher Skillstreaming Checklist ratings
Results: As a group, boys with learning difficulties received significantly poorer scores as rated by their teachers. Most difficult areas in order included (1) Classroom Survival Skills; (2) Friendship-Making Skills; (3) Skill Alternatives to Aggression; (4) Skills for Dealing with Stress; and (5) Skills for Dealing with Feelings. Authors concluded that the Teacher Skillstreaming Checklist is a comprehensive and valid assessment tool.

A number of conclusions can be drawn from the above research:

- TPS is an appropriate program for elementary school-age children experiencing behavior control issues;
- TPS has demonstrated effectiveness in improving self-control, problem solving, cooperation, following rules and other behaviors important to functioning effectively in a classroom and at home;
- TPS effectiveness has been demonstrated multiple times using statistically valid tools, including the one used by HSA (Teacher Skillstreaming Checklist) and in reducing discipline referrals; and
- TPS effectiveness increases with the dosage experienced by the students.

I.C. Target Population, Number Served and Sites

HSA's TPS program targets at risk youth ages 6-9, by implementing on Teaching Pro-Social Skills six to ten-session series each semester at the following school locations:

- Bayshore Elementary School in Daly City
- Hoover Elementary School in Redwood City
- Fair Oaks Elementary School in Redwood City
- Taft Elementary School in Redwood City
- Belle Haven Elementary School in Menlo Park

HSA's contract calls for approximately 8 students per group and stipulates that additional individual counseling services and/or linkages to other relevant services will also be provided. Contract negotiations between HSA and BHRS were not concluded until December and so HSA only operated TPS for one semester during 2013-14.

I.C. Budget Amount

HSA was awarded a contract with a budget of $126,748 for the period beginning January 1, 2014 through June 30, 2014. Funding supported a .10 FTE Supervising Mental Health Clinician, .10 PSW II (get full spell out), and a .75 Caseworker who facilitated the TPS groups. In addition, the county paid $23,308 for TPS training using a combination of Title IV-E (35%) and MHSA funding (65%).

Section II Evaluation Process

The evaluation plan was developed in December 2013 and January 2014 in a series of meetings that included the evaluator and Donovan Fones, the Supervising Mental Health Clinician

for the program. A plan was agreed to to collect the following data to assess the degree to which the TPS met its contract deliverables and had a positive impact upon the targeted population.

- Client-level data was collected on attendance in all groups from January 2014 through the end of June 2014;
- Data on source of referral, ethnicity, home language and age;
- Pre-post test administration of the Skillstreaming Teacher checklist that afforded teachers an opportunity to rate students they referred to TPS on specific social skills that were the focus of the TPS groups; and
- Parent satisfaction surveys which were never administered, as described under evaluation question III below.

Section III Evaluation Findings

There are seven evaluation questions that frame the evaluation of the Prevention & Early Intervention programs supported with Mental Health Services Act funds.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to the contract funding the program?
Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?
Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?
Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?
Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?
Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?
Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

HSA's TPSS groups met both their service delivery and service impact objectives with each group sustaining the involvement of a core number of students referred by teachers. Group size at each site ranged from 6-10 students, as identified as the goal in the contract and attendance was consistent at each site. Groups adhered to the TPSS framework by introducing positive behaviors to students, targeting the behaviors to respond to behaviors identified by teachers as needing development. As such, each site's group was customized to the needs identified by teachers. A pre- and post test was administered that specifically asked teachers to identify the level of specific positive behaviors among referred students at the point of intake and at the end of the groups. This data shows consistent growth across sites in virtually every single behavior being addressed. The exception to this finding is that in two sites post-test results were mishandled resulting in one site not having any post-test results and one site having them for only three of the six students in that group. Another area of concern was the lack of engagement of family members, a shortcoming with which the program manager agreed. Plans to address this issue and the handling of assessment data have been developed, as described under EQ # 7.

Each evaluation question is discussed separately below.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to its contract?

The evaluator reviewed participation levels in all groups to determine the degree to which TPS met its productivity objectives stipulated in the contract. HSA's contract stipulated that it would provide groups at five elementary schools, with groups extending for six to ten sessions including approximately eight participants. The table below summarizes enrollment and attendance at all five sites.

Table I: Enrollment & Attendance

School Site	Number Enrolled	Ave Attendance Per Group	Ave # of Sessions Attended	Most Attended	Least Attended
Bayshore	10	8.8	8.8	10	8
Belle Haven	6	5.3	8.83	10	8
Fair Oaks*	5	3.3	8.25	9	0
Hoover	11	9.5	8.63	10	6 (1)
Taft	6	5.2	8.67	10	8
Totals	38	6.42	8.47	10	0

As Table I illustrates, attendance in TPS groups across all sites were exemplary. Across all 38 students, participants averaged attending almost 8.5 sessions out of ten possible sessions. Across all five sites, only one referred student did not attend any groups (Fair Oaks) and only one other student attended less than seven times (Hoover). Otherwise all students referred attended at least 8 times. What's more, the consistency of participation suggests a program that either participants felt beneficial and/or that were well integrated into the schools, preventing school scheduling for testing, field trips and other schedule adjustments rarely, if ever, interrupted delivery of groups. However, given that the contract stipulated a required 8-10 sessions and TPS delivered ten at all sites and an average participation level of 8.47, clearly this objective was met. The contract also stipulated that the average group size would be approximately 8 and over five sites, the average group size was 7.6 while this qualifies as 'approximately' eight participants per group, viewed another way, only two of the five sites achieved a census of eight and so increasing communication with teachers at Taft, Fair Oaks and Belle Haven is advised.

The HSA contract also called for TPS staff to participate in TPS training with $23,308 of funding dedicated to that purpose. On November 4th and 5th of 2013, the Psychiatric Social Workers and Community Workers were trained by CIMH in Aggression Replacement Therapy which included TPSS. On May 6, 2014, the same staff received a booster training.

Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?

To evaluate the degree to which each site had a positive impact upon participating children, TPS used the Streamlining Teacher Behavior Checklist, a 60-item survey that asks teachers to rank the frequency with which students they have referred to TPS have demonstrated any of 60 positive behaviors that are being emphasized in the group. A score of 1 reflects the teacher's view that behavior almost never is evident; 2 = seldom; 3 = sometimes; 4 = often; and 5 = almost always. Each site selected up to ten such behaviors to be the focal point of groups based upon the unique needs of the group participant as determined by teacher referrals. This means that each site had vastly different behaviors being taught in the groups at the five sites making it impossible to compare across sites. Tables II-V below identify the level of either increased or reduced teacher identification of positive behaviors. It should be noted that there are tables for only four of the five school-based programs as one school, Fair Oaks, failed to collect the post test results and another school. Also, one school, Taft, despite having six students with good attendance throughout, only

administered the pre and post test with three students and with these students, only obtained responses on six of the ten targeted behaviors. This partial data is reported below.

Table II: Bayshore Behavior Checklist Change			
Behaviors	Pre-	Post	Change
Following instructions	3.3	4.0	+.7
Recognizing another's feelings	2.5	3.0	+.5
Dealing with your anger	1.8	3.0	+1.3
Using self-control	2.3	2.5	+.2
Asking permission	3.9	4.0	+.1
Responding to teasing	2.1	2.6	+.5
Dealing with an accusation	2.0	2.4	+.4
Making a complaint	1.7	2.6	+.9
Being a good sport	2.3	3.2	+.9
Dealing with being left out	2.3	3.1	+.8
Average	2.42	3.04	+.62

At the Bayshore site, ten participants enrolled in the group and based upon the Checklist demonstrated increases in all ten targeted behaviors. Overall, the average gain was .62, the largest average gain of any site and an improvement of just over 25% on the baseline. The two behaviors most in need of improvement and ranked as least evident in the pre-test (dealing with your anger and making a complaint) also had the highest gains. To illustrate how this translates into teacher perceptions of classroom behavior for dealing with your anger, in the pre-test only one of ten students was ranked as sometimes exhibiting this behavior 'sometimes' with the rest either seldom or almost never. In all but one student showed a gain of at least one point with the other student remaining the same and scoring the only "seldom" on the post test with all other students registering sometimes or often. Similarly, on Making a Complaint, four students scored a 1 or almost never on the pre-test and four others scored 2 or seldom. In the post-test, no student scored a 1, four scored a two and the rest all scored 3 or higher. Finally, only one of the ten students showed a decline in their average score over the ten behaviors and that decline was only .1 point from a 2.1 to a 2.0. As a former teacher, the evaluator would comment that shifting your most challenging students from rarely or almost never exhibiting positive behaviors to sometimes or often will make a dramatic difference in how a classroom functions, so these gains are significant.

Table III: Belle Haven Behavior Checklist			
Behaviors	Pre-	Post	Change
Listening	3.0	2.83	-.17
Deciding on what to do during free time	1.83	3.33	+1.5
Completing assignments	2.83	2.83	NC
Setting a goal	2.00	2.17	+.17
Ending a conversation	2.17	2.67	+.5
Joining in an activity	1.67	2.5	+.83
Knowing your feelings	2.33	2.83	+.5
Recognizing another's feelings	2.17	2.33	+.16
Expressing concern for others	2.33	2.83	+.5
Rewarding yourself	2.83	3.17	+.34
Ave.	2.32	2.75	+.43

The Belle Haven site also registered consistent gains, on the pre-post checklist with only one behavior declining (listening), one remaining the same (completing assignments) and all others showing significant gains. As with Bayshore, the two behaviors identified as least evident by teachers--deciding what to do during free-time (1.83) and joining in an activity (1.67) were the two behaviors that increased the most in the post-test with the 1.5 gain in deciding what to do during free time being the largest gain across all sites. Of the six students in the Belle Haven groups all but one student made significant gains, with the two students exhibiting the positive behaviors most infrequently (ave. score of 1.7 and 1.9) each making gains of over 1 full point and one student who had averaged a score of 2.4 on the pre-test, improving to a 4.0 on the post-test. The overall improvement in identified positive behaviors from pre-to post-test was .43 or 18.5%.

Table IV: Hoover Behavior Checklist Change			
Behaviors	Pre-	Post	Change
Listening	1.64	2.27	+.63
Asking for help	2.27	3.00	+.73
Introducing yourself	2.73	3.00	+.27
Apologizing	1.73	1.73	NC
Expressing your feelings	1.64	2.45	+.81
Dealing with your anger	2.09	2.27	+.18
Responding to teasing	1.64	2.09	+.45
Staying out of fights	2.27	2.91	+.84
Dealing with group pressure	1.82	2.36	+.54
Dealing with wanting something that isn't yours	3.00	3.64	+.45
Ave.	2.08	2.58	+.50

The Hoover site had the lowest average pre-test scores of any site just barely over 2.0 and with half of the positive behaviors rated below 2 (less than seldom). As with the other two sites analyzed above, Hoover also showed significant gains, with improvement identified in all but one behavior (apologizing) which remained at 1.73. Otherwise gains were made in nine behaviors with five behaviors increasing in frequency by more than half a point and an average improvement of .5. In addition, five of the eleven students served averaged less than a 2.0 (seldom) with three students averaging a 1.2, 1.3. and 1.4, the lowest student averages found at any site. All three students made gains on the post-test. The average gain from pre-to post-test was .50 or 19.3%.

As noted above, the Taft site served six students, but only retained the post-test scores for three students and pre and post-test results for the remaining three students were only recorded for six of the ten desired behaviors. As a result, drawing firm conclusions from these results is not possible. Results are reported below and do show generally positive change in four of the six behaviors, no change in another and a somewhat steep drop in teacher's noting evidence of children dealing well with wanting something that is not theirs. While a very small sampling, the increase of 1.28 points from pre to post-test represents a 64% increase. The table summarizing Taft's results is at right.

Table V: Taft Behavior Checklist Change			
Behaviors	Pre-	Post	Change
Joining in	2.67	3.33	+.66
Knowing your feelings	2.0	4.0	+2.0
Recognizing another's feelings	3.0	3.0	NC
Showing understanding of another's feelings	2.67	3.33	+.66
Using self control	2.33	3.0	+.67
Dealing with wanting something that isn't yours	4.33	3.0	-1.33
Ave.	2.00	3.28	+1.28

In summary, except for the Fair Oaks site where the post-test data was misplaced and unavailable, all sites showed significant gains from the pre to the post-test with Bayshore showing gains in all ten behaviors. The HSA contract called for an increase of 10% in positive social skills and according to the Streamlining Checklist, the four sites where pre and post-tests were administered all exceeded this 10% by wide margins. What's more, according to the Streamlining Checklist, across all sites, the average gain in Belle Haven and Taft were the only sites to have a decline in any behavior and each only had one. Average increases in positive behaviors targeted at each site ranged from .45 points to .5 points, .62 points to 1.28, although this last gain was among only three students. Taken together the consistency of attendance described in Table I and the consistent gains in teacher perceptions of evidence of positive student behavior points to a program that is making a significant impact at all five sites. HSA did not collect data on the numbers of student discipline referrals among program participants. The literature suggests that declines these referrals should be expected. For 2014-15, the HSA Program Director is going to work with the schools to obtain data on the number of referrals the semester prior to participation, the number of referrals during the semester that the student is participating and in the semester after participation. This should provide more evidence of the impact the program is having on child behavior. In addition, in 2014-15, HSA is going to begin communicating with parents, sending them

information about each child's 'homework' along with guidance as to how parents can reinforce student learning of more positive behaviors. Each semester, parents will be asked to complete the checklist which will provide more evidence as to whether or not the groups are having the desired impact, not just in school but at home. Finally, it is a concern that assessment results were mishandled at two sites, preventing a more complete analysis of the program's impact. This has been discussed with the program manager and is addressed further in EQ 7.

Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?

During meetings with the Program Manager, a plan was made for the administration of a teacher satisfaction survey that focused on communication, scheduling, responsiveness, and impact of the TPS program. The questions were identified after a review of prior end-of-year reports submitted by HSA to BHRS where there had been problems identified about these issues. Unfortunately, HSA did not administer the survey and while school is now again in session, the teachers would be being asked about the program from prior year. The Program Manager has agreed to use the satisfaction survey next year, both with teachers and parents each semester.

While no 'satisfaction' data is available, with a program enjoying such strong attendance and with teachers finding such marked increase in positive behaviors, it is likely that teachers would be satisfied. Without communication with parents (the case in 13-14) it is unlikely parents would have a credible opinion of the program. However, in 14-15, HSA is committed to more consistent communication with parents about the behaviors that are being fostered and how they can support this, resulting in the likelihood of more informed perceptions by parents.

Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?

The TPS successfully targeted and served the students at highest risk of social emotional problems at each of the five sites as determined by the teachers--who are best able to make this assessment. The population served was almost 100% students of color, with only one Caucasian student among the 38 students. The positive outcomes experienced at the four sites that collected pre and post-test data suggest that the program was responsive to the teacher-identified needs. For 2014-15, it is advised that parents are engaged and their support for skill development and program input sought.

Of the 38 children participating in the program, 26 come from homes where Spanish is the home language. The lead Community Worker who facilitated all the TPS groups is bilingual Spanish speaking. The PSWs who helped to coordinate the groups and have relationships with the teachers and the parents are all also bilingual Spanish speaking. In fact, one of the groups at Hoover was conducted in Spanish due to the language needs of the children in that group.

Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?

The vision, mission and values of San Mateo County Behavioral Health & Recovery Services stress empowering individuals to direct their own recovery process. BHRS stresses the adoption of culturally competent treatment approaches and through its MHSA planning processes, a further focus has been placed upon implementing evidence-based practices that have demonstrated the

capacity to support client wellness and recovery. From the perspective of prevention, BHRS has also described the journey towards a transformed system requiring that programs:

- move "upstream" to primary prevention strategies;
- partner with other health prevention efforts to focus on wellness and recovery;
- achieve desired outcomes; and
- integrate efforts to support sustainability;

The TPS groups clearly address the first bullet above, moving upstream, identifying children who are at risk at an early age and providing an evidence-based intervention that has shown positive results with grade-school children. Pre-test results show that among all 38 participating children, across a wide range of potential positive social behaviors, teachers had indicated that these positive behaviors were uniformly seldom evident. Elementary school children who seldom can control their emotions, follow directions, share, control their anger, ask for help, stay out of trouble or avoid fights, clearly are at-risk and in need of intervention. The TPS program is a strength-based, helping children develop social skills that will help them better navigate school, family and community stresses. In short, HSA targets young children whose teachers have identified them as being at very high risk and TPS provides an evidence-based approach designed to address the precise behaviors identified by teachers as needing development.

BHRS goals identified in the contract are listed below with commentary as to the degree to which the program has addressed these goals.

1. Reduce out-of-home placement.
2. Reduce risk and/or involvement in the juvenile justice system.
3. Increase school attendance.
4. Improve child functioning in home, school and community.
5. Achieve high level of consumer satisfaction.
6. Achieve high level of youth, family and professional partnership.
7. Achieve high degree of interagency coordination and collaboration.
8. Achieve high degree of cultural competence while addressing disproportional (over representation of a group) in reporting, removal, placement, reunification and permanence.
9. Reduce acute care usage.

Targeted children have been identified as being at risk of failure in the classroom and moreover have identified social skills needed to be successful at home or in the community. While most all the children are too young to be considered at risk of acute care usage, they do seem at risk in relation to each of the first four goals above. While HSA has addressed these four goals, it failed to collect satisfaction data that could measure the degree to which schools or parents are satisfied and more importantly, it has not provided individual family counseling or effectively engaged parents to help build their capacity to reinforce the skill-building conducted in the TPS groups. This is a missed opportunity.

Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?

Certainly the use of an evidence-based program with a track record of success in building positive social behaviors is one of the most important factors contributing to the success of the program. While no data was collected to validate that teachers felt that the program was

responsive to their needs, that teachers at all sites referred students and completed pre and post test surveys suggests that teachers bought into the groups. However, HSA should ensure that in 2014-15, teacher (and parent) satisfaction surveys are administered to validate this and/or identify ways the program could be strengthened.

According to the program manager, one area where HSA struggled with was in getting the students to turn in their TPSS 'homework' and practice. While no data was collected on this, the program manager indicated that it was not common for this work to be completed. The evaluator has suggested and the program manager has agreed that in 2014-15, facilitators will make a greater effort to engage parents, inform them of the importance of the homework and send home monthly communication describing the skills being worked on and how they can reinforce what is being learned. This should strengthen the program, enhance student learning of new behaviors, and increase student homework completion.

Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

While attendance in groups has been exemplary, service level only marginally below contract goals, and outcomes significantly exceeding contract goals, there is still room for improvement in program services and data collection. Specifically,

- Communication with parents should begin with the very first group, ongoing communication should be sustained throughout groups, consistent communication about the importance of students doing the homework should occur, and a end-of-group satisfaction survey should be conducted with parents;
- This parent communication should also include an offer to provide a comprehensive assessment which is the necessary first step toward accessing individual or family counseling services.
- Outreach and ongoing communication at Belle Haven, Taft and Fair Oaks should be conducted to increase group participation to the contract-stipulated eight participant level;
- The Program Manager should oversee pre-post test administration more closely to ensure that all students are tested and that records are maintained effectively so that all five sites can report on the behavior checklist; and
- The Program Manager should work with the principals at each site to explore the feasibility of tracking student discipline referrals and student attendance, each of which are important indicators of school success with the research identifying reductions in referrals as an outcome common to the program.

While these improvements would, no doubt, strengthen the program and improve the capacity of the evaluation to validate these improvements, the TPS program clearly is benefiting the children served and helping them build the kind of social skills they will need to succeed at home, in school and in the community and in so doing, contribute to their avoiding the need for higher end services and supports.

Section V Demographic Summary

The data below will be reported with different programs having customized reports if their programs have unique features that would benefit from separate reporting. For example, if a program:

- Offered its programs in different communities; or
- Offered the same program at a school to different students in the first semester than the second; or
- Delivered two or more very different program components, e.g. consultation to school professionals and direct service to children and/or families.

Table I: Demographic Summary					**Source of Data**
Total Unduplicated Served					
Gender		**Clients**	**Program Staff**		
	#	%	#	%	
Male	22	58%			
Female	16	42%			
Other					
Age	#		%		
Children 0-15	38		100%		
Transition Age Youth 16-24					
Adult (25-59)					
Older Adults 60+					
Families (can include families with children or TAY)					
Ethnicity		**Clients**		**Program Staff**	
	#	%	#	%	
Caucasian	1	2.6%			
Latino	30	79.0%			
African American	2	5.3%			
Asian	1	2.6%			
Pacific Islander	4	10.5%			
Native American					
Multi-Ethnic					
Other					
Home Language	**#**	**%**	**#**	**%**	
English	12	31.6%			
Spanish	26	68.4%			
Cantonese	0				
Mandarin	0				
Underserved Pops Served	**#**	**%**	**#**	**%**	
LGBT	0				
Blind/Vision Impaired	0				
Deaf/Hearing Impaired	0				
Veterans	0				
Homeless	0				

Program Components Table and discussion are on the next page.

Section VI Program Components:

The information in Table II will be used to report to MHSA as part of the statewide evaluation. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator.

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.		
	Yes	**No**
II-1) Access for Underserved Populations	**X**	
Details:		
II-2) Outreach for Early Recognition of Need	**X**	
Details:		
II-3) Access or Linkages to Care		**X**
Details:		
II-4) Reduction of Stigma		
Details:		
II-5) Screening for Needs	**X**	
Details:		
Program Activities	**Yes**	**No**
II-6) Addressing Trauma		X
Details:		
II-7) Specific Risk Factors	Risk factors include: lack of pro-social skills, risk of school failure, impulse control.	
Details:		
	Provide specific details very briefly. 1-3 sentences per line.	
II-7) Indicate the location where program activities occur (identify places where services occur	Five locations in San Mateo County. See	
II-8) Specify the roles for Peers (mentors Outreach, Peer education, other)…Please specify.	None	
II-9) Specify the sectors with which you collaborate on this program (housing, criminal justice, public health, education, child welfare)	Program collaborates closely with teachers, but could increase collaboration with parents.	

Section VII Program Alignment with SMC MHSA PEI Priorities:

Providers will mark Y for Yes for any community need or priority population addressed. In the space provided, please explain how these needs or populations were served. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator during which time a discussion will occur to amplify and provide details or examples.

Table III: Alignment with SMC MHSA PEI PRIORITIES				
	Children & Youth	**TAY**	**Adult**	**Older Adult**
1-PEI Key Community Needs				
1-A) Disparities in Access to Mental Health Services	X			
Details: The two major demographic populations served (Latino 79% and Pacific Islander 10%) are both identified as being under-served populations and having problems accessing mental health services.				
1-B) Psycho-Social Impact of Trauma				
Details:				
1-C) At-Risk Children, Youth and Young Adult Populations	X			
Details: Students were identified by teachers as lacking important social skills, placing them at risk as they mature.				
1-D) Stigma and Discrimination				
Details:				
1-E) Suicide Risk				
Details:				
2- PEI Priority Populations				
2-A) Trauma Exposed Individuals				
Details:				
2-B) Individuals Experiencing Onset of Serious Psychiatric Illness				
Details:				
2-C) Children and Youth in Stressed Families	X			
Details: While at this point HSA does not work with families directly, this is something being called for in the contract and being recommended by the evaluator for the 2014-15 year. Clearly young children lacking social skills in the classroom are likely to have behavioral issues at home as well and intervening early and in partnership with the parents should be a priority.				
2-D) Children and Youth at Risk for School Failure	X			
Details: Quite obviously students referred by teachers for lacking social skills in the classroom are by definition at risk of school failure.				
2-E) Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	X			
Details: Students who are unsuccessful in the classroom are disproportionately likely to become juvenile justice involved.				

Section I Agency & Program Description
I.A. Description of Program Services

Founded in 1889, Family Service Agency is San Francisco's oldest and largest provider of outpatient social services. In its 125-year history, FSA has been a leader in social service innovation having introduced numerous research-informed services and social service reforms over the years. These historic advances are FSA's legacy, a legacy that has continued into the 21st Century with the founding of the *Felton Institute* in 2004, to provide a home for university-FSA research partnerships and a home within FSA where innovation could be borne, tested, refined and replicated. FSA offers a unique setting for testing a broad range of social service innovations. FSA directs over 30 community-based social services, offered in 11 languages, serving more than 13,000 individuals of all ages. In 2014, FSA changed its name to Felton Institute since it was replicating a variety of innovative treatment approaches in communities outside San Francisco, San Mateo being one.

One of Felton's signature programs is Prevention & Recovery in Early Psychosis (PREP), developed in partnership with the University of California, San Francisco that is now operating in five Northern California counties. While delivered somewhat differently in each county, in San Mateo County PREP is comprised of the following five evidence-based practice components:

Early, rigorous diagnosis: The PREP diagnosis and assessment is both rigorous and comprehensive, addressing not only the psychotic disorder but other mental health or substance abuse issues the client might have. The focus of PREP-SMC is on first onset clients, PREP used the Structured Clinical Interview for DSM-IV (SCID). PREP staff goes through a one-year training, testing, and clinical supervision process to ensure that they can use these tools reliably.

Cognitive Behavioral Therapy for Early Psychosis (CBTP): Widely available in England and Australia but not in the US, this therapy teaches clients to understand and manage their symptoms, avoid triggers that make symptoms worse and to collaboratively develop a relapse prevention plan. CBTP represents the heart of the PREP intervention.

Algorithm guided Medication Management: The first goal of the PREP medication algorithm is to guide the doctor, the patient, and the family toward finding the single best antipsychotic medication—one that can provide symptom control with the fewest side effects. This then becomes a medication regimen to which the client is much more likely to adhere over the long-term. Secondly, the algorithm guides treatment for the additional behavioral health issues that a client is experiencing. Third, the model emphasizes close coordination between therapist, psychiatrists, clients, and family members. In the PREP model, all treatment options are explained (including risks as well as benefits). A treatment plan is developed that coordinates medication with psychosocial treatment, that has the agreement of all parties (including the client and outside providers, as relevant), and that is closely monitored for effectiveness over time.

Multifamily Psychoeducation Groups (MFG): A number of studies have shown that extended multifamily group education and support has a strong positive impact on outcomes for the client, independent of the client's level of commitment to treatment. PREP provides MFG groups for the families of teens and young adults experiencing schizophrenia. Even when the primary client chooses not to attend treatment, the family is served. In addition to MFG, PREP engaged family members in individual/family psycho-education, consultation with family about medication and case management.

Education and Employment Support: Schizophrenia tends to erupt into a young person's life during the time when they are making the most important steps into adulthood. PREP follows Dartmouth's *Individual Placement and Support* (IPS) model of education and employment support. This model

was developed specifically to assist people with mental health problems to find and retain competitive employment. The approach emphasizes a swift return to the competitive workforce or education rather than volunteer work or extensive training. The intent is to normalize the client's life experience as quickly as possible.

I.B. Research Basis for Approach

PREP is based upon research that shows the efficacy of early intervention in treating early psychosis. A 2009 Australia study that used a matched historic cohort to assess the comparative impact of Early Psychosis Prevention & Intervention Teams with a matched TAU group. In an eight-year follow-up, EPPIC participants experienced significantly fewer and less severe symptoms, with 62.5% not actively psychotic in the last two years compared with only 33% of TAU and with over half of EPPIC participants experiencing a continuous symptom-free course while less than a fifth of TAU did so. What's more, this level of symptom relief was delivered at a fraction of the cost of TAU as the average annual costs for services were $3445 versus TAU costs of $9503. This is but one of many UK studies validating the importance of early intervention (Mihalopoulos C., Harris M., Henry, L., Harrigan S., and McGorry P. 2009).

To maximize the benefit of an early intervention, PREP integrates the five EBPs identified above into a single treatment approach. A very brief summary of research support for the efficacy for each of the EBPs employed is provided.

Research-based Diagnoses. The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) is a diagnostic exam used to determine DSM-IV Axis I disorders (major mental disorders). The SCID-II is a diagnostic exam used to determine Axis II disorders (personality disorders). There are at least 700 published studies in which the SCID was the diagnostic instrument used.

Algorithm Guided Medication Management. The PREP medication algorithm is based upon the Texas Medication Algorithm Program (TMAP), the largest study of the use of algorithm-based medication management with individuals with schizophrenia. In the TMAP comparison study, after 3 months of treatment, patients with schizophrenia who received treatment in the sites that were trained and staffed to use the TMAP algorithms had greater improvement in symptoms than did patients in the comparison sites (Miller AL, Crismon ML, Rush AJ, et al, 2004). Patients in both algorithm sites and nonalgorithm sites showed improvement over time in test scores measuring cognitive functioning, ***with the patients in the algorithm sites showing greater improvement that was sustained as of the final (9 mo) measurement of cognitive functioning.*** What's more, algorithm-based medication has been shown to reduce medication costs while improving client outcomes (Kashner, T; Rush, AJ; Crismon, AL; Toprac, M; Carmody, T; Miller, A; Trivedi, M; Wicker, A; Suppes, T., 2006).

Cognitive Behavioral Therapy for Early Psychosis (CBTp). CBT for early psychosis has a growing evidence-base and has been established as a recommended treatment for schizophrenia, having been included in schizophrenia guidelines published by the National Institute of Clinical Excellence in the United Kingdom. In a meta-analytic review of 34 randomized controlled trials, Wykes and colleagues concluded that CBT for psychosis is associated with improvements in positive symptoms, negative symptoms, and functioning Til Wykes, Ph.D.; Vyv Huddy, Ph.D.; Caroline Cellard, Ph.D.; Susan R. McGurk, Ph.D.; Pál Czobor, Ph.D., 2011). In a more recent study, CBT was also shown to have significant impact on positive and general symptoms six months beyond treatment for clients who had been medication resistant (Amy M. N. Burns, M.Ed.; David H. Erickson, Ph.D.; Colleen A. Brenner, Ph.D., 2014).

Family Psycho-education. Family involvement, particularly in psycho-educational groups, can create a supportive therapeutic community that has resulted in significant reductions in relapse, reduced acute episodes and increase adherence to medication regimen. In three studies, participation in Psycho-educational MultiFamily Group (MFG) correlated with significantly improved client outcomes and reduced reliance upon emergency psychiatric hospitalization. In one study, a total of 172 acutely psychotic patients, aged 18 to 45 years, with DSM-III-R schizophrenic disorders were randomly assigned to single- or multiple-family psycho-educational treatment at six public hospitals in the state of New York.

Supported Education. Seventeen randomized controlled trials of the efficacy of Individual Placement Support (IPS) were conducted between 1996 and 2012 in various parts of the USA and in a number of countries abroad. Competitive employment rates were significantly higher in programs that implemented the IPS model. More jobs were acquired, for more hours per week, with a shorter period of time to placement on the job, and for better wages, in the IPS model programs than in the controls. Research also indicates that programs that followed the IPS model, conducted fidelity reviews and used the results of fidelity reviews to drive performance improvement had consistently better employment outcomes for enrolled consumers.

Taken together, the research strongly suggests that early intervention in early psychosis is critical to reducing long-term care costs and increasing the likelihood of sustained recovery. What's more, the components that comprise PREP's service model each have a strong basis of support in the literature. Certainly, PREP meets one of BHRS' priorities in the use of PEI funding: that interventions be grounded in research and represent evidence based practices.

I.C. Target Population, Number Served and Sites

Felton's contract called for it to begin engaging 80-100 eligible SMC residents and after a year of operations serve 48 clients a year. During the program year 2013-14, PREP engaged 84 potential clients with 46 of those engaged in the program. The contract did not stipulate a definition of clients served or stipulate a sustained caseload. Caseload and clients served is analyzed under Evaluation Question # 1. The demographic breakdown for clients served is captured in Table I, below. While no stipulation in the contract indicated that 'under-served' populations be targeted, clearly PREP engaged highly diverse populations with almost two-thirds being from populations of color.

Table I: PREP Client Ethnicity Summary

Caucasian	Latino	Afr. Amer.	Asian	Pacific Isl.	Nat. Amer	Mixed	Other
34.8%	32.6%	4.3%	13.0%	8.7%	0.0%	2.2%	4.3%

Section II Evaluation Process

The evaluation plan was developed in two stages, in June-July 2013 through a series of participatory meetings that included the evaluator and Felton's Research Director, Dr. Erika Van Buren. A second series of meetings was held in July 2014 with the new Research Director, Dr. Shobha Pais, and the new Research Assistant, Julia Gloria Godzikovskaya. In addition, the evaluator consulted with Drs. Rachel Loewy (UCSF) and Kate Hardy (UCSF and now Stanford), each of whom played key roles in the development of the PREP model. Considerable work was done by Ms. Godzikofskaya, and others at Felton, to extract data from Felton's data system. The results of these

efforts are evident in the quality of the evaluation below. Among the data collected and reported by PREP:

- Client-level data was collected on attendance in all program components;
- Demographic and home language data was collected on all clients;
- A range of validated tools were used to capture change in client symptoms with these tools being administered at six month intervals;
- A highly detailed Semi-Annual Evaluation Form Consumer Evaluation Tool completed by all clients that is comprised of an array of validated tools was used to assess client satisfaction with an array of programmatic components—this semi-annual evaluation is composed of a number of validated assessment tools that provides a robust report not just on client satisfaction but in relationship to therapist-client alliance, access to various program components, symptoms and symptom management and other measures important to understanding the program's impact. These validated tools are described below; and
- A Staff Survey was developed by the evaluator and administered to assess the degree to which staff felt prepared to deliver PREP's complex model, the impact of staff turnover and to identify areas of the program that staff felt could be improved.

Together these tools provided ample data for answering the evaluation questions that form the framework of this evaluation. It should be noted that there was considerable back and forth between the evaluator and research staff at PREP. It is clear that the complex data systems they utilize were not aligned well and depending upon who ran which report, data on service delivery varied significantly initially. The process led PREP to unearthing these inconsistencies, determining and fixing the source of the problem—usually inconsistent data entry or definition of terms in preparing reports. In the end, the process led PREP to retool its data entry and report generation system, significantly strengthening its ability to generate accurate reports on program services and outcomes.

Section III Evaluation Findings

There are seven evaluation questions that frame the evaluation of the Prevention & Early Intervention programs supported with Mental Health Services Act funds.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to the contract funding the program?
Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?
Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?
Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?
Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?
Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?
Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

Evaluation findings are described in detail below, but in brief, PREP collected far more data on program operations than any PEI program resulting in a robust understanding of program operations and their impact. This shed considerable light on all that worked at PREP while also illuminating important areas where improvement would be desirable. Clients experienced a reduction in symptoms and significantly reduced level of hospitalizations, with every one of a dozen outcome measures showing improvement to varying degrees. What's more, clients were extremely satisfied with the program as is evidenced through a detailed client self-assessment survey administered every six months. These important outcome gains were achieved despite some areas where significant improvement in service delivery is indicated, something that PREP leadership has fully embraced. A summary of findings and areas for improvement is provided below. These findings are described in detail under EQs # 6 and 7. The most important findings are identified first.:

Staff turnover. The impact of ten staff changes within a 12-month period is compounded by a complex treatment model for which staff must be trained. This created a significant challenge to consistent service delivery and consistent charting. In relation to charting, the evaluation itself revealed how turnover and a complex data system led to inconsistent charting. The process has led to changes in protocols around data entry and a better understanding of how this impacts reports that PREP relies upon for program improvement. PREP leadership has also identified program design changes to help prevent turnover and reduce its impact when turnover inevitably occurs.

Multi-Family Group (MFG)-Family Engagement. While prep providers effectively engaged families in a variety of consults related to medication, case management, and psycho-education and initiated a psycho-educational Friends & Family group as a vehicle for engaging even more families, this did not translate into high numbers of families participating in the therapeutic MFG groups. PREP leadership has identified strategies deployed in the Stockton PREP site that will significantly improve family participation in MFG.

Medication Charting. While the data showed that many clients did not receive medication consultations, it appears that this is more a function of inconsistent data entry than a function of not delivering medication consultations. Many PREP clients enter the program with medication prescriptions and sustain their relationship with the prescriber. In these instances, the PREP Nurse Practitioner consults directly with the prescriber and it appears that these consultations are not being captured.

Medication Consultation. Nonetheless, the data also shows that many clients who are not using medication, have not had even one consultation regarding medication, something that PREP leadership has agreed to address. PREP needs to ensure that all clients, including those not utilizing antipsychotic medications have at least one medication consultation as the PREP model calls for all clients to have a medication consultation monthly—regardless of whether the client is using medications.

Client Engagement. It would benefit PREP to continue its efforts to identify and define signs of clients who are not engaged fully in treatment and are at high risk of hospitalization. While PREP did reduce hospitalization episodes by 34%, this reduction was compromised significantly by two clients with 166 and 67 days in the hospital.

Continue to clean data system and clearly define PREP Model. Service utilization data across program components show inconsistent patterns of data entry and/or definition of criteria in

preparing reports. This initially led to significantly different summaries of service delivery and/or outcomes. From data provided, it is clear that potential clients contact PREP, schedule an assessment, and if eligible, begin to schedule appointments for case management, CBT, medication consultations, and IPS while PREP initiates engagement with family. But some clients appear to spend considerable time in the engagement process, completing the assessment, meeting with a case manager and perhaps having a medication consultation, but not becoming fully engaged by the program. There does not appear to be a clearly defined point where this newly engaged individual is considered a "PREP client" who is fully enrolled. What's more, PREP does not have a clear set of minimum threshold service levels for clients enrolled in the program. It is unclear how many CBT sessions, medication consultations sessions or IPS trainings should occur per quarter or what percent of clients are expected to have an engaged family member of friend engaged in the program and participating in F&Fs groups and/or MFG. While PREP is customized to meet the individual needs of each client, some threshold levels of service delivery is necessary to define what being in PREP means. Finally, criteria that would distinguish a client exit as either a 'drop out' or a 'graduation' does not exist. The charts simply indicate that a client has terminated from the program. PREP needs to clearly define a graduation from a drop out.

Many of the inconsistencies in data collection and reporting were resolved during the evaluation process and leadership has developed strategies for clarifying terminology and expectations regarding service delivery and program exit. These issues are discussed in detail below. ***However, these issues aside, it is important to acknowledge that of all the PEI programs, PREP is by far the most complex involving the use of five EBPs with a population that is difficult to engage. PREP has achieved significant positive outcomes across the board and as importantly, PREP leadership has entirely embraced the evaluation findings and is using them to inform significant improvements in how PREP is delivered and how data is collected and reported.*** With these changes in place in the next few months, the evaluator would expect that the outcome gains experienced in 2013-14 would improve and clients would experience a more consistent, more highly structured program with that improved experience being captured in the data.

Each evaluation question is discussed separately below.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to its contract?

PREP was launched in San Mateo County in 2011, with a planned ramp up of services reaching full operation 18 months from start-up. This evaluation covers a time frame when the program had been fully launched and so efficiency of the program will be discussed in terms of the degree to which it has met contract objectives in relation to clients served and services delivered.

As noted above, the contract called for PREP to engage 80-100 residents ages 18-35 and serve 48 clients each year. While PREP largely met these objectives by engaging 84 residents and serving 46 with an average monthly census of 40.5 and with the census climbing from July 2013 (34) to December (40), and May (49) it would be better if the program could sustain active caseloads of 48 throughout the year. The contract did not specify the number of services to be delivered of each of the EBP treatments described above, the table below describes with some precision the level and type of services delivered. The contract does not specify the length of time a client should be served or define how a client could be considered to have successfully 'graduated.' During the 2013-14 program year, nine clients exited the program with another seven exiting in

July 2014. While the numbers reported generally meet contract stipulations, going forward, it would be useful to create clear definitions for what distinguishes between a client 'dropping out' and a client successfully graduating from the program. What's more, the data shows clients 'enrolled" in the program for as long as 30 months and with many clients in the program for 18+ months and it is very hard to assess whether clients in the program were in a kind of contemplative phase upon entry, perhaps meeting with the case manager and participating in medication consultations but not being fully engaged in the program, followed by a period where the client is fully engaged in the program, participating in CBT, medication consultation, IPS employment / education supports and in family work. It is likely that this phase of full engagement is followed by a period where clients may still be enrolled but are now in a more stable, aftercare phase. PREP leadership feels that they need to precisely define these phases operationally and specify with precision the dosage of each program component that should be delivered during each phase. Not only would this result in a more precise evaluation, more importantly, it would make the program more accountable internally. In conversation with PREP leadership, they acknowledged the need to create these definitions.

Table II: Service Delivery Summary

Service	Total	Ave per Client	Details-Comments
SCID Assess.	49	N/A	During the 13-14 program year, PREP completed 49 SCID assessments resulting in 18 new intakes during the year resulting in an increase in the caseload from 34 in July 2013 to 47 in June 2014.
CBT Session	933	20.3	The average shows an average of almost 2 sessions a month. A closer look at the client-level data shows that 25 clients received 15 sessions or more with seven others receiving at least 10 and nine receiving 3 or less. CBT, case management and IPS supports appear to be the PREP components most consistently accessed by clients.
Med Mgt. Consult.	415	9.06	The average of 9 sessions per client masks client-level data that reveals that 19 clients received no medication consultation and six received but one, meaning that over half of the clients served had one or less medication consultations. However, according to PREP client files only 19 clients were utilizing anti-psychotic medication during the year and fourteen of these clients received 10 or more medication consultations while six others received at least 5. The low-level of medication consultations is mitigated by delivery of family consultations focused on medication issues that were delivered to 16 clients with a total of 134 such consultations provided over the year, or over 8 per client. Another factor contributing to the low number of consultations is a combination of poor reporting and frankly, failure to fully implement the model. Poor recording is a factor because many PREP clients continue their relationship with their psychiatrist who continues to monitor their meds. PREP leadership indicated that the Nurse Practitioner should be recording consultations with these outside psychiatrists and because that had not been occurring, those medication consultations are not reflected in the data. While inaccurate charting may partially describe the low number of medication consults, it is clear that many clients are not having consistent medication consultations. While the above data suggests that clients are not accessing sufficient

			medication support, in the Client Satisfaction survey, only 4 clients disagreed or strongly disagreed with the statement that they were able to discuss medication options or that they were able to discuss medication side effects, suggesting that among clients surveyed, there was consensus that medication consultations were available. What's more, a review of the Medication Adherence Rating Scale (MARS) scores described below suggests that those clients using medications are increasing in adherence over time (see EQ 2 below) again pointing to effective medication supports. ***Surveys aside, the PREP model calls for every client to receive an initial medication consultation and continuing consultations regardless of whether or not they are taking antipsychotics. This is an area of concern that PREP leadership acknowledges needs to be addressed.***
Family Engagement and Family Groups	89	1.934	Data provided by PREP indicates that 91 family members were involved in treatment, with all but one of 46 clients having at least one family member identified as being engaged in treatment. The 91 family member figure represents formal staff-family member contacts and this total meets the contract requirement of 80-100 family members engaged. The range of involvement is captured by the number of family case management episodes (232 or an average of 5 per client); family medication conferences (134 among 16 clients or an average of 8 per client); and family psycho-education contacts (390 or an average almost 8 per client family). From this data, it appears that PREP successfully engaged high numbers of family members and substantially involvement in the treatment plan. While no specific levels of involvement in MFG were stipulated in the contract, it is very clear that despite the high level of family engagement MFG was not engaging sufficient numbers of families. The average number of MFG sessions per client is below 2. A closer examination of client-level data reveals that only 4 clients had ten or more MFG sessions with 5 others receiving 3 or more. In other words, of 46 clients in the program, less than 10 experienced more than two family sessions. Indeed, over half of all clients (24) had no family sessions at all. What's more, of the twelve clients in the program 18 or under, only three participated in MFG, none more than twice. The PREP contract describes MFG as being a six-module program meaning that only four clients and families achieved this threshold. Certainly staff turnover and transition could have contributed to the failure to engage families more effectively. Another factor is that MFG is a closed group that operates twice monthly. During each cycle new families can't be added to the group. Recognizing that it was having a difficult time engaging families in MFG, PREP developed the psycho-educational Friends and Families Groups to serve families waiting for a new MFG group and to provide some level of psycho-education that might better prepare these families for MFG. The Friends & Family groups are offered alternate weeks (on weeks that MFG is not offered) and as families become more familiar with them, they could serve as a bridge to MFG. But given that in the spring of 2014 (when F&F groups were first initiated) only seven families have attended at least one F&F session, it appears that engagement of families for scheduled sessions is a challenge whether in relation to F&F or MFG. MFG is a highly structured therapeutic group that is closed so that new families must wait until a new cycle begins. While designed as a bridge to MFG, there is no evidence that this is occurring as reflected in the very low participation rates of families in MFG. While PREP's contract does not stipulate a specific number for how many clients and families will participate in MFG or for how many sessions will occur, it is a central component of the PREP

			model and the contract stipulates that it is a six-module program, suggesting that clients/families should participate in a minimum of six sessions. This is simply not occurring. Certainly not all PREP clients will want to involve there families in treatment, but part of the PREP model calls for engaging a circle of family ***and/or friends*** who are educated and prepared to support the client's sustained recovery after program exit. Clearly, however you define family, the consistent development of friend/family support systems is an area in which improvement is strongly indicated. PREP leadership recognizes this as perhaps the single most important program improvement revealed in the evaluation and has developed strategies outlined under EQ 7 below.
Voc'l / Educ'l Support	833	18.1	The average number of educational/vocational support services is somewhat inflated as PREP clinicians did not distinguish between case management and educational and vocational consultations since typical case management sessions involved one or both of educational and vocational issues. This aside, the 18.1 average shows consistent levels of support. Client-level data showed that 20 clients received at least 15 of these consultations. While staff turnover has been identified as a problem and is analyzed below, there has been no turnover in IPS as the same Care Advocate has been delivering IPS services for two years, a real program strength.

The analysis above is based upon was based upon the 46 clients served over the course of the 13-14 program year, but some of these clients may have entered in spring of 2014 meaning they would have had less opportunity to be engaged in services and receive a full compliment of services available. Similarly some of these 46 clients may have entered in 2012 or 2013, been served for some of 2013-14 and exited after only a few months of the program year. However twenty-eight of the 46 clients included above were enrolled the entire 2013-14 program year. Table III below captures the same data above but just examining these 28 clients.

Table III: Services Delivered **Service**	**Total**	**Ave/ Client**	**Details-Comments**
SCID Assess.	N/A		Discussed above
Active Caseload			The average caseload was calculated by obtaining the caseload at the start of each month and dividing by 12. The average caseload was 40.5 with a range of 32 to 49. The caseload did increase over the year as in July and August the caseload 34 and 33 and by the spring it ranged from 43-47.
CBT Session	777	27.75	The average number of CBT sessions is 30% higher with these more engaged clients than with the full client census (above) and fully 22 of the 28 clients had at least 15 sessions and ten was the fewest number.
Med Mgt. Consult.	327	11.68	Ten of 28 clients had no medication management consultation and two had one each, suggesting that these clients were not utilizing medication. Among the 18 clients who were using medication ten clients had at least 18 sessions and an additional four had at least five sessions. Data in the previous table also describes a relatively high number of family consultations related specifically to medication (134). As per above, improved charting will enable PREP to track medication consultations with outside prescribers and no interpretation of the level of medication consultations conforms with the proscribed PREP model of at least one consultation with every client, regardless of whether they are using medications.

Table III: Services Delivered			
Family Engagement and Family Group	70	2.5	Family engagement numbers above related to case management, psycho-education and medication consultation provide ample evidence of successful family engagement. While among more active clients, the average number of MFG sessions rose from under two to 2.5, the increase is not significant. Twelve of he 28 clients had no MFG and of the seven clients 18 and under, only three had MFG sessions and none had more than three. Given that the contract stipulates that MFG is a six-module program the data reveals that none of the younger clients (18 and under) met this threshold and four didn't have any MFG sessions. As noted above Friends & Family Groups are being offered on alternate weeks, potentially a good bridge to MFG, but not a viable alternative. The evaluation recommends that PREP find administrative and clinical strategies to increase friend and family member involvement in both F&F groups and MFG.
Voc'l / Educ'l Support	684	24.42	As in Table II, this component was the most consistently delivered with all clients receiving at least one and 23 of 28 clients receiving at least ten sessions.

The service dosages were higher across all service components among the 28 clients that were enrolled the full program year, suggesting that they were more engaged in services. However, a concern remains related to inconsistency in recording and/or delivering medication consultations and the very low rate of participation in MFG. What's more, a close examination of client-level data makes it difficult to gauge the consistency with which clients are experiencing each component in a coordinated way. Clearly defining phases of treatment, as described above, would help clarify this and make it easier to manage clinician case loads as each provider could have a balance of pre-treatment, engaged, or transitioning to aftercare clients.

One factor that may have impacted the lower number of intakes, the failure to engage families and to deliver more consistent services relates to staff turnover. Retention in mental health programs is a well-recognized concern, cited in the President' New Freedom in Mental Health Commission which stated that without significant attention to workforce development in the mental health field, all of the Commission's goals were largely unattainable. Indeed in a Community Living Brief published by the Independent Living Research Unit the following amplification on this issue was identified.

> "Although staff shortages affect all levels of professionals, including psychiatrists, social workers, and psychologists, the problem is especially daunting for mental health workers whose jobs do not require advanced degrees, for example case managers, frontline hospital staff, community treatment workers, and mental health technicians."

It is worth noting that PREP relies almost entirely upon staff who do not posses advanced degrees. It is also worth noting that the majority of PEI programs were impacted by staff turnover to a significant degree.

Table IV, below, depicts the timing of staff turnover and the resulting staffing levels throughout the year. Direct Service Clinicians are coded in black, administrative support is shaded light and administration and supervision is shaded dark. As noted, PREP's program relies heavily

upon staff without advanced degrees and while paying salaries comparable to other community based mental health programs can't compete with public sector or HMOs and PREP's heavy investment in training makes experienced PREP clinicians highly marketable. So it is no surprise that PREP experienced significant turnover during the program year. Indeed, over the twelve-month period ten staff exited the program. This turnover could well be a contributing factor to the difficulty experienced sustaining involvement of family members in MFG and the challenges in sustaining consistency in charting and data entry. While family engagement and consistent data entry may have been impacted by turnover, it is worth noting that except during the month of December, PREP did have at least three therapists on staff, with four being in place from April through the end of the program year. December was also the only month without supervision from an Associate Director. It is worth noting that a Peer Advocate was in place and providing IPS services throughout the entire year and indeed has been a consistent PREP provider for over 24 months. But clearly staff retention is an issue and one acknowledged by PREP leadership.

Table IV Staff Retention

Title	FTE	J	A	S	O	N	D	J	F	M	A	M	J
Therapist/Care Manager	1												
Case Manager	1												
Staff Therapist	0.53												
Therapist	1												
Staff Therapist	1												
Therapist	1												
Staff Therapist	1												
Family Partner	1												
Nurse Practitioner	1												
Care Advocate (IPS)	1												
Research Assistant													
Receptionist/Admin. Assistant	1												
Clinical Program Manager	1												
SCID Assessment Supervisor													
Associate Director	1												
Medical Director	1												
Associate Director	1												

The issue of staff turnover is discussed in more detail under EQs # 6 and 7.

Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?

To evaluate program impact, the evaluation examined changes in client symptoms, medication adherence, and functioning, as well as levels of psychiatric hospitalizations. To measure changes in symptoms, functioning and medication adherence PREP utilized a battery of standardized assessment tools identified in Column 2 below. A brief summary of each instrument is provided below.

PHQ-9. The Patient Health Questionnaire Depression Scale (PHQ-9) is a 9-item depression scale from the Patient Health Questionnaire (PHQ). It yields a single score ranging from 0 to 27 that yields both provisional diagnosis of depression and a measure symptom severity. The PHQ-9 has proven to be sensitive to change over time. It has been validated in a variety of U.S. practice settings and used successfully in international contexts.

GAD-7. The Patient Health Questionnaire Anxiety Scale (GAD7) is a validated 7-item measure of generalized anxiety scale from the Patient Health Questionnaire (PHQ). It yields a single score ranging from 0 to 21 that yields both provisional diagnosis and a measure symptom severity.
MARS. The MARS is a 10-item self-report scale of medication adherence that is specifically designed for individuals with psychosis. The MARS assesses willingness and ability to take oral medications, as well as perceptions of medication side effects. The MARS is only completed by consumers who are currently being prescribed medication for psychosis at the time of evaluation.
QSANS-QSAPS. Both tools involve the provider assessing the level of positive and negative. symptoms manifest in the client using the Quick Scale for the Assessment of Positive Symptoms (QSAPS) and the Quick Scale for the Assessment of Negative Symptoms (QSANS). On both scales, providers are asked to rate the presence of positive and negative symptoms on a scale of 0 to 100, with the following response anchors: 0= "Absent," 20= "Minimal/Questionable," 40= "Mild/Minimal," 60= "Moderate," 80= "Marked," and 100= "Severe." Responses associated with positive symptoms (e.g. hallucinations, delusions), disorganized symptoms (e.g. disorganized speech, disorganized behavior, agitation/aggression), and negative symptoms (e.g. affective flattening or blunting, alogia, avolition, anhedonia, and asociality) were summed and averaged to create 3 scales. Two items were also added to assess distress associated with hallucinations and delusions, respectively.
Global Functioning Scale. The GFS Social scale assesses the "quality of peer relationships, level of peer conflict, age-appropriate intimate relationships and involvement with family members" (Cornblatt et al., 2007). The GFS Role scale assesses performance in school, work and domestic responsibilities. Both scales provide an assessment of functioning that accounts for age and stage of illness, that avoids confounding functioning with symptoms of illness, and that are specifically designed for use with individuals in prodromal and recent on-set phases of psychosis (Cornblatt et al., 2007). Each of the two scales is assessed with a one-item measure of functioning. Both are rated on a 10-point rating scales and detailed criteria is provided for each response option. The same scale is used to make ratings of current functioning, highest functioning in the past year, and lowest functioning within the past year.

The table below includes the use of p-value to project the degree to which the change described could be attributed to the PREP intervention or could have occurred randomly. Another way to express this is that the p-value is a measure of the degree to which the change in measure is statistically valid with the lower the p-value the higher the validity. Generally, a value between zero and .05 is viewed as being highly valid, a p-test value between .05 and .1 having low level of validity and a p value over .1 having no significant validity. Scores related to all measures except medication adherence and functioning decrease to reflect a reduction in symptoms, the MARS and GFS scales increase with improved adherence and functioning. As can be seen from Table V, all outcomes trend in the right direction with all symptoms showing signs of reduction, functioning improving and medication adherence increasing.

Table V: PREP Impact on Client Condition

Symptom	Tool	N	Baseline	Post	Difference	p-value (1-tailed)
Depression	PHQ9	19	9.26	6.21	3.05	0.022
Anxiety	GAD 7	19	6.53	4.58	1.95	0.018
Med. Adherence	MARS	11	6.64	7.00	0.36	0.320
Psychosis						
Positive	QSAP	19	37.55	29.87	7.68	0.105
Distress	QSAP	19	29.08	20.42	8.66	0.107
Negative	QSAN	19	48.63	39.75	8.88	0.059
Disorganized	QSAN	19	29.09	22.14	6.95	0.068
Functioning	GFS	24	50%	79%	29%	0.158

The strongest and most valid gains were in relation to reductions in anxiety and depression. In relation to depression a score of 5-9 indicates mild depression with

a score of 10 representing moderate depression and a score of 4 indicating minimal depression. Hence, PREP clients moved from moderate depression at intake to the lower end of mild depression. In relation to the GAD 7 measure of anxiety, a score of between 5-10 represents moderate anxiety with a score below five representing mild anxiety. PREP clients on average moved from moderate anxiety to mild anxiety. In relation to evidence of psychosis, clients achieved moderately significant improvement in relation to Negative psychotic symptoms and in relation to disorganized thinking. Again, in relation to all of the above measures, the trend lines were in the direction of improvement.

As Table VI illustrates below, PREP clients also experienced significant reductions in psychiatric hospitalization events (-54%) as well as a reductions in total hospitalization days (-34%). Given the very significant reduction in hospitalization events, the relatively small reduction in hospitalization days is surprising until you examine client-level hospitalization data. Voluntary hospitalization days showed a reduction consistent with the reduction in intakes, but involuntary hospitalizations were significantly impacted by two clients one of whom was hospitalized involuntarily while in PREP for 67 days and another client who was hospitalized for 162 days. If these clients were omitted from the analysis the number of involuntary hospitalization days would drop by 229 days, resulting in a total decline of 459 hospitalization days and an even more significant 67% drop in days hospitalized. The impact of these two clients' hospitalizations masks significant improvement among the remaining clients.

Table VI : Hospitalization Intakes and Days Year Prior to PREP & While Enrolled

	Intakes			Hospital Days		
	1-Year Pre-PREP	During PREP	Change	1-Year Prior	During PREP	Change
Voluntary	11	9	-2 (-18%)	138	76	-62 (-45%)
Involuntary	59	19	-40 (-62%)	540	372	-168 (-31%)
Total	60	28	-32 (-54%)	678	448	-230 (-34%)

Table VII: Client Hospitalization Days

Hospitalization Days	**#**	**%**
Clients who reduced #	27	59%
Clients who maintained (at 0)	11	24%
Clients who increased	8	17%

Another way of viewing PREP impact on hospitalizations is to measure the number and proportion of clients who either reduced the number of hospitalization days or who had not experienced hospitalization days prior to or during PREP. Fully 27 PREP clients experienced a reduction in the number of hospitalization days from the prior year and an additional 11 clients who experienced no hospitalization days either the year prior or the year while in PREP. Lastly, ten of 46 clients experienced at least ten days of hospitalization prior to PREP and experienced zero hospitalizations while in PREP. Table VII at left summarizes this. Clearly, over 80% of clients either reduced reliance on higher levels of care or maintained their level of care without hospitalizations. This meets one of the contract requirements of 80% maintaining their level of placement. Not only did 80% maintain that level just shy of 60% decreased it.

Nonetheless, the PREP program is designed to engage and support ***any*** individual experiencing early psychosis and it is worth considering how PREP might be better able to identify client disengagement early and provide intervention and support to prevent extended hospitalization use by even just two clients. The challenge of identifying clients with potential for intense need for long-term hospitalization and effectively intervening with those clients to prevent or at least reduce hospitalizations is discussed under EQ # 7.

Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?

In order to assess client satisfaction, PREP went well beyond gathering data on a narrow definition of satisfaction, administering the Working Alliance Inventory (Short Form), a 12-item survey that across multiple studies has been a very strong predictor of positive client outcomes. In addition, PREP administered Naik and Bowden's (2008) Service Satisfaction Scale, an 18-item assessment that assesses satisfaction with services along a number of very specific and critical domains of service delivery. As Tables VIII and IX demonstrate clearly, PREP clients are extremely satisfied with services. Table VII summarizes the data captured in the 25 clients who were in the program for at least six months during the program year 2013-14. As reflected below, the questions ask respondents the frequency with which specific client-clinician relationship qualities were manifest. The Working Alliance Inventory uses a seven-point scale and with the exception of items 4 and 10 (which should be reverse scored) the lowest average response was 4.8 (Item 2) and the highest was a 5.58 (Item 7). The distribution of scores shows that the vast majority of clients found the positive qualities always or very often present and on the other end of the scale only about 20% of clients found positive relationship qualities absent. Clearly, the vast majority clients felt positively about their relationship with their clinician.

Table VIII Working Alliance Inventory Short Form

Question	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always	Ave
	1	2	3	4	5	6	7	
1. My clinician and I agree about the steps to be taken to improve my situation.	4	1	2	2	4	2	10	4.88
2. What I am doing in therapy gives me new ways of looking at my problem.	4	2	2	1	3	4	9	4.8
3. I believe my clinician likes me.	3	1	2	0	1	4	14	5.52
4. My clinician does not understand what I am trying to accomplish in therapy	*12*	*4*	*4*	*2*		*1*	*2*	*2.40*
5. I am confident in my clinician's ability to help me	3	1	2	2	2	4	11	5.2
6. My clinician and I are working towards mutually agreed upon goals.	4	0	3	2	1	5	10	5.12
7. I feel that my clinician appreciates me.	3	0	2	0	2	4	13	5.58
8. We agree on what is important for me to work on.	4		3	0	3	6	8	5.0
9. My clinician and I trust one another.	3	1	2	1	3	4	10	5.16
10. My clinician and I have different ideas on what my real problems are	*9*	*3*	*4*	*1*	*1*	*3*	*4*	*3.42*
11. We have established a good understanding of the kind of changes that would be good for me.	3	2	1	1	2	7	8	5.08
12. I believe the way we are working with my problem is correct.	3	1	1	2	5	4	8	5.04

Table IX below summarizes the data related to client satisfaction with a wide range of services with this data also describing overwhelmingly positive client satisfaction. Here a five-point scale is used asking respondents to score the degree to which they agree or disagree with statements about services. The only item that was rated less than a 3.5 (the standard measure of satisfaction on this five-point scale) was the first item that is related to the difficulty clients experienced finding help in the first place. While more outreach and community education on the part of PREP might increase this score, this one item is more reflective of the mental health system than it is of the PREP program itself and is something cited in multiple national studies as being a significant problem, as delays in access appropriate treatment have been shown to translate into much poorer long-term outcomes. Otherwise all scores were above 3.5. Scores that approached a 4.0 average related to the convenience of the location, adequate time for appointments, ease in scheduling appointments, opportunities to discuss troubling thoughts, having a better understanding of their mental health problems and feeling that PREP had helped with their recovery. Three items exceeded a 4.0 average--feeling that they were treated with respect, feeling hope for their recovery, and knowing who to contact if they need help. All of these are extremely important factors in any effective treatment program. In particular the degree to which clients felt that they could access services, appointments, and meaningful support, all reflect a program that clients felt was operating effectively and meeting their needs. The responses go a long ways toward mitigating concerns described above about staff turnover.

One aspect of the responses to this survey warrants mention. While the average scores on every item show high satisfaction with program services, three respondents were responsible for every response indicating 'never' with two of these respondents answering never to every single item and the other answering 1 or 2 to every item. The scores from these three respondents significantly diminished averages across all items. One of those who responded 'never' to all questions was the client who was hospitalized 162 days which could indicate significant failure to engage this client or very possibly that the client was symptomatic and simply checked boxes. On the other end of the spectrum, the client who responded never or rarely to all questions is a client who had experienced 120 hospitalization days in the year prior to joining PREP and none while in PREP. Regardless of why these three clients responded as negatively as they did, clearly the overarching sentiment among clients was that PREP was responsive to their needs in all dimensions.

Table IX: Service Satisfaction Survey Results Statement	Strongly Disagree	Disagree
1. When I first had mental health problems it was easy for me to know where to go to get help	8	4
2. It was easy for me to see the PREP team once I had been referred	3	2
3. I felt I was seen by PREP quickly enough after my doctor (or someone else) had referred me	3	0
4. My initial contact with a PREP team member was useful	3	1
5. I am able to schedule appointments with PREP at times that are convenient for me	3	0
6. I am seen in a place that is convenient for me	3	0
7. I am given enough time at each appointment	3	0
8. I am offered enough appointments	2	1

9. I am/was offered support with structuring my day e.g. social activities	3	1
10. I am/was offered help to cope with troubling thoughts and feelings relating to my experiences	2	1
11. I am able to discuss medication options for me and their effectiveness	3	0
12. I have the opportunity to discuss any side effects of my medication	2	2
13. I feel actively involved with my treatment plan	3	2
14. I am treated with respect and dignity	3	0
15. I feel that PREP gives me hope about my future recovery	3	0
16. I feel I have a better understanding of my mental health problems and how to cope should things be difficult again	3	0
17. I know who to contact at any time if I am in need of help	3	0
18. I feel that involvement with PREP has helped with my recovery	3	1

One concern that is an extension of PREP's not engaging significant numbers of families to attend MFG is that there was no family satisfaction data to analyze. The evaluator would recommend the implementation of a simple satisfaction survey for family members, hopefully in a context of a far higher percentage of families engaged in treatment planning and MFG.

Given the high levels of staff turnover, the complexity of the PREP model, the need for intensive training before implementing the model and the ongoing need for consistent clinical supervision, the evaluator developed a staff survey to track staff readiness for delivering services and the sufficiency of training, clinical supervision, and administrative support—all factors that could have been impacted by staff turnover. As Table X demonstrates (below), three-fourths of the clinicians agree or strongly agree that they are prepared to deliver CBT and feel that they receive adequate clinical supervision and administrative support. What's more, when the survey includes all PREP staff, between 75-80% of staff agree or strongly agree that PREP effectively engages clients and family members and contributes to clients achieving recovery. However, clinicians did not feel adequately trained in MFG and did not feel prepared to deliver MFG. Moreover, one clinician strongly disagreed with being prepared to deliver either MFG or CBT and only one of seven respondents felt that turnover was not impacting the quality of services delivered. An examination of hire dates indicates that two therapists were hired in April 2014, one in late April and this could explain why one clinician did not feel prepared for performing these functions. Whatever, the case, the survey data suggests that once staff is on board, they do feel trained and able to deliver services

Table X: Staff Satisfaction Survey—First four statements were only asked of therapists (4) while the last questions included both clinicians and managers and administrative and research support (7)

Statement	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
I feel fully prepared to deliver CBT with clients	1 (25%)	0	0	0	3 (75%)
I feel fully prepared to facilitate MFG groups	0	1 (25%)	2- (50%)	1 (25%)	0
I have received good training in CBT.	1- 25%	0	0	1 (25%)	2 (50%)
I have received good training in MFG.	1 (25%)	2 (50%)	0	1 (25%)	0
I have consistent access to clinical supervision	1 (25%)	0	0	1 (25%)	2 (50%)
Staff turnover has not had a significant impact on the quality of PREP services.	2 (28.6%)	2 (28.6%)	2 (28.6%)	1 (14.3%)	0
There is adequate administrative support for PREP.	0	2 (28.6%)	2 (28.6%)	2 (28.6%)	1 (14.3%)
I am confident that the treatment provided by PREP is helping clients achieve recovery.	0	0	1 (14.3%)	5 (74.2%)	1 (14.3%)
PREP does a good job of engaging clients when they first seek treatment.	0	0	1 (14.3%)	4 (57.1%)	2 (28.6%)
PREP does a good job of engaging family members.	0	0	1 (14.3%)	3 (42.9%)	3 (42.9%)

and that clinical supervision is accessible as needed. The survey results suggest the need for some kind of adjustment to staff induction to ensure that a therapist isn't still feeling unprepared to do their job five months after having been hired. The survey was administered in late September 2014. In wrestling with evaluation findings, PREP leadership has identified a staffing adjustment that will help address staff readiness to deliver the full range of PREP interventions. See EQ # 7.

Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?

The satisfaction data above shows clearly that clients felt that services were responsive to their needs. The program targeted a high-risk population where early intervention has demonstrated great promise for reducing long-term hospitalization and fostering recovery. PREP also served a highly diverse population with over 2/3 of clients being from demographic groups that are historically under-served. By all measures, the PREP program is responsive to the population targeted by the contract.

Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?

The vision, mission and values of San Mateo County Behavioral Health & Recovery Services stress empowering individuals to direct their own recovery process. BHRS stresses the adoption of culturally competent treatment approaches and through its MHSA planning processes, a further focus has been placed upon implementing evidence-based practices that have demonstrated the capacity to support client wellness and recovery. From the perspective of prevention, BHRS has also described the journey towards a transformed system requiring that programs:

- move "upstream" to primary prevention strategies;
- partner with other health prevention efforts to focus on wellness and recovery;
- achieve desired outcomes; and
- integrate efforts to support sustainability;

What's more, San Mateo's MHSA plan clearly described the priority of intervening early and identified stress, PTSD, and use of alcohol and drugs as factors where early intervention were most important, particularly in relation to individuals from historically underserved populations.

Schizophrenia is one of the most common and devastating of mental illnesses, generally beginning in late adolescence or early adulthood and lasting a lifetime. It is estimated that this single disease accounts for about 2.5 - 3% of US healthcare expenditures. (Mauskopf, JA, David, K, Grainger, DL, Gibson, PJ, 1999). Although the disease occurs in a socioeconomic cross-section of the population, long-term treatment costs tend to fall disproportionately on Medicaid, as chronic schizophrenia sufferers age off parental health insurance and are unlikely to have stable employment through which private health coverage would be available. (Marcus, FC, Olfson, M, 2008)

Once schizophrenia has manifested itself, the prognosis for sustained recovery is poor. Within the first five years of the disease, fewer than 14% show sustained recovery, and perhaps 30% achieve stable remission over the longer term (Insel TR, , 2010). Life expectancy for schizophrenia sufferers may be shortened as much as 15-25 years. In addition to the loss of both quality and duration of life, there are serious cost implications for treatment of physical health conditions of this chronically ill population. Key physical health issues include much higher risks of cardiovascu-

lar disease, obesity, smoking, and substance use, as well as the consequences of physical inactivity, homelessness, misadventure, and suicide. (Chang, C, Hayes, RD, Perera, G, Broadbent, M, Fernandes, A, Lee, W, Hotopf, M, Stewart, R, 2011). In delivering an intervention program to treat psychosis early in the disease, PREP is clearly meeting a critical BHRS priority. What's more, PREP is employing multiple evidence-based practices in treating early psychosis. As Table VIII demonstrates, prior to enrolling in PREP, clients found accessing mental health services very difficult and thus PREP is also serving a population that had had difficulty finding either effective services or any services prior to enrolling in PREP. By any measure, PREP is addressing a clear BHRS priority with services aligned to its mission, vision and values.

Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?

The deep dive into PREP data revealed a program that was achieving very strong outcomes, but that also was beset by a number of operational challenges, including:

Staff turnover is clearly having a negative impact on service delivery, particularly as relates to staff involved in MFG delivery, including Family Partner, AA and clinicians who must complete an intensive MFG training in order to deliver the model to fidelity. A one-day training in MFG was delivered to all SMC PREP staff in July which should improve the entire staff's understanding of the role of MFG and its importance. Delivering the core treatment intervention, CBTep also requires intense training and clinical supervision. As the staff survey indicated, while most clinicians felt strongly that they were trained and prepared to deliver CBT, most felt that they were unprepared to deliver MFG. This points to the challenge imposed by turnover and the reality that complex, costly training in either CBT or MFG can't be delivered every time a single staff member is hired. The evaluator and PREP leadership spoke at length about this issue. See the plan to address this challenge under EQ # 7 below.

Low Involvement of Clients in MFG. MFG is a complex approach to implement to fidelity and failure to engage large numbers of clients is likely related to the turnover problem. While PREP engaged 91 family members and engaged them in a significant level of treatment planning, including family involvement in treatment planning, case management, psycho-education and medication consultation. But this engagement did not translate into a sufficient number of families participating in either F&F groups or MFG. MFG is a critical component of PREP because MFG is how PREP educates family members about psychosis, helping them to identify symptoms that correlate with relapse and helping them develop a long-term recovery plan through which family members can support the client after graduation from PREP. The introduction of a Friends & Family Group that now meets alternate weeks, is a step in the right direction, but with only 8 families engaged in this and fewer in MFG, less than 1/4th of PREP families appear touched by family groups of any kind. It is important to note that PREP defines 'family' liberally so clients whose immediate family are not considered a resource by the client, can look outside the traditional family definition to include friends, neighbors, partners, etc.

Need for strategies for identifying potential high-end users. As described at length above, two clients used 67 and 162 hospital days respectively significantly reducing the percentage drop in hospital days. While the data shows that while in PREP 29% had zero hospitalizations and another 54% of clients reduced their hospital days while in PREP (i.e. 83% of all clients), to maximize the fiscal benefit to the County and to alleviate client suffering, it is important to identify evidence of treatment disengagement, presenting symptoms, or other indicators that could predict developing crisis and find ways to intervene to prevent a crisis or at least to reduce the length of

hospitalization. Conversation with PREP leadership on this topic led to a number of identified strategies outlined in EQ # 7 below.

Lack of a definition for what constitutes an 'engaged client, when a client 'drops out' or 'graduates' can obfuscate outcome data and make caseload planning more challenging. The emergence of this issue resulted from the deep dive into hospitalization data and going beyond treatment dosage averages by examining client-level data. This deeper analysis of data illustrates the kind of program improvement efforts that can emerge from honest reflection on data. PREP maintains far more client data than any PEI program and hence is better able to identify problems that could go unnoticed if all that is reviewed is trends in symptom management, client satisfaction, and hospitalization days and averages related to service delivery numbers. While the data in all these areas points to PREP having a very positive impact upon over 80% of clients, this deeper dive into the data reveals ways in which the program could be still stronger. A discussion of how all of the areas for improvement identified in this passage translated into relatively simple changes to the PREP model that will likely result in still better outcomes for more PREP clients. See EQ # 7 below.

Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

PREP leadership has been unflinchingly eager not just to comply with the evaluator's requests for data, but to dig even deeper than requested, not to find ways to dispute initial findings, but to use the process to find more areas where improvements could be made. Development of this report required far more time from staff and the evaluator than any other report, as just as it appeared all the data was in, another layer of data was found that shed a different light on program operations. For each of the areas for improvement identified above, PREP leadership, in consultation with the evaluator, identified clear strategies to further strengthen the program.

Stronger PREP Leadership and Focus on SMC. Since receipt of a highly competitive *Centers for MediCare Services Innovations* grant, Felton Institute, the agency responsible for developing and implementing PREP has been replicating the model in two new counties, at virtually the same time that it started PREP in SMC. In a series of interviews, PREP leadership was candid that this process both over-extended leadership and impeded consistent attention to each of PREP's five sites. But they also noted that the replication process had led both to the development of stronger PREP leadership and a better idea of how to implement and oversee the model. Felton has promoted the Stockton PREP Director to PREP Network Director. In an interview with Al Gilbert, Felton COO, he made it clear that her highest priority is to focus upon using this evaluation to implement the strategies below and then to apply lessons learned from this evaluation to other sites. Adriana Furuzawa was the original Program Director in Stockton under her leadership Stockton has emerged as the strongest PREP site with little staff turnover, high morale, and a strong MFG program. Ms. Furuzawa was deeply involved with the evaluation and her experience in Stockton will be a real strength as she directs proposed program improvements outlined below.

Program structure. Analysis of client-level service utilization data revealed patterns in service utilization that suggest that rather than being a straightforward treatment model from assessment and intake to discharge, PREP is really comprised of three phases of treatment:

1) **Engagement and Pre-treatment**. Most clients do not undergo an assessment, meet with a clinician to discuss treatment and then immediately enter a clearly defined number of CBT, medication consultations, IPS sessions, and MFG. Rather, some clients may participate in case management, meet with a clinician a few times and get

acclimated to the idea of intensive treatment. For some clients it could take weeks and in some case months for them to become fully committed to treatment. PREP leadership feels it is critical that it identify markers during this phase where treatment resistance and/or evidence of specific symptoms could predict an emerging crisis. Both of the clients who consumed high levels of hospitalization did so during what might be viewed as pre-treatment, indeed, one client had only had one session with a clinician before being hospitalized. This highlights the importance of PREP developing a better understanding of how some signs may suggest immanent crisis. To be fair, no treatment program can completely prevent hospitalizations among this population and especially among clients who have had only one session, but PREP leadership is committed to researching this challenge and identifying a better capacity to do just that.

2) **Intensive PREP Treatment.** During this phase, almost no PREP clients experienced hospitalization and there was far more consistent service delivery. However, PREP leadership was alarmed that MFG participation and medication consultations were not consistent even among clients in this phase. They have committed to meeting to identify a clear definition of what it means to be in this phase, definitions that will specify threshold dosage levels of CBT, IPS, medication consultation and MFG that constitute 'being engaged in PREP treatment.' This will greatly clarify the degree to which PREP managers can monitor and ensure that clients in each treatment phase are receiving the level and mix of services likely to produce the most positive outcomes.

3) **Transition to Community.** There also appears to be a third phase of treatment where the client has stabilized and is beginning to transition to recovery in the community. During this phase, the focus of treatment may be solidifying housing, employment or education and developing a clear relapse prevention plan. In discussions with PREP leadership, completion of a written relapse prevention plan would be considered as a viable definition for program 'graduation' with the absence of a written relapse prevention plan indicating that the client had not graduated.

The adoption of a clearly defined phased treatment model has important implications in relation to addressing all of the areas identified for improvement throughout this evaluation. The definition of dosage levels for CBT, medication consultation, IPS and MFG will clearly delineate program expectations. PREP leadership knows that these levels can be achieved, as they have been in the Stockton program as well as in Monterey, the two CMS-funded sites that have been operating for almost two years now. With the focused attention of the new PREP Network Director, support from other PREP leadership and direction from this report, PREP has a roadmap for moving forward and improving the consistency with which all clients access the full PREP model. By making it more explicit the precise range of service delivery of each program component, program managers and clinical supervisors, and clinicians will have a clearer shared understanding of what constitutes PREP to fidelity and with the staff adjustments described below, PREP leadership is confident it can both reduce staff turnover and mitigate the impact on treatment services when the inevitable staff transition occurs.

Staff Retention & Staff Assignments. For some time PREP leadership has been wrestling with strategies to reduce staff turnover and mitigate the impact of transitions that are inevitable. Currently, new clinicians must assume caseloads of the departing staff member almost immediately, virtually ensuring that new staff will be asked to implement CBT and MFG before they can possibly have received sufficient training to adopt the approaches to fidelity or to feel confident in their performance. Staff satisfaction survey results suggest that this has occurred in SMC. In and of itself, this will contribute to staff turnover, as staff who are feeling overwhelmed and stressed will often seek to exit the situation. PREP leadership has designed a staffing structure that will

respond to this dynamic. New clinicians will be assigned clients who have just entered the program and are in Phase I while the caseload for the departing clinician will be divided between other clinicians who have been trained and have been delivering the full range of PREP treatments. This will contribute to a number of key program improvements. First, and most importantly, it will allow new clinicians to get acclimated to the program, conducting outreach activities, engaging new clients and families and providing case management services, including encouraging families to become involved in F&F and MFG groups. This will also ensure continuity of quality care for clients while affording new clinicians time to complete training and participate in case conferences where other, more experienced clinicians discuss treatment issues with a clinical supervision. With this experience under their belt, the new therapist will gradually add clients moving from pre-treatment to Intensive PREP Treatment having been involved with the program for weeks or months, instead of days.

Improve Consistency in Data Collection & Charting. PREP has ambitious goals. It was borne to serve as a model to address a national crisis—the extraordinarily poor care afforded to individuals wrestling with psychosis, despite ample evidence of benefits to be derived from implementing EBPs. To achieve its larger vision: creating a replicable model of early psychosis treatment requires a level of consistent, reliable data collection to methodically document results and to identify signs of program drift from the model. This data is important to funders, but still more important to program leadership, as before any model is ready for broad dissemination the model must be clearly defined, carefully documented, and demonstrate consistent results across sites. The evaluation helped PREP leadership identify a significant number of glitches in their data collection protocols and caused staff to pull from multiple databases. The evaluation shed light on these deficiencies at the same time that it made clear the benefit to having easily accessible data on key indicators of smooth program operations, consistent service delivery, accurate charting, and improved client outcomes. PREP leadership has assumed responsibility for continuing to improve its data collection and charting protocols to create data reports that more easily generate, clear, and consistent. Achieving their long-term vision depends upon it.

It is important to note, that it would have been very easy for PREP leadership to mask over most every area of operational improvements that have been identified simply by not offering up more and more data to analyze. Without question, this evaluation delved more deeply into client level data, both in terms of service delivery, individual client dosages, client outcomes and satisfaction than any other PEI program. And it is critical to note that outcomes for PREP are generally excellent, client satisfaction is high, hospitalizations are being significantly reduced even when considering clients who may not have been fully engaged in treatment and that over 80% of clients are benefiting significantly.

Despite the operational shortcomings identified above, PREP has delivered excellent results. However, PREP is an extraordinarily complex model that has only been in operation for six years and leadership is still wrestling with its experience replicating the program, researching emerging trends in treatment of early psychosis, and exploring how to address operational challenges. The evaluator has been impressed with how honest and unflinching PREP leadership has been, seeking solutions to improve the program rather than providing excuses. Over the next two months, PREP leadership has committed to developing a written plan for program improvements and sharing it with BHRS leadership. The plan will include both specific staffing and operational changes, including service delivery thresholds for each component, as well as mid-term indicators that, within six months, should provide evidence that these changes are having an impact on service delivery and client outcomes. While the level of effort involved in developing this report was extraordinary, it points to how an evaluation driven by data can illuminate both program successes

and areas where improvement can enable the program to continue to improve and to expect still better outcomes in the future.

Section V Demographic Summary

The data table below and the tables that follow have been customized for different types of programs. It will be used by BHRS in reports to MHSOAC.

Table X: Demographic Summary					**Source of Data**
Total Unduplicated Served					
Gender		**Clients**			
	#	%			
Male	32	70%			
Female	14	30%			
Other					
Age		#			
Children 0-13		0			
Transition Age Youth 14-25		85%			
Adult (26-59)		15%			
Older Adults 60+					
Families (can include families with children or TAY)					
Ethnicity		**Clients**		**Program Staff**	
	#	%	#	%	
Caucasian	16	34.8%	15	71.4%	
Latino	15	32.6%	0	0%	The absence of Latino staff is a concern that is somewhat mitigated by PREP having one bilingual Spanish therapist.
African American	1	4.3%	3	14.3%	
Asian	6	13%	3	14.3%	
Pacific Islander	4	8.7%			
Native American	0	0%			
Multi-Ethnic	1	2.2%			
Other					
	Clients		**Staff**		
Home Language	**#**	**%**	**#**	**%**	
English	31	67.3%	15	71.4%	
Spanish	10	23.9%	1	4.8%	
Cantonese	0	0%	0	0%	
Mandarin	0	0%	1	4.8%	
Tagolog	1	2.1%			
Other	3	6.5%	2	9.6%	
Underserved Pops Served	**#**	**%**	**#**	**%**	Data was not completed on most Under-served populations.
LGBT					
Blind/Vision Impaired					

Table X: Demographic Summary					Source of Data
Deaf/Hearing Impaired					
Veterans					
Homeless	2	4.3%			

Section VI Program Components:

The information in Table II will be used to report to MHSA as part of the statewide evaluation. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator.

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.		
	Yes	**No**
II-1) Access for Underserved Populations	**X**	
Details: 65% of clients served are from demographic groups that historically under-served. Also, a high proportion of clients at intake indicated that they had had difficulty accessing services and the research indicates that individuals with psychosis can go years without accessing appropriate services.		
II-2) Outreach for Early Recognition of Need	**X**	
Details: PREP targets individuals who have just begun manifesting symptoms of psychosis.		
II-3) Access or Linkages to Care		
Details: No evidence of close coordination with other providers was presented.		
II-4) Reduction of Stigma		
Details: [Insert info on community education when it is provided.]		
II-5) Screening for Needs		
Details: PREP conducts extensive assessment of psychiatric needs and case management functions work with clients on education and vocational needs. No tools provided demonstrate screening for housing, health, or social/recreational needs, however, these needs are also addressed through case management.		
Program Activities	**Yes**	**No**
II-6) Addressing Trauma	X	
Details: Part of CBTp is to help clients manage trauma associated with psychosis.		
II-7) Specific Risk Factors		
Details: Early psychosis is highly correlated with a conversion to full psychosis and schizophrenia.		
	Provide specific details very briefly. 1-3 sentences per line.	
II-7) Indicate the location where program activities occur (identify places where services occur	Program is located in San Mateo. Client surveys indicate high levels of satisfaction with the location.	
II-8) Specify the roles for Peers (mentors Outreach, Peer education, other)…Please specify.	Family Partners and Care Advocate	
II-9) Specify the sectors with which you collaborate on this program (housing, criminal justice, public health, education,	Delivery of hundreds of family case management and individual case management services has required PREP to become more integrated into the	

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.	
child welfare)	SMC systems serving the population, however, no formal partnerships with other systems have been developed.

Section VII Program Alignment with SMC MHSA PEI Priorities:

Providers will mark Y for Yes for any community need or priority population addressed. In the space provided, please explain how these needs or populations were served. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator during which time a discussion will occur to amplify and provide details or examples.

Table III: Alignment with SMC MHSA PEI PRIORITIES				
	Children & Youth	**TAY**	**Adult**	**Older Adult**
1-PEI Key Community Needs				
1-A) Disparities in Access to Mental Health Services		X		
Details: As noted above, 65% of the clients served are from demographic group that are historically under-served and individuals with psychosis historically are challenged to find appropriate treatment.				
1-B) Psycho-Social Impact of Trauma		X		
Details:				
1-C) At-Risk Children, Youth and Young Adult Populations		X		
Details: Individuals with psychosis are at extreme risk of unemployment, school dropout, homelessness, co-occurring, chronic health conditions, isolation, premature death and suicide.				
1-D) Stigma and Discrimination		X		
Details: PREP is supposed to conduct extensive community education but has not presented evidence of this occurring.				
1-E) Suicide Risk (See 1-C above)		X		
Details:				
2- PEI Priority Populations				
2-A) Trauma Exposed Individuals		X		
Details: Clearly TAY participants who are experiencing high levels of trauma and psychosis are at high-risk of trauma related to the symptoms of psychosis and common life experiences associated with psychosis (homelessness, hospitalization, under-employment, etc.).				
2-B) Individuals Experiencing Onset of Serious Psychiatric Illness		X		
Details: By definition, PREP targets and intervenes early with individuals who are just developing early psychosis.				
2-C) Children and Youth in Stressed Families		X		
Details: Clearly TAY participants who are experiencing high levels of trauma and psychosis are at high-risk of family stress.				
2-D) Children and Youth at Risk for School Failure		X		
Details: Clearly TAY participants who are experiencing high levels of trauma and psychosis are at high-risk of school failure.				

Table III: Alignment with SMC MHSA PEI PRIORITIES				
2-E) Children and Youth at Risk of or Experiencing Juvenile Justice Involvement				
Details:				

Section I Agency & Program Description
I.A. Description of Program Services

Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students), is considered a SAMHSA model program that prevents and reduces substance use and abuse and associated behavioral issues among high risk, multi-problem adolescents. It works by placing highly trained professionals (Project SUCCESS counselors) in the schools to provide a full range of prevention and early intervention services. Project SUCCESS counselors use the following intervention strategies: information dissemination, normative and prevention education, problem identification and referral, community-based process and environmental approaches. In addition, resistance and social competency skills, such as communication, decision making, stress and anger management, problem solving, and resisting peer pressure are taught. The contract describes counselors as primarily working with adolescents individually and in small groups; conducting large group prevention/education discussions and programs, training and consulting on prevention issues with alternative school staff; coordinating the substance abuse services and policies of the school and refer and following-up with students and families needing substance abuse treatment or mental health services in the community.

In 2013-14 Puente de la Costa Sur (Puente) delivered Project SUCCESS services at three Southcoast schools, La Honda Elementary, Pescadero Middle School and Pescadero High School. In addition to Project SUCCESS groups where coping skills, communication, decision-making and other social skills, are introduced, Puente delivers a range of educational and prevention services in large, schoolwide presentations, particularly at the high school. The SUCCESS groups and the school-wide presentations also serve as a point-of-entry to individual counseling services available at all three schools. Groups are designed to meet once per week for 8 weeks with the exception of the high school group which has met consistently once per week since being launched in December. However, as this report will delineate, the extremely small size of the schools Puente serves makes it very challenging to achieve the number of students required to sustain a series of eight week groups. For example, at the elementary level, there has been no 5th grade class at Pescadero Elementary for three years, with only 25 fifth grade students enrolled at La Honda Elementary. For the first time in three years, in 2014-15, the district has fifth grade classes at both elementary schools. Nonetheless for 2013-14, with such a small sample size from which to draw, Puente has been unable to offer more than one group at La Honda elementary due to the small class size from which to draw students and has faced similar challenges at the Middle School. Puente has been resourceful in identifying other ways to have a positive impact in Southcoast and overcoming the challenge posed by working in such small schools.

The Project SUCCESS counselors are all either licensed or pre-licensed MFT or LCSW's. High school age youth are either self-referred or are referred based on teacher recommendations. The elementary and middle school participants are assigned based on the Project SUCCESS Assessment. The counselors primarily work with adolescents individually and in small groups; conduct large group prevention/education discussions and programs; train and consult on prevention issues with school staff; coordinate with the school; refer students and families needing substance abuse treatment or mental health services in the community and provide follow- up. The following four program components are utilized in Project SUCCESS:

The Prevention Education Series - An Alcohol, Tobacco and Other Drug prevention program conducted by the Project SUCCESS Counselor with small groups of students.

Individual and Group Counseling - Project SUCCESS counselors conduct time-limited group

counseling at school for students following participation in the Prevention Education Series; individual assessments and individual sessions are provided as needed.

Summer Supervision Groups. With funding from SMC BHRS and local foundations, each Summer Puente Hires Youth ages 14-18 from the community to work at Puente. The youth are given a two-week orientation and divided into supervision groups by age and placement. The Project SUCCESS team provides weekly supervision for each group. Puente utilizes the Project SUCCESS model to educate the youth about drugs and alcohol prevention. The youth are assigned for working roles throughout the area, some working at the local YMCA camp, school district recreation programs, local businesses, non-profits and ranches. The program provides a foundation of understanding of issues related to drugs and alcohol while then providing students opportunities to use their skills, work with adults and other peers, and develop assets that are consistent with the Search Institute model.

Referral - Students and parents who require treatment, more intensive counseling, or other services are referred for individual therapy at Puente or SMC BHRS.

Parent Programs - Project SUCCESS includes parents and teachers as collaborative partners in prevention through parent education programs,

- ***Enough Abuse*** is a Spanish only parenting model sanctioned by the county. Two Project SUCCESS team members were trained in the approach and deliver this program. The group is a one-time event and focuses on increasing awareness of Child Abuse. Puente incorporated a section on Drug and Alcohol Prevention Strategies and how the use of drugs and alcohol is often intertwined with incidents of Child Abuse in our society. This program and training also provided a cultural competency training opportunity Puente staff and the ability to utilize a model that specifically targets the Latino community.
- ***Zumb***a. Puente has held Zumba classes twice per week at Puente. The group serves largely Latino mothers struggling with depression, and fits into the framework of Project SUCCESS because the group is based on providing a culturally significant and healthy forum to bring together the parents in the community. Puente's Project SUCCESS team took some time at the beginning, middle and end, to provide basic information about drug and alcohol prevention strategies and to promote our work within the schools.
- ***Group de Madres*** was an (11) session group. This group was based on a process group model and served Latino women and parents who were identified as having had difficulties with maternal depression and parenting skills.
- ***The Spanish Parenting 2013*** is Project Success' group comprised of six sessions focused on developing positive parenting skills.

In addition, Puente serves as the Differential Response program for Southcoast. So, for example, if someone calls Children's Protective Services (CPS), CPS could elect to refer the case to Puente. Similarly, if Puente identifies a child, parent, or family in need of services more intensive than those available through Project SUCCESS, Puente need not work through ACCESS and can simply enroll the individual or family in need for more intensive services provided by Puente. In this way, Project SUCCESS can serve as a point of entry to comprehensive services for anyone in Southcoast identified as in need of those services. In this way, Puente serves as a de facto one-stop-shop for behavioral health services.

I.B. Research Basis for Approach

Identified by SAMHSA as an evidence-based approach to prevention, Project SUCCESS builds on the findings of other successful prevention programs by using interventions that are effective in reducing risk factors and enhancing protective measures such as those promoted by the Search Institute. The San Mateo County Health System has adopted the Search Institute's 41 Developmental Assets as the framework to use when addressing the needs of young people in the community. This strengths-based model works with youth, their families, schools and community to promote the forty-one (41) internal and external assets needed to build positive self-esteem, the ability to solve problems and build healthy social relationships. Research has shown that youth with high levels of assets over thirty (30) are more likely to succeed academically, maintain good health, and contribute to their community. For the 2014-15 program year, Puente is adopting a range of Search Institute tools designed to document the degree to which Project SUCCESS participants are developing assets and building resilience. The Search Institute's 58-item, forced choice assessment will enable Puente to assess each student in terms of the number of developmental assets they possess at intake and then measure again when the student exits the group program, providing valuable data to validate the degree to which the groups are building student assets. The aggregated pre-test assessment data for a group of students will also inform the group facilitator as to areas where the group may have common areas where assets need to be developed, enabling the program to target these assets for development.

Two studies were examined by SAMHSA in determining SUCCESS to be an evidence-based practice:

1) Morehouse, E. R., & Tobler, N. S. (2000). Project SUCCESS final report: Grant number 4 HD1 SP07240. Report submitted January 26, 2000, to the Center for Substance Abuse Prevention, U.S. Department of Health and Human Services.
2) Vaughan, R., & Johnson, P. (2007). The effectiveness of Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) in a regular secondary school setting. Unpublished manuscript.

Both studies utilized a revised version of the American Drug and Alcohol Survey (ADAS) to measure changes in attitudes and behaviors related to ATOD. The survey was revised so that it could be administered in one class session. A drug use index was created by summing the scores of self-reported use of 13 drugs: tobacco, alcohol, marijuana, crack, cocaine, heroin, inhalants, LSD, PCP, amphetamines, meta-amphetamines, ecstasy, and "andrenochomes," a false drug included to identify students who over-reported drug use.

In one study, for the purposes of analysis, students were classified as ATOD users and nonusers based on their pretest use status. At posttest in the first year of a study involving alternative secondary school students:

- Self-reports showed a 37% decrease in ATOD use among Project SUCCESS participants relative to students in the comparison group who did not participate in Project SUCCESS ($p < .001$).
- Of the students using ATOD at pretest, 23% of those in the Project SUCCESS program reportedly stopped ATOD use, whereas only 5% in the comparison condition reported stopping ($p < .001$).
- For those Project SUCCESS students who did not discontinue ATOD use, there was a significant reduction in reported ATOD use across the drugs assessed, ranging from 17% ($p < .05$) to 26.6% ($p < .01$).

- At follow-up in the second year of the same study, among Project SUCCESS students who reported using ATOD at pretest, 33.3% reportedly stopped using alcohol, 45.0% reportedly stopped using marijuana, and 22.9% reportedly stopped using tobacco (all p values < .05).

In another study, 21 months following the intervention, regular secondary school students who were involved in Project SUCCESS were less likely than students in the control group to report having ever used marijuana, having smoked in the past month, and having ever used any other substance alone (all p values < .05).

Among pretest users, 21 months following the intervention:

- Among students who used alcohol and cigarettes at pretest, students in the control group were 2.32 times more likely than similar intervention students to report continued use of alcohol and cigarettes; 4.3 times more likely to report use of alcohol, cigarettes, and marijuana; and 5 times more likely to report use of illicit substances (all p values < .05).
- Among students who used alcohol, cigarettes, and marijuana at pretest, students in the control group were 4.16 times more likely than similar intervention students to report continued use of alcohol and cigarettes; 4.54 times more likely to report continued use of alcohol, cigarettes, and marijuana; and 7.33 times more likely to report use of illicit substances (all p values < .05).
- Among students who used illicit substances at pretest, students in the control group were 4.76 times more likely than intervention students to report continued use of alcohol and cigarettes; 5 times more likely to report continued use of alcohol, cigarettes, and marijuana; and 2.7 times more likely to report continued use of illicit substances (all p values < .05).

It is important to note that the Project SUCCESS model generally and the Search Institute's 41 Developmental Assets was not designed for rural, highly Latino, low-income populations where low literacy is commonplace. However in a meta study by Peter Benson that examined programs and communities adopting models based upon the intentional creation of community wide connections and partnerships focused upon providing youth with opportunities to develop assets, it was found that no matter the ethnic population, income levels or size of the community or community setting, youth benefit tremendously from "asset accumulation." A part of Puente's Project SUCCESS is its Summer Supervision program which is an excellent example of the intentional establishment of an expanding community partnership focused on providing summer opportunities for adolescents to participate in community functions, work with adults, build personal competence and accumulate assets.

I.C. Target Population, Number Served and Sites

In 2013-14 Puente's Project SUCCESS provided site-based group and individual counseling services at three La Honda-Pescadero Unified School District sites: La Honda Elementary, Pescadero Middle School, and Pescadero High School all located in the Southcoast community of Pescadero. In 2014-15 Pescadero Elementary School had sufficient enrollment to open a fifth grade class for the first time in three years and so Puente is now offering groups at all four Southcoast schools. Puente's contract for Project SUCCESS did not include projected numbers served and only indicated

Table I: Student Data

School	Enrollment	Free-Reduced Lunch	English Lang. Learner	Hispanic	Anglo	Mixed
Pescadero High	93	74%	50%	71%	27%	2%
Pescadero MS	67	72%	65%	77%	23%	1%
La Honda Elem	68	77%	68%	76%	23%	1%
Pescadero ES	110	73%	72%	75%	23%	2%

the need to target populations that are historically under-served. According to a report submitted by Puente to SMC BHRS on July 17, 2014, Project SUCCESS served 97 students across sites, with over 60% (60) identifying as Latino/a, a demographic group identified by BHRS as being under-served. However, as this report will describe, the evaluator had concerns that the numbers reported to the evaluator, were lower than those reported to the county. During a structured interview with Puente CEO and Project SUCCESS Clinical Director some context was provided related to the relatively low numbers of groups and group participants and to personnel changes that impacted data collection. Puente staff described the extraordinarily small number of students attending each school, an assertion verified by the evaluator by obtaining district enrollment data from the California Department of Education. Table I, below, provides demographic and enrollment numbers for each school. As you can see, there are fewer students enrolled in the schools served than would be enrolled in a single grade in most urban schools. As will be described low enrollment and other district policies and practices described under Evaluation Question # 1, create a challenge in trying to sustain groups with sufficient student participation.

Table I also demonstrates that Puente clearly serves under-served populations as the percent of Hispanic students exceeds 70% in each school, as does the percentage of Free-Reduced Lunch, a data proxy for living in poverty and the majority of students are English Language Learners, another risk factor in terms of school success. What's more, Southcoast is consistently identified in County social welfare, juvenile justice, and behavioral health reports as an under-served community, another indicator that the Puente program is addressing populations targeted by the MHSA and San Mateo County Prevention and Early Intervention programs.

Section II Evaluation Process

The evaluation plan was developed in June-July 2013 through a series of meetings that included the evaluator and Puente's Clinical Director Joann Watkins. During these conversations plans were made for Puente to deliver:

- Pre-Post data on students using the Hemingway Measure of Adolescent Connectedness Survey and the Coopersmith Self-Esteem Inventory, both tools used by Puente in the past;
- Satisfaction surveys of parents participating in parent groups; and
- Data on student participation in counseling sessions, case management and referrals to other resources.

At the end of the program year, when the evaluator contacted Ms. Watkins to begin receiving data, she indicated that, "my data collection was not done well this year" and then in a second interview she went on to explain that she had lost a key staff person due to maternity leave and that with an under-staffed team, data collection had been neglected. Over the course of two or three weeks, Ms. Watkins worked with the evaluator to provide what data was available and reassured him that Program Year 2014-15 would be different. Instead of reports with student level data, the evaluator received a combination of global summaries, limited participation data, pre-post data on 15 elementary and middle school students who participated in Project SUCCESS groups, and thirty-nine high school student satisfaction surveys, but no parent or teacher satisfaction data. The report that follows tried to utilize the data provided, but with so little data to work with the evaluation could only make limited definitive findings and so focused more on the scope and scale of services delivered, the challenges faced in trying to implement a school-based program under challenging conditions and how data collection could be improved to ensure that in 2014-15 Puente could report more effectively on its productivity, impact on clients, and satisfaction of parents and school faculties.

At one point in the process, the County's Mental Health Services Act Coordinator asked the evaluator to see if it were possible to use data provided to the county as part of Puente's semi-annual report. Data from Puente's end-of year report was a useful resource in the evaluation, but the report also included some data that initially conflicted with data provided to the evaluator. For example, productivity levels described in the County report greatly exceed the numbers served as reported in client-level data provided for the evaluation, however, during structured interviews with Puente leadership it was revealed that the end of year report included individual counseling numbers for non-Project SUCCESS students. Data collection issues are discussed in more detail in Section III below.

From dialog with the Clinical Director and Director of Prevention Services the evaluator learned that Puente's Project Success was contracting with the Search Institute to obtain both training to ensure that Project SUCCESS adhered to evidence-based practices in introducing and supporting development of the Institutes 41 developmental assets. Puente also purchased Search Institute's pre and post assessment tools expressly designed to document impact and to measure at program entry and exit changes in the number of developmental assets for each student. With this in place, it is hoped that the 2014-15 evaluation can be far more robust and useful to both Puente and the County.

Section III Evaluation Findings

There are seven evaluation questions that frame the evaluation of the Prevention & Early Intervention programs supported with Mental Health Services Act funds.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to the contract funding the program?
Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?
Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?
Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?
Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?
Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?
Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

Each evaluation question is discussed separately below.

Data provided by Puente was limited to pre-post test data on the Hemingway Connectedness Scale with a sample size of 15 elementary school students, with no data on outcomes from the high school. Participation data indicated that across all sites, a total of 27 students participated in groups with 14 of these students also accessing individual counseling services. The contract did not stipulate a projected number of students to be served. Satisfaction data was only collected after one high school presentation on healthy dating. Taken together this represents a significant shortcoming in relation to data collection, seriously impeding the evaluation from assessing program impact on students. The challenges experienced by Puente in collecting and reporting data are underscored by a discrepancy between what was reported to the county in terms of participation and what was reported to the evaluator, a discrepancy that was clarified in the process, as Puente had reported individual counseling numbers for both Project SUCCESS and non-Project SUCCESS counseling services.. ***As the report makes clear, this says a good deal more about a single year in which data collection procedures were not implemented consistently than it says about the quality of the program.*** Indeed, in the end-of-year structured interview with Puente leadership, they candidly acknowledged their data collection challenges, presented plans to ensure that 2014-15 would be far better, and described a number of strategies employed in 2013-14 to overcome the relatively small numbers of students engaged in group and individual counseling services via summer programming, targeted prevention strategies, and strong engagement of the parent community.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to its contract?

As discussed in Section I and summarized again under EQ#7, Puente faced formidable challenges in offering the Project SUCCESS model within the La Honda Pescadero Unified School District. Four sites each with extremely low student populations result in exceedingly small pools of students from which to draw. At the elementary school level, since the program only serves students age 10 and over, this meant that the total number of age-eligible students for elementary groups was about 25. What's more, the schools were uniformly slow in mailing out and collecting the passive consent forms required to be on file before a student can be served, with collection extending well into October. Finally, all four schools prohibit students from being excused from class to attend groups, a restriction that requires students to attend during their lunch period. Collectively, these barriers pose significant challenges. In the structured interview that was conducted after an initial draft report was developed, the Puente CEO and Clinical Director described how every year she meets with district administrators to try to address both the slow process of gathering permission slips and that prohibiting students from having groups scheduled during class time each represented formidable challenges to implementing the model. But to date, district practices have not changed.

Puente provided a print out of participation levels and number of treatment services delivered for each student enrolled at the three schools. This table did not include participation levels in groups so the service levels reflect only individual treatment services. Tables II-IV, at right and below, identify the school, the students served by that school (using unique identifiers), the age of the student, the number of individual counseling services received and the date that their Project Success group began meeting.

As can be seen, a total of five groups were delivered across the three sites with two at La Honda Elementary, two at Pescadero High and one at Pescadero Middle School. Twelve La Honda students, five middle school and ten high school students participated in groups for a total of 27 students across sites.

Table II: Student Participation: La Honda Elementary School—Unique Identifier	Age	# of Tx sessions	Group Start
Group 1 students			
10298	12	31	12-2-13
10583	11	12	12-2-13
10625	11	0	12-2-13
10641	11	28	12-2-13
10643	11	0	12-2-13
10820	11	0	12-2-13
11059	12	0	12-2-13
11155	11	7	12-2-13
11176	11	0	12-2-13
12458	11	0	12-2-13
Group 2 students			
12127	11	7	2-4-14
12457	11	12	2-4-14
Totals La Honda			
LH total students in groups	12		
Tot LH students in Indiv. Couns.	6		
Tot Indiv. Sessions	97		
Ave sessions per LH student	16.16		

In terms of individual counseling, a total of six students participated in individual counseling at the elementary school, 2 at the middle school and 6 at the high school for a total of 14 students participating in individual counseling with an overall average of 16 sessions per student. While there is no productivity level specified in the Puente contract, the County requires reports from all MHSA-funded programs, reports that sought productivity, satisfaction and impact data. From its July 17, 2014 end-of-year report to the County, Puente reported serving 67 students in individual counseling, a significantly larger number than captured in the data provided to the evaluator which reflects 14 students receiving individual counseling. But the difference is easily explained as in its report to the County Puente was reporting on both Project SUCCESS students and non-Project

Table III: Student Participation Pescadero Middle School Student Identifier	Age	Indiv. Tx Sessions	Group start
11337	13	0	1-14-14
11338	13	0	1-14-14
12505	13	0	1-14-14
12506	12	24	1-14-14
12507	13	1	1-14-14
Tot # in groups	5		
Total Students in Indiv. Counseling	2		
Total Sessions	25		
Ave session/ child	12.5		

SUCCESS students. The students that did receive individual counseling services participated in an average of between 12.5 sessions (middle school) and 17.2 sessions (high school).

While the discrepancy in numbers reported to the evaluator and the County is a concern, it is likely the error in the County report resulted from the program being short-handed with a key staff person being absent due to a maternity leave. Nonetheless, the relatively low number of students participating in groups and in individual counseling was a concern to the evaluator and while Puente leadership described ways in which it had provided additional services and supports for parents and high school students (below), there remains a need to develop a strategy that effectively engages more students in either individual or group sessions and that programming can begin earlier in the school year. See EQ # 7 for a discussion of this issue.

Table IV: Participation Rates Pescadero High School & SUCCESS Totals Pescadero High School			
Group 1			
11283	17	46	12-10-13
11534	17	12	12-10-13
11535	16	1	12-10-13
Group 2			
10776	14	0	4-5-14
10792	17	0	4-5-14
10956	17	24	4-5-14
11162	15	2	4-5-14
11535	16	0	4-5-14
12283	17	17	4-5-14
12284	17	0	4-5-14
Pescadero High Totals			
Total High School Students in Group	10		
Total Students in Individual Couns	6		
Total Indiv. Svcs.	102		
Ave sessions per student	17		
Puente Project Success Totals			
Total Students in Group	27		
Total Students in Individual Couns	14		
Total Indiv. Svcs.	224		
Ave # Sessions per student	17.2		

In the structured interview conducted after evaluation data had been reviewed and a draft report developed, Puente leadership explained the challenges faced in delivering the programs in relation to small school sizes and other barriers described at the beginning of EQ # 1. More importantly, leadership described the steps taken to either overcome these challenges with new initiatives at each school site to ensure that the student and parent community were served effectively.

At the high school, Puente offered a range of prevention activities targeting low income and new immigrant populations, programming that is being expanded to the middle school in 2014-15 to expand the range of services available there.

In 2013-14, a Puente clinical staff member and two chaperones took 20 female high school students to the Princess Project in Santa Clara to pick out a prom dress and accessories free of charge. Most of the students came from rural low-income families and wouldn't have otherwise been able to afford to buy a dress and attend the prom. Puente used the Princess Project as a platform for conveying information about dating, refusal skills, and alcohol and drugs. Puente reported that feedback from this event was very positive and that many of the young men in the high school commented that they would like to have a similar program that would allow them to either borrow tuxedo's or be given appropriate clothes to wear to the prom. Puente plans to conduct outreach to community partners to try and establish a donor fund that Puente can make this possible for the

next academic year. Puente promotes healthy dating because it believes that it goes hand in hand with drug and alcohol prevention education. Puente staff believes that this type of event is extremely valuable as a way to bring a greater sense of self-esteem and sense of self-worth to the students. The hypothesis is that if you feel good about how you look, and understand the boundaries of healthy dating, then you will be less likely to use drugs and alcohol as a way to mask the fear and insecurity when self-esteem and confidence are lacking. This is an excellent example of addressing a tangible, social need of a low-income, historically underserved population and using it as both a gateway to providing important prevention messages while also cementing Puente's status in the Southcoast community.

In addition to the Princess Project, all high school students attended a healthy dating/domestic violence prevention workshop developed and put on by Project SUCCESS staff. The topic of healthy dating has come up continually as a concern among students, teachers, and family members. Because this topic is tied closely to student use of drugs and alcohol Puente wanted to target the whole school and provide a comprehensive overview, and handouts with phone numbers for the National Domestic Violence Hotline, and the Child Abuse and Prevention Hotline. In addition students were given the Power and Control wheel of physical and sexual violence. Student feedback on this event was positive with many students asking that the workshop be done in small groups with more time for dialogue, and question and answer. This valuable information will be shared with the School District Staff in hopes that the school might allow more time for the session and to enable it to be presented in small groups in 2014-15. Puente views this presentation as a potential gateway for students to participate in Project SUCCESS groups. See also data from the healthy dating presentation discussed under EQ # 3.

Another new high school program is an excellent example of Puente combining prevention education focused on drugs and alcohol while also providing opportunities to build student developmental assets by working in the community. In 2013-14 Puente initiated a Summer Supervision Group that supervised twelve students in community placements throughout Southcoast and provided group counseling and a two-week induction program during which students were introduced to a range of alcohol and drug prevention education. The small group, prevention education approach was consistent with the Project SUCCESS model. As with the Princess Project, this initiative meets a tangible student need (employment), leverages other community partners where students are placed to perform work contributing to community organizations while also building their skills. As with the Princess Project, this kind of school-community initiative not only meets the needs of the participating students, but it builds Puente's stature in the community, critically important to success in a small, rural community. While not part of the 2013-14 evaluation, Puente reported that in 2014 twenty-nine students participated in this program, an indication of its being well-received by students and that the community valued the program enough to identify additional slots for students in positions in the community.

The middle school will benefit from Puente adapting the healthy dating program for middle school students. The schoolwide presentation of important information about dating and alcohol and drugs will also provide Puente with an opportunity to invite students to explore the issues more deeply in the Project SUCCESS groups. During structured interviews with SUCCESS leadership, it was reported that Puente staff has been participating in middle school staff meetings and that as a result middle school have increased significantly in 2014-15.

At the elementary level, Puente offers groups designed to serve students ten years of age or older, essentially all fifth graders. In 2013-14 (and for the two preceding years) only one of the two elementary schools had sufficient enrollment to have a fifth grade class (La Honda) and so Puente

had a pool of only 25 students from which to draw, a situation that has changed in 2014-15 with Pescadero Elementary now offering a fifth grade class, as well as La Honda. As a result, Puente will offer groups at both sites this year. Puente is working with the district to arrange for Project SUCCESS to include the entire fifth grade class in groups in 2014-15, which should boost participation levels significantly.

Puente also initiated a range of parent education groups operated from the high school that have successfully engaged parents and sustained consistent participation. In 2014-15 early intervention parenting groups will be offered in Spanish and English at both the elementary schools and middle school. Groups include:

- Launched in June 2013, a project SUCCESS counselor began a weekly, six-session process group with twenty-one Spanish speaking women with children. This group has been designed to be self-motivating and loosely organized around promoting "healthy family systems."
- An eleven session group, Grupa de Madres serves six parents;
- A Zumba group that meets twice a week, targets parents suffering from depression providing culturally responsive exercise to combat depression for over 35 women; and
- Another one-time parenting skills group focused on child and domestic abuse prevention drew forty parents.

Lastly, Project SUCCESS serves as a point-of-entry into Puente's more comprehensive array of behavioral health services since Puente is the Differential Response program for the Southcoast community. As a result, Project SUCCESS students or families identified as in need of intensive services can bypass the ACCESS system and enroll in those services with Puente. For 2013-14, 43 students and 18 adults have received the level of services their condition warrants. What's more, because Children's Protective Services is so distant to Southcoast, Puente often functions as a de facto extension of CPS as Puente clinicians are asked often to conduct initial assessments of cases referred to CPS. While these functions are not supported by PEI funding, this important collaborative role is relevant to understanding how Project SUCCESS and Puente serve as a single-point-of-contact behavioral health service for a highly under-served community.

It should be noted that the evaluator worked with another community agency offering Seeking Safety groups in Southcoast. It had the same difficulty engaging sufficient numbers of clients to sustain groups at all. This agency adjusted to meet Southcoast needs by offering Seeking Safety content via individual counseling sessions and using these sessions to build a relationship with clients and the community. It is planning to reinstitute groups in Southcoast in January. Similarly with Puente, while the group and individual counseling data above reflect a considerably low penetration rate for school-base services, especially at the elementary and middle schools, Puente has been very resourceful in initiating new programming that addresses unmet student, parent and community needs, engages and serves historically under-served students and parents, and includes collaboration with key community stakeholders. In doing so, it is building its stature in the school and community and hopefully will contribute to stronger engagement of students in important group and individual counseling.

Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?

Evaluation of Project SUCCESS' impact upon clients was to have involved analysis of both the Hemingway Connectedness Scale and the Coopersmith Self-Esteem inventory. These instruments are described in the Puente's report to the County dated July 17, 2014, one month after the end of the program year.

> "All of our youth participants are administered the Hemmingway connectedness scale and the Coopersmith Self-Esteem inventory, pre and post group. In addition participants are asked to complete a satisfaction survey at the end of each 8 week cycle."

However, when the evaluator sought pre-post data, there were only 3 students with pre and post-test data for the Coopersmith Self-Esteem and data from 15 La Honda Elementary School participants who completed the Hemingway Connectedness Scale. As noted above, data collection suffered considerably with the exit of a key staff person due to maternity leave and the lack of pre-post data should not be viewed as a reflection on the quality of services delivered to students but more just the result of a small program being hamstrung by the lose of a key staff person and this resulting in a failure to collect data consistently.

The 57-item Hemingway Scale did provide data covering a range of issues and domains. While individual student level data was not available for analysis, aggregated data from 15 elementary school respondents was provided. Respondents rate how true each of the 57 statements are using a five-point Likkert Scale with a score of 1 for Not at all; 2 for Not Really; 3 for Sort of True; 4 for True; and 5 for Very True. The overall average score across all 57 items was precisely the same for both the pre and post test, a score of 3.6, indicating no change from between the pre and post test across all clients. As has been found in other PEI evaluations, averages across respondents can mask important differences. With student level data on participation and pre-post test, for example, it is possible to assess the degree to which higher levels of participation contributed to better outcomes, or whether outcomes were achieved by students involved both in group and individual treatment. This kind of analysis was not possible with Project SUCCESS as assessment data was not available at an individual student level so it assessment results could not be correlated with participation levels, a limitation that should be corrected in 2014-15. However, the Hemingway provides ten subscales allowing for analysis of change in the following specific areas.

- Relationship with the neighborhood
- Relationships with friends
- Relationship with siblings
- Relationship with teachers
- Reading practices
- Self-esteem
- Relationship with parents
- Relationship with school peers
- Feelings about the future
- Future

Analysis of each subscale follows. Each subscale was comprised of six statements except for the scale related to reading habits, which had four and the scale related to the future, which had five. Table V (on the following page) shows summarizes responses. Given that across scales there was no change between the pre and post-test, it isn't surprising that there was very little variation in scores in the subscales. Declines were reflected in student relationships with neighborhood, friends, siblings, teachers and peers. While gains were manifest in relation to self-esteem, school involvement, and in terms of the students' view of their future, only the gains in self-esteem and

view of their future were statistically significant. Declines in student relationships with the neighborhood and siblings were statistically significant. Other changes were not significant.

As noted above, in 2014-15 Puente is utilizing a pre-post test tool developed by the Search Institute that should elicit more robust data that is specifically designed to elicit change in student asset development. The evaluator will work Puente staff to ensure that this assessment data can be integrated with student participation data to allow for analysis of the impact of increased program involvement upon asset development.

Table V: Hemingway Connectedness Subscale Summary			
Subscale	Pre	Post	Change
Neighborhood	3.15	2.95	-.20
Friends	3.25	3.13	-.12
Self Esteem	3.16	3.38	+.22
Parents	3.93	3.97	+.04
Siblings	4.13	3.91	-.22
School	3.36	3.46	+.10
Peers	2.83	2.81	-.10
Teachers	3.79	3.71	-.08
Future	3.26	3.62	+.37
Reading	2.73	2.52	-.21

Puente leadership also described how for 2014-15, the school district had agreed to provide student attendance, discipline referral and suspension data on students participating in Project SUCCESS groups, thereby providing another form of data that could be useful to measuring the impact of Project SUCCESS programming.

Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?

As with the data on program impact, satisfaction data provided by Puente were responses from 32 students who had participated in a single prevention presentation, the healthy dating presentation. Hence there is no data capturing student satisfaction with either individual or group services. In the absence of satisfaction data from any elementary or middle school students or satisfaction data on high school students served in individual or group services, drawing conclusions about overall satisfaction with the primary components of the program is impossible. In the future, it is recommended that satisfaction data be collected at the last session of groups and last individual session at all sites, satisfaction data from teachers at all sites, and parents participating in parent groups.

Table V: Satisfaction Data After Healthy Dating Presentation. N = 32						
Question	Not Good at all	Not Very Good	Just OK	Pretty Good	Great	Excellent
	0	1	2	3	4	5
How would you rate this presentation?	4	0	13	6	8	1
How would you rate the presenter?	1	0	8	10	10	3
Was the information thorough and complete?	0	4	2	7	8	11

Student responses reflect both an endorsement of the value of the program while offering input into how it could be improved. Over half of respondents indicated that the presentation was just ok or not good at all. The presenter appears to have been better received with almost 75% of respondents indicating pretty good or better. Students were very satisfied with the content with 60% rating it excellent or great and 75% indicating that the information was pretty good or better.

Taken together, it would appear that students valued the information received and from further input provided to Puente staff, would appreciate the opportunity to have the information shared in smaller groups that would allow for more discussion and question and answer. Based upon this experience, Puente is asking school administration to facilitate the presentation being done in small groups. It is also planning to adapt the presentation for a middle school audience.

It is clear that Puente missed many other opportunities for data collection to verify satisfaction with Project SUCCESS, from clients at all sites at the last session of groups, with teachers and administrators and with parents participating in parent groups. The critique here is not that program is not of a very high quality or that clients are dissatisfied, it is that there is no evidence of satisfaction because the data was not collected. The importance of this goes well beyond conforming with an evaluation, it has to do with not getting direct client and stakeholder input into the program, input that can often help program leadership identify ways in which a program could be improved and/or areas of a program that are particularly effective or appreciated and should be sustained or expanded. For example, input from students about the healthy dating presentation has led Puente to get district cooperation in offering the presentations in smaller groups, allowing for more discussion and demonstrating to students that their voice matters. Similar information could be available in relation to all program components affording Puente with critical information to drive program improvement efforts and increase student engagement.

Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?

From demographic data provided in the report to the County, it is clear that the demographic profile of the students served are consistent with the County's priority of serving populations that are historically under-served. What's more, the community served—Southcoast—has been identified in numerous county reports as being an under-served community. By these criteria, the program has been attempting to meet the needs of those populations identified in the contract. The Princess Project clearly targeted low-income, rural and Hispanic students and by collaborating with a Santa Clara project was able to help these students participate in prom activities while receiving valuable prevention information about drugs and alcohol. The summer Supervision Groups provided high school students with both jobs and income, along with prevention education related to drugs and alcohol. In addition, effective outreach to the parent community resulted in a significant increase in parent involvement in Puente programming. Of particular note are the Spanish-speaking parent group and the Zumba group, both being linguistically and culturally appropriate initiatives. Zumba provided culturally relevant exercise to help parents fighting depression, at the same time that the group was used to introduce parenting information and promote participation in other parenting groups. Taken together, while it is clear that there are numerous challenges in serving a small, rural community, Puente has shown great resourcefulness in ensuring it is addressing the needs of the under-served.

Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?

The vision, mission and values of San Mateo County Behavioral Health & Recovery Services stress empowering individuals to direct their own recovery process. BHRS stresses the adoption of culturally competent treatment approaches and through its MHSA planning processes, a further focus has been placed upon implementing evidence-based practices that have demonstrated the capacity to support client wellness and recovery. From the perspective of prevention, BHRS has also described the journey towards a transformed system requiring that programs:

- move "upstream" to primary prevention strategies;
- partner with other health prevention efforts to focus on wellness and recovery;
- achieve desired outcomes; and
- integrate efforts to support sustainability;

What's more, San Mateo's MHSA plan clearly described the priority of intervening early and identified stress, PTSD, and use of alcohol and drugs as factors where early intervention were most important, particularly in relation to individuals from historically underserved populations.

Project Success meets most of these criteria:

- It works upstream by engaging youth in elementary through high school, providing mental health services at the school site to make access to services easier;
- It introduces an evidence-based approach to prevention, building assets of students, helping them develop coping skills and educating them about the risks from drug and alcohol use and their alternatives; and
- It serves populations that have been historically under-served.
- As Puente serves as the County's Differential Response resource in Southcoast, students or families identified in Project SUCCESS as in need of more intensive services, can do so immediately. This places Pserves as a de-facto point of entry into the Puente's comprehensive continuum of behavioral health services and as an extension of Children's Protective Services.

However, Project SUCCESS falls short on providing evidence of the program's success in generating positive outcomes: boosting student use of coping skills, building assets, foregoing the use of drugs / alcohol, increasing their success at school, or satisfying its clients.

Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?

The report has described a number of factors that have impeded effective delivery of services. Among those factors:

Extremely small enrollment at every grade level. The small number of students, particularly at the elementary and middle school levels, limits the pool of students from which to draw. More typically sized elementary and middle schools would have 4-5 times the number of students, significantly reducing the challenge in engaging sufficient numbers of students for a series of eight-week groups.

District requirement that groups not occur during class time. In most schools, students enrolled in individual or group counseling are routinely released from class for this purpose. This makes it far easier to sustain consistent participation. In La Honda-Pescadero, despite efforts on the part of Puente leadership, students participating in groups can only do so during lunch-time, a time that is historically viewed by students as being "their" time. This is a very significant barrier to group work and could explain by itself the low numbers in groups.

Slow school process gathering passive consent forms. In order to participate in Project SUCCESS groups, the school district must collect these forms signed by parents. This is a challenge in all schools, as school staff priorities are more focused on getting instructional programs launched than

in promoting or supporting counseling or after school programs. As a result, Puente is unable to launch groups until late fall.

Small staff impacted by maternity leave. Programs funded via P&EI funding do not receive funds for data collection and in most all instances operate with very lean staffs. In several evaluations, the departure of a single staff member resulted in some element of service delivery suffering. In one program it was its parent engagement, but in most, the first thing to be lost is a commitment to consistent data collection. Puente lost a key staff person due to maternity leave resulting in the Clinical Director performing dual roles. This contributed to data collection falling far short of what was expected. In the structured interview with the Puente CEO and Clinical Director, this shortcoming was acknowledged and both committed to ensuring that data collection practices are significantly strengthened. Evidence of this commitment is Puente's purchasing evaluation tools and training from Search Institute.

These challenges are not easily overcome and from the structured interview, it is clear that Puente has made significant efforts to work with the district to achieve changes that might make group services more accessible to students. It has also introduced a range of alternative programming to better serve the high school and parent communities. Nonetheless, the counseling program, particularly group and individual counseling at the elementary and middle schools are critical Project SUCCESS components reaching students early and helping them build developmental assets that can be foundational to their success academically and socially. Low engagement of these younger populations simply isn't compensated for by delivering more robust parent or high school programs. And Puente leadership understands this.

Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

In truth, during conversations beginning in June 2013, the evaluator had the impression that Project SUCCESS was a very well managed program, collected good data and would be one of the easiest of programs to evaluate. That Puente had challenges this year collecting data (as described above) should not necessarily be cause for concerns about the quality of the program, but does point to the need for significant improvement in their data collection processes. In addition, a review of the data that was available points to specific improvements are possible, particularly in the scale of services and the numbers served at the elementary and middle school levels. The following recommendations are made:

1. ***Search Institute adoption.*** Share with the evaluator the new tools and protocols that will be part of Puente's contract with the Search Institute, including specific pre and post-test assessment instruments, specific plans for when those instruments will be administered and with whom.

2. ***Consistent administration of pre-post assessments.*** Ensure that Search Institute Pre-Post Data for participants in groups and in individual work.

3. ***Facilitate analysis of the impact of higher levels of student participation in programming***. Ensure that data collected from Pre-Post tests, whether for individual or group work, can be provided at a student level in a spreadsheet or report that allows comparison of outcomes between students who participate in individual versus group work and to compare outcomes for students who participate with consistency with those who are not as engaged. The evaluator will work with Puente to facilitate this occurring.

4. ***Expand use of satisfaction surveys***. Satisfaction surveys can provide valuable data to program managers and to the county as to how well a program meets client needs. It can also facilitate specific input into how programming can be improved. Puente should administer satisfaction surveys with students and parents participating in both group and individual work at all four sites, as well as from teachers.

5. ***Obtain student attendance, suspension, and discipline referral data.*** Puente should follow up with the district to ensure receipt of data on student attendance, discipline referrals, and suspensions. This data is generally easily accessible by school districts and requires no work on the part of Puente other than seeking it and providing lists of participating students. But if the program is having a positive impact on these outcomes, the resulting report can only increase the district's commitment to the program. What's more, it would be invaluable data for Puente grant proposals and other funding requests.

6. ***Sustain development of new programming that addresses community needs and serves as a gateway to other programming***. Sustain expansion of parenting groups and Summer Supervision groups and use them as building blocks for establishing greater enrollment in other Project SUCCESS counseling services.

7. ***Increase engagement of students in the 5th grades at Pescadero and La Honda Elementary Schools and Pescadero Middle School***. This is perhaps the most important recommendation and yet the most challenging. It appears to the evaluator that Puente has approached the district to remove barriers to student participation in groups, but that the district is adamant about prioritizing classroom time over time devoted to building student assets, coping skills and understanding of the consequences of the use of drugs and alcohol. While it is common practice at other schools to release students for group counseling, this is not going to happen in Southcoast in 2014-15 and so Puente will have to use the same resourcefulness it has used with the high school students and parents to better engage students in middle school and high school. The expansion to the middle school of schoolwide education related to dating is one such strategy and working with the district to allow for Project SUCCESS groups to serve the entire fifth grade classes at La Honda and Pescadero Elementary Schools is another. Puente leadership indicated that 40-minute, whole-class groups have been launched during lunch at the elementary schools and at the middle schools, a lunch group has also been initiated.

Puente clearly did not engage sufficient numbers of elementary and middle school students and some of the reasons that impeded that engagement have been discussed. At least part of the challenge at the elementary school level had been that the last three years, the district only had one 5th grade class to draw from. In 2014-15, the district created two fifth grade classes, so this challenge will be abated to a degree. Puente was very resourceful in expanding programming at the high school and in relation to its work with parents. It appears that plans are in place that could build service numbers at both the elementary and middle school and in relation to data collection. Puente is to be commended for facing up to its challenges and developing plans for improvement in 2014-15. With significantly expanded data in hand for the 2014-15 evaluation, the evaluator is confident a fair and thorough evaluation can be conducted next year.

Section V Demographic Summary

The data below will be reported with different programs having customized reports if their programs have unique features that would benefit from separate reporting. For example, if a program:

- Offered its programs in different communities; or
- Offered the same program at a school to different students in the first semester than the second; or
- Delivered two or more very different program components, e.g. consultation to school professionals and direct service to children and/or families.

Table I: Demographic Summary					**Source of Data**
Total Unduplicated Served					
Gender		**Clients**	**Program Staff**		
	#	%	#	%	
Male	58	62%	1.0 FTE	16.6%	
Female	35	38%	5.0 FTE	83.4%	
Unknown	1	<1%			
Age	#		%		
Children 0-15	55				
Transition Age Youth 16-24	21				
Adult (25-59)	21		6.0 FTE		
Older Adults 60+					
Families (can include families with children or TAY)	61				
Ethnicity	**Clients**		**Program Staff**		
	#	%	#	%	
Caucasian	22	22.7%	3	50%	
Latino	65	67%	3	50%	
African American					
Asian					
Pacific Islander					
Native American					
Multi-Ethnic					
Other	10	10.3%			
Home Language	**#**	**%**	**#**	**%**	
English	18	19%			
Spanish	45	46%			
Cantonese					
Other (or declined to state)	34	35%			
Underserved Pops Served	**#**	**%**	**#**	**%**	
LGBT	0				
Blind/Vision Impaired	0				
Deaf/Hearing Impaired	0				
Veterans	0				
Homeless	0				

Section VI Program Components:

The information in Table II will be used to report to MHSA as part of the statewide evaluation. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator. See table on next page.

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.		
	Yes	**No**
II-1) Access for Underserved Populations	**X**	
Details: Puente serves a clearly identified under-served community and initiatives such as the Princess Project and Summer Supervision program clearly targeted low-income students while the parent program offers programming culturally responsive to the Hispanic population.		
II-2) Outreach for Early Recognition of Need	**X**	
Details: Screening tools used at all four schools are designed to identify needs at an early age.		
II-3) Access or Linkages to Care	**X**	
Details: While not a primary component, students and families requiring access to other services can get referrals through Puente.		
II-4) Reduction of Stigma	**X**	
Details: Schoolwide and group presentations offer information that is intended to de-stigmatize behavioral conditions and educate students and parents about behavioral health.		
II-5) Screening for Needs	**X**	
Details: See II-2 above.		
Program Activities	**Yes**	**No**
II-6) Addressing Trauma	X	
Details: Building developmental assets can develop resilience and coping skills, as well as peer, family and school support when students encounter trauma.		
II-7) Specific Risk Factors	X	
Details: The primary risk factor addressed by Project SUCCESS is under-age drinking and use of drugs, but the program also provides prevention education related to unhealthy dating and domestic violence.		
	Provide specific details very briefly. 1-3 sentences per line.	
II-7) Indicate the location where program activities occur (identify places where services occur	Three school sites in the La Honda Pescadero community, two elementary schools and one site that serves both middle and high school students.	
II-8) Specify the roles for Peers (mentors Outreach, Peer education, other)…Please specify.	Peers are used in the Summer Supervision program with paid students assigned to roles in the community and then the students meet in group to provide peer support.	
II-9) Specify the sectors with which you collaborate on this program (housing, criminal justice, public health, education, child welfare)	In addition to a very close relationship with the school district, Puente collaborates with an array of community agencies in placing students in the Summer program. Communication with child welfare is commonplace as is the practice of making	

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.	
	referrals to other service agencies including BHRS and primary care.

Section VII Program Alignment with SMC MHSA PEI Priorities:

Table III: Alignment with SMC MHSA PEI PRIORITIES				
	Children & Youth	**TAY**	**Adult**	**Older Adult**
1-PEI Key Community Needs				
1-A) Disparities in Access to Mental Health Services	X	X	X	
Details: Southcoast has a highly discussed challenge in accessing mental health services, a gap addressed by Puente's co-location at all Southcoast's public schools.				
1-B) Psycho-Social Impact of Trauma	X	X	X	
Details: Building assets can build resilience enabling students to overcome trauma. The program does not explicitly target treatment for trauma.				
1-C) At-Risk Children, Youth and Young Adult Populations	X	X	X	
Details: As the demographic data in Section II describes, the school community is high poverty, with the vast majority of students being Hispanic.				
1-D) Stigma and Discrimination	X	X	X	
Details: Schoolwide presentations and group work are designed to address stigma.				
1-E) Suicide Risk	X	X	X	
Details: : Building assets can build resilience enabling students to overcome depression. The program does not explicitly target treatment for depression except for the Zumba group for adults.				
2- PEI Priority Populations				
2-A) Trauma Exposed Individuals	X	X	X	
Details: Students and parents who seek out Puente services are most often doing so as a result of stress, trauma or depression.				
2-B) Individuals Experiencing Onset of Serious Psychiatric Illness	X	X		
Details: Assessments and group work can be instrumental in identifying students experiencing early onset, especially germane at the high school where more signs of serious psychiatric illness emerge.				
2-C) Children and Youth in Stressed Families	X	X	X	
Details: High poverty, rural and under-served families and youth are clearly living in stress**.**				
2-D) Children and Youth at Risk for School Failure	X	X		
Details: Clearly students lacking developmental assets are more at risk of school failure and increasing their stock of assets will build their resilience and capacity to succeed in school.				
2-E) Children and Youth at Risk of or Experiencing Juvenile Justice Involvement		X		
Details: While not primarily juvenile justice program, low-income students who do poorly in school , have limited future employment options and have low-resilience are more susceptible to the allure of crime.				

Section I Agency & Program Description
I.A. Description of Program Services

Formerly known as Youth and Family Enrichment Services, StarVista came into being when Youth and Family Assistance and Family and Community Enrichment Services merged in 2003. StarVista offers counseling, prevention, early intervention and education resources and services to more than 34,000 people throughout San Mateo County every year. One program operated by StarVista is the Early Childhood Community Team, a project supported with San Mateo County's Mental Health Services Act, Prevention & Early Intervention funding,

Early Childhood Community Team (ECCT) project incorporates several major components that build on current models already operative in San Mateo County. The ECCT is designed to support healthy social emotional development of young children. The ECCT is comprised of a community outreach worker, an early childhood mental health consultant, and a license-eligible clinician. BHRS PEI funding is supporting one team with hopes that StarVista can identify additional funding so there might be two teams something that has been accomplished, as StarVista now operates a North County team with MHSA funding supporting the clinical component and private funds and First 5 supporting the consultation and outreach components. The ECCT targets the geographically isolated Coastside community experiencing a significant degree of interpersonal violence, which has traumatic impact on families and young children. It is also a community identified in multiple County reports as being historically underserved, low-income, rural, and with many migrant farm residents.

While the ECCT delivered three distinct service modalities, in many cases a child or family identified as being at risk and referred to ECCT might benefit from all three of these services. Indeed, from the perspective of the community, the ECCT represents a systemic intervention that addresses the needs of children and families and builds the capacity of the community of service providers who work with these families.

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

The ECCT community outreach worker networks within the community and provides community based services to identify young families with children from birth to five with an emphasis upon children zero to three and connects them with necessary supports both as provided by ECCT and other community agencies. The community outreach worker also provides both home based and group based parent education services. Groups for families with young children, integrate concepts drawn from Brazelton's Touchpoints Program, the Parents as Teachers curriculum, the Promoting First Relationships curriculum, and the Circle of Security Parenting DVD, approaches in which ECCT team members have been trained. Participants learn how to use relationship-building and communication strategies when they deliver care and interact with children and families. The Touchpoints groups include fathers as well as mothers and other caregivers.

ECCT clinical services are delivered by ECCT licensed clinicians who provides focused services to families who have been identified as being in need by the ECCT community outreach worker. The clinician screens for postpartum depression and facilitates appropriate service plans with primary care and/or mental health services. The SV ECCT clinician has been trained in Infant-

Parent and Early Childhood mental health and/ or Child-Parent Psychotherapy (CPP). CPP model has been shown to be particularly effective with young families at risk due to trauma. The goal of CPP treatment is to support and strengthen the parent-child relationship as a vehicle to long-term healthy child development. With trauma-exposed individuals, these treatments incorporate a focus on trauma experienced by the parent, the child, or both. Sessions include the parent(s) and the child and can be conducted in the home. Individual parent, child, or family sessions may be added as needed.

Another ECCT team member, the Early Childhood Mental Health Consultant, focuses on supporting social emotional development in child care settings by providing early childhood mental health consultation. This service typically consists of the following activities:

- Observing the interaction of the caregiver(s) with young children;
- Observing a child's interaction with caregiver(s) and other young children;
- Consulting with the caregiver(s) regarding overall support of positive social emotional development;
- Consulting with the caregiver(s) on developmental or behavioral concerns regarding a specific child;
- Facilitating family and caregiver meetings; and
- Facilitating referrals for additional services for children and families

Historically early childhood mental health consultation services were operated by another agency that merged with SV and now SV operates all consultation in the county[Prior to launching the ECCT in Coastside, ECCT services were offered throughout the County. Since StarVista operated consultation in 34 sites in San Mateo County, including Head Start preschool programs, Early Head Start family childcare programs, and other programs in Redwood City, Daly City, South San Francisco, central San Mateo and East Palo Alto. Through these ten sites, childcare consultation reaches about 2000-2200 children, with consultants working with childcare settings ranging from those provided by licensed family day care providers, license exempt providers, and family/friends/neighbors.

I.B. Research Basis for Approach

The Mental Health Services Act proscribes that funding is used to adopt, adapt and implement prevention and treatment services that are evidence-based. The ECCT initiative is informed by the following evidence-based or promising practices and ECCT staff has been trained in or have utilized practices and principles from each of the following:

- The Circle of Security Parenting DVD
- Child Parent Psychotherapy
- Touchpoints
- Parents as Teachers
- Promoting First Relationships
- Early Childhood Mental Health Consultation.

Each model is described briefly, followed by a summary of the research base that supports the efficacy of each approach.

The Circle of Security DVD [Circle of Security Parenting Training© is a DVD parent education program offering the core components of the evidence-based Circle of Security protocol. This 4-Day seminar trains professionals to use an eight chapter DVD to educate caregivers. The program presents video examples of secure and problematic parent/child interaction in the zero to five age range, healthy options in caregiving, and animated graphics designed to clarify principles central to Circle of Security. Circle of Security Parenting implements decades of attachment research in an accessible step-by-step process for use in group settings, home visitation, or individual counseling.

Parents as Teachers (PAT) is an early childhood family support and parent education home-visiting model. Families may enroll in Parents as Teachers beginning with pregnancy and may remain in the program until the child enters kindergarten. Based on theories of human ecology, empowerment, self-efficacy, and developmental parenting, Parents as Teachers involves the training and certification of parent educators who work with families using a comprehensive research-based and evidence-informed curriculum. Parent educators work with parents to strengthen protective factors and ensure that young children are healthy, safe, and ready to learn. The goals of the model are to increase parent knowledge of early childhood development, improve parenting practices, provide early detection of developmental delays and health issues, prevent child abuse and neglect, and increase children's school readiness and school success. Different curriculum materials are used for those working with families of children up to age 3 and those working with families of children from age 3 to kindergarten.

Home visitation is the key component of the Parents as Teachers model, with personal visits of approximately 60 minutes delivered weekly, every 2 weeks, or monthly, depending on family needs. Parent educators share research-based information and use evidence-based practices by partnering, facilitating, and reflecting with families. Parent educators use the Parents as Teachers curriculum in culturally sensitive ways to deliver services that emphasize parent-child interaction, development-centered parenting, and family well-being. Parent-child interaction focuses on promoting positive parenting behaviors and child development through parent-child activities. Development-centered parenting focuses on the link between child development and parenting and on key developmental topics (i.e., attachment, discipline, health, nutrition, safety, sleep, transitions/routines, healthy births). Family well-being includes a focus on family strengths, capabilities, skills, and the building of protective factors.

Parents as Teachers was established and first piloted in Missouri in 1981 to alleviate the learning and achievement gaps in children entering kindergarten. More than 2,000 Parents as Teachers affiliates are implementing the model, serving more than 250,000 children in more than 200,000 families across all 50 States and in other countries (including Australia, Canada, England, Germany, Mexico, New Zealand, Scotland, Switzerland, and Wales). Research studies have been conducted and supported by State governments, independent school districts, private foundations, universities, and research organizations, and outcome data have been collected from more than 16,000 children and parents. The intervention has been evaluated in four independent, randomized controlled trials and many quasi-experimental and qualitative studies, many of which have been described in peer-reviewed publications.

Touchpoints. This approach, developed by T. Berry Brazelton, is based on the concept of building relationships between children, parents and providers around the framework of "Touchpoints," or key points in early development. The quality of the infant-caregiver relationship is a risk or protective factor for infants' later development. Infants who develop a "secure" attachment relationship with the primary caregiver during the first year of life are more likely to

have positive relationships with peers, to be liked by their teachers, to perform better in school, and to be more resilient in the face of stress or adversity as preschoolers and later. Infants who develop an insecure attachment relationship are at risk for a more troublesome trajectory; factors associated with insecure relationships include maternal mental health problems, including depression, substance abuse, family violence, and unresolved grief. Because of the strength of influence of the infant-caregiver relationship, any factors that impact the infant-caregiver relationship play a determining role in the emotional functioning of the young child (Zeanah et al.,2000). As a specific program, one study finds that the Touchpoints model increases the parenting self-confidence of adolescent parents (Percy et al, 2001).

Child-Parent Psychotherapy. Child-Parent Psychotherapy (CPP) is an intervention for children from birth through age 5 who have experienced at least one traumatic event (e.g., maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence) and, as a result, are experiencing behavior, attachment, and/or mental health problems, including posttraumatic stress disorder (PTSD). The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and improving the child's cognitive, behavioral, and social functioning.

The type of trauma experienced and the child's age or developmental status determine the structure of CPP sessions. For example, with infants, the child is present, but treatment focuses on helping the parent to understand how the child's and parent's experience may affect the child's functioning and development. With older children, including toddlers, the child is a more active participant in treatment, and treatment often includes play as a vehicle for facilitating communication between the child and parent. When the parent has a history of trauma that interferes with his or her response to the child, the therapist helps the parent understand how this history can affect perceptions of and interactions with the child and helps the parent interact with the child in new, developmentally appropriate ways.

CPP was developed in the 1980s through an adaptation of the infant-parent psychotherapy model, which was developed in the 1970s by Selma Fraiberg and colleagues. The first efficacy trial of CPP began in 1985. The Child Trauma Research Program began disseminating CPP through the National Child Traumatic Stress Network (NCTSN) in 2002. Since then, approximately 143 sites have implemented the intervention. Five randomized controlled trials have been conducted, and the findings from these studies have been published. In addition, reports have been written on the evaluation of dissemination efforts, including the dissemination of CPP within the NCTSN. Since 1996, more than 527 individuals have received training in CPP. Approximately 10 additional individuals per year have received CPP training through internships and fellowships with the Child Trauma Research Program, and other internships and fellowships in CPP are available through the Child Witness to Violence Program; the Tulane University Infant Team; the Louisiana State University Child Violence Exposure Program; and the Mount Hope Family Center, University of Rochester.

Early Childhood Mental Health Consultations (ECMHC). Early childhood mental health consultation builds upon the well- established field of mental health consultation, pioneered by Gerald Caplan in the mid-sixties. In Caplan's seminal work (1964), he outlined an approach that involves mental health professionals working with human services staff to enhance their provision of mental health services to clients. Similarly, in ECMHC, a professional consultant with mental health expertise "works collaboratively with Early Childhood Educatoin (ECE) staff, programs, and families to improve their ability to prevent, identify, treat, and reduce the impact of mental health

problems among children from birth through age 6" (Cohen & Kaufmann, 2000; revised 2005). Ultimately, early childhood mental health consultation seeks to achieve positive outcomes for infants and young children in early childhood settings by using an indirect approach to fostering their social and emotional well-being.

Studies on the impact of ECMHC in early childhood settings are increasing in complexity, and evidence of the effectiveness of this approach is mounting. In a clustered randomized control study of Chicago School Readiness Program classrooms, outside observers found that teachers receiving ECMHC had significant improvements in teacher sensitivity and enhanced classroom management skills, compared with teachers in classrooms without consultation (Raver et al., 2008). Observers also found that the classroom climates improved after consultation, with more positive interactions between teachers and children and fewer negative exchanges, in contrast to classrooms where no consultation was present. Staff members also rated themselves as significantly more able to manage children's difficult behavior after consultation in 9 of 11 studies reviewed by Brennan et al. (in press; see, for example, Alkon, Ramler, & MacLennan, 2003; James Bowman Associates & Kagan, 2003; Olmos & Grimmer, 2004). Finally, teachers have also generally reported lower levels of job stress after they receive consultation services (Green et al., 2006; Langkamp, 2003; Olmos & Grimmer, 2004). Teachers in classrooms with ECMHC services reported that children had fewer problem behaviors after these services were implemented (Bleecker & Sherwood, 2004; Gilliam, 2007; Perry, Dunne, McFadden, & Campbell, 2008; Upshur, Wenz-Gross, & Reed, 2008). Particularly, there is evidence that externalizing (aggressive, disruptive) behavior was less frequent after consultation (Gilliam, 2007; Raver et al., 2008; Williford & Shelton, 2008). Children with difficult internalizing (withdrawn, disconnected) behavior showed improvement in some studies (Bleecker, Sherwood, & Chan-Sew, 2005; Raver et al., 2008), but not in others (Duffy, 1986; Gilliam, 2007). Positive social skill development also accelerated for children with ECMHC services in several studies (Bleecker & Sherwood, 2003, 2004; Farmer- Dougan, Viechtbauer, & French, 1999; Upshur et al., 2008). Finally, there is evidence that when mental health consultation is available in early childhood programs, the rate of expulsion of children with difficult or challenging behavior decreases (Gilliam, 2005; Perry et al., 2008). While there is less evidence related to the impact of ECMHC interventions on longer-term outcomes for children and families, this is largely due to the complexity of such evaluations and that early childhood providers do not typically track these outcomes. Nonetheless, there is ample evidence that ECMHC has a positive impact upon child functioning in the classroom and teacher capacity to address the needs of children exhibiting challenging behaviors.

I.C. Target Population, Number Served and Sites

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

In addition, a second ECCT operates in North County with MHSA funding supporting the

clinical services and private funding supporting the consultation component. This team has not been able to engage the North County community quite as effectively as in Coastside. See EQ # 7 for more on this.

Operating with a primary office in donated space in Half Moon Bay contributed by Cabrillo School District, Mental Health Consultation services continue to support staff and families at early care and education settings in the Coastside. Consultation services continue to have a significant impact on the families and staff at the four programs receiving this service in the Coastside: Half Moon Bay Head Start; Moonridge Head Start and Early Head Start, and Coastside Children's Program. While these are the primary early childhood mental health consultation sites, the ECCT is highly mobile, providing services at four early childhood programs as well as in the homes of families. The table at left summarizes the ethnicity of the children served and the primary language of the parent/caregiver. While data is not collected about income status of families, three of the four early childhood programs are Head Start or Early Headstart programs that have income criteria for enrollment and approximately one-fourth of the families enrolled in the fee-for-service center are subsidized by state early childhood subsidies eligible to low-income families. A summary of the units of services and types of services delivered is provided under EQ # 1.

Table I: Client Ethnicity		
Ethnicity	#	%
Latino	73	90%
Caucasian	4	5%
Mixed Race	3	3.6%
Middle Eastern	1	<1%
African American	1	<1%
Other	1	<1%
Total	83	100%
Primary Lang		
Spanish	62	75%
English	16	19%
Bilingual	3	3.6%
Other	2	2.4%

Section II Evaluation Process

The evaluation plan was developed in June-July 2013 through a series of participatory meetings that included the evaluator, Program Director, Christina Lansdown and Sarah Dobkin Program Manager for the Early Childhood Mental Health Consultation Program. A second series of discussions occurred in November and December of 2013 with a final series of conversations occurring in October and November 2014 when the final evaluation report was developed. In June 2013, ECCT leadership shared with the consultant a myriad of screening, assessment, observation and diagnostic tools utilized in their practice. The evaluator reviewed the varied tools and together a plan was developed to use and determined that the following tools would be used in the evaluation.

Arnett Global Rating Scale. The Arnett is an observational tool used with the ECMHC program that is designed to measure changes in the caregiver's approach to a child in their care.

The Devereaux Early Child Assessment, a pre-post assessment tool comprised of a sixty-two item, forced choice assessment that can be completed by a caregiver, mental health consultant or by a parent with each item representing a kind of child behavior. The assessment produces subscale scores for: initiative, self-control, withdrawal, emotional control problems, attention problems, aggression, as well as Total Protective Factors and Total Behavioral Concerns.

Child Behavior Checklist. A pre-post test assessment which is used more for therapeutic purposes to assess how services are impacting the child's behavior.

Parent Stress Index. Is a pre-post assessment tool designed to capture the level and type of stress experienced by the parents.

Life Stressor Checklist that provides a good profile of the kinds of stresses experienced by families served by ECCT. It is only given at intake so it does not contribute to evaluating the program's impact.

Assessing Angels. A qualitative interview tool used asking about the parents' childhood memories and what they would want for their child.

The Parenting Relationship Questionnaire. Developed by the authors of the BASC-2, the Parenting Relationship Questionnaire (PRQ) is an assessment that can be completed in 10-15 minutes by a mother, father or other primary caregiver. It is designed to capture a parent's perspective on the parent-child relationship. The PRQ has two forms, one for Preschool (ages 2-5) and another for Child and adolescent (ages 6-18). Features of the PRQ:

- Multiple dimensions that are relevant to the development of strong and healthy parent-child relationships;
- Normative samples, for both female and male raters, that are closely matched to U.S. Census population estimates;
- Items written at a third-grade reading level;
- Validity indexes that can be used to detect careless or exaggerated responding;
- Three types of record forms: hand-scored, computer-entry, and scannable; and

- Computer software that provides detailed single- or multiple-administration reports, including progress reports and multi-rater reports that can be used to compare mother and father settings

Provider Satisfaction Survey. A seventeen-item forced choice survey was used with 15 of the 20 teachers who had received mental health consultation services.

With such a rich array of validated tools, the evaluator and ECCT leadership were confident of being able to develop a robust evaluation support by a variety of forms of data. Unfortunately when discussions began first in July and then in October-November, 2014, the evaluator learned that each of these tools is used to respond to very specific kinds of client families and children and more importantly, the focus of the ECCT was to use these for diagnostic and clinical purposes, not for evaluation. These factors, plus the reality that many cases closed quickly without allowing for a battery of post-test assessments, led to an extremely low N for many of the above tools. Factors contributing to a small number of post-test results included:

- High turnover in the early child care programs, with teachers with whom ECCT consultation team was working, leaving without sufficient time to arrange a post-test observation;
- While the ECCT served 83 children, some were served through consultations with parents, others in play groups, others through consultation with teachers, and still others in child-parent psychotherapy. Each of these service components utilize different tools to suit their specific clinical and programmatic focus; and
- High mobility among client families involved in group and/or individual counseling services and with families exiting the program without scheduling an exit interview where a post-test might have been administered.

Despite these challenges sufficient data was organized to assess the degree to which the program had served the Coastside community. Data included

- Program participation data which captures the number of families and childcare professionals served by a range of distinct services;
- Pre-post data from the Parenting Relationship Questionnaire (PRQ) and the Child Behavior Checklist (CBCL). While in both instances the N was small relative to the number of parents taking the pre-test, the results still showed reasonably clear trends in terms of program impact.
- Parent satisfaction survey results for six parents, again a relatively low N but with clear indications of satisfaction;
- Childcare professional satisfaction survey indicating level of satisfaction and impact of consultation services, with an N of 15 being a more representative sampling; and
- Structured interviews with ECCT staff used to construct two case studies illustrating how the ECCT system operates and how it has become an integrated component of the Coastside family service system.

While this data allowed for a reasonably rich evaluation, many opportunities for data collection were missed that could have contributed to the program achieving a clearer, more specific view of its program effectiveness and impact. StarVista leadership acknowledged these missed opportunities and is committed to taking better advantage of them in 2014-15. These opportunities are discussed under EQ # 7.

Section III Evaluation Findings

There are seven evaluation questions that frame the evaluation of the Prevention & Early Intervention programs supported with Mental Health Services Act funds.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to the contract funding the program?
Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?
Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?
Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?
Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?
Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?
Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

The ECCT program evaluation encountered a significant challenge resulting from the program delivering three distinct components, each of which utilized different assessment tools for clinical purposes. This significantly reduced the size of the N on any one of these assessments. Nonetheless, available data was sufficient to produce a reasonably robust evaluation report. The process of developing the report also resulted in identifying opportunities for expanded data collection that will result in a more data rich report next year as well as opportunities for use of data in program improvement activities.

Despite the limitations imposed by the low N described above, from the available data there were clear signs that the ECCT was an extremely effective and efficient program. The ongoing waiting list is indicative of a program that is both needed and valued. Satisfaction data shows high levels of satisfaction among both parents and teachers served by the ECCT. Pre and post test data, while having a low N, indicate strong gains by children and parents.

The evaluation process also identified numerous recommendations for program improvement and improved data collection including strategies to expand and improve ECCT penetration in North County, strategies for expanding the use of satisfaction surveys with parents and teachers; strategies for clarifying the ECCT role in Kick-Off to Kindergarten, a partnership with Cabrillo Unified School District; and strategies for expanded use of pre-post test through the adoption of a tickler system that prompted the use of post-tests before families exit the program.

These recommendations are described in detail in the discussion under Evaluation Question VII. While these are certainly recommendations that, if adopted, would improve the impact of the ECCT, that there are these recommendations should not diminish the prevailing finding that ECCT is providing a valuable and effective service, in a historically underserved community, serving rural, low-income, largely Latino families. Evaluation findings are discussed in detail under EQ # 7.

Each evaluation question is discussed separately below.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to the contract funding the program?

Table II: Units of Service Type of Service	UOS Total
PlayGroup	229
Family Therapy	281
Collateral - family/significant others	120
Collateral Contact (Outside Agency)	28
Consultation – Parent Meeting	75.5
Consultations with Teachers (no parent)	421
Phone Call	10.63
Consultation – Parent-Teacher Meeting	36
Assessment	40
Observation	154
Case Management	169
Individual Therapy	6.5
Direct Client Service	2
School Meetings	264
School Group	4

As with most all of the PEI programs, StarVista's contract for ECCT services did not delineate expectations about the number of clients to be delivered, the number of services to be delivered, or the expected dosage of services. As a result, the evaluation reviewed the level of service delivery without assessing whether or not that level met a pre-determined expectation for productivity. Table II is based upon reports provided by StarVista and reflects the levels of services delivered in 2013-14. A closer examination of client-level data shows the following trends in services:

- Of the 83 child clients served during 2013-14, either through family counseling or consultation with childcare workers, thirty-one families were identified as having completed the program successfully and 48 were identified as currently enrolled on June 30, 2014;
- Two referred families were unable to be reached, one refused service and one moved after being enrolled for 83 days;
- The average length of enrollment was 212 days;
- There currently is a wait list, indicative of a program operating at maximum capacity; and
- Referrals came from head start programs, parents, Cabrillo Unified School District, Coastside Mental Health, a variety of local elementary schools, Edgewood Center, Pre-3, and Watch Me Grow: an indication of the degree to which the ECCT has become known throughout the Coastside community.

Unfortunately, the way in which units of service was reported to the evaluator, it was impossible to capture the dosage or mix of services that each child received, data that could then be correlated with outcomes to see if there was a correlation between involvement in specific types of levels of services and outcomes. Another limitation is that while it was possible to calculate the average number of days that clients were engaged in the program, it was not possible to glean from the data what level of engagement and receipt of services a family/child might be receiving while still enrolled in the program. This would be good data to have for the 2014-15 evaluation. However, from ECCT's end-of-year report, some descriptive narrative was provided concerning the level of services. Mental health consultation services were provided to 4 childcare programs in the Coastside region serving 116 children and 20 staff. More intensive, ongoing case consultation services were provided to 29 families. Consultation activities included weekly visits with childcare providers, individual and group consultation meetings, meetings with parents, observations of classrooms and individual children and assistance with resources and referrals. Consultation was provided on a weekly basis in either group and/or individual meetings depending on the specific needs of each center and staff members.

Weekly child-parent psychotherapy services were provided to 14 families in the Coastside region and 8 families in the Daly City/Northern San Mateo County region. An additional 6 families

received a mental health assessment, but did not move into the treatment phase. Weekly services include family therapy, collateral individual sessions, and additional collateral contacts such as school observations, participation in TDM or IEP meetings, etc. Most participants receive psychotherapy services for about one year.

The ECCT Community Worker provided services to 28 families with services including case management, parent education and assessment. An additional 26 children and their caregivers attended our Parent-Child Activity groups. Services are provided weekly, monthly or on an as needed basis.

In addition to implementing the variety of services that are central to the ECCT model, StarVista engaged the Coastside community to find ways that the team's expertise could build community capacity or fill unmet needs. One example of this is in the teams provision of training in areas related to early child development. ECCT staff has collaborated to respond to the needs expressed by ECCT partners at the school district and the Coastside Clinic to provide multiple workshops this year. Themes included School Readiness, Children and Trauma, Social Emotional Development, and Positive Discipline. These presentations were adapted for each unique audience. In this manner we were able to serve diverse groups such as teachers, providers, and administrators as well as parents. While no data was collected to document the numbers in attendance or a pre-post test to determine impact or perceived effectiveness, StarVista leadership agreed that this could be possible going forward.

Another excellent example of extending expertise to meet community needs has been how ECCT staff supported teachers and families participating in Kick-Off to Kindergarten this year by administering the ASQ-3 and ASQ-SE screening tools and providing needed referrals to any child identified with a potential need for additional support. The Early Childhood Community Team collaborated with Cabrillo Unified School District in June and July of 2013 to perform screenings of children entering kindergarten and to connect with families with young children needing additional support services through the Kick-Off to Kindergarten program. During this time period, the ECCT Community Worker provided eight evaluations and received around 16 referrals. Of these 16 referrals, about half of the referrals became clients. About five referrals were not appropriate for services provided by ECCT and in the remaining referrals, parents either did not want to engage or did not respond to outreach.

ECCT identified two areas that felt particularly important in reflecting on the collaboration this summer: teachers' communication to parents (both with regards to the referral to ECCT and around the child specifically) and inappropriate referrals. To improve communication this year, the ECCT Community Worker spoke with the school district when referrals started coming directly from teachers to make sure that parents were being informed that a referral was being made. Even though the outreach worker was able to arrange for initial contact to be made by teachers or the school secretary, many parents still did not have a clear understanding as to the purpose of the referral or the services the ECCT would be able to provide. One note of concern to ECCT with regard to teachers speaking to parents about their children was an incident in which a mom and kindergarten teacher were each told by a summer teacher "this is the worst kid I have ever seen." In conversation with ECCT leadership, it was noted that training for teachers in more appropriate language for voicing concerns about a child's behavior would be important going forward.

Less appropriate referrals included referrals of children in which the primary concern identified by the teacher was an academic concern, e.g. "he doesn't know how to write his name" or "she doesn't know rhyming words." While teachers at the Kick-Off to Kindergarten program work

with a list of academic and behavioral expectations for children entering kindergarten provided to parents and preschools, ECCT will need to clarify expectations around the types of deficits that would trigger referral to ECCT and that academic concerns, while important, are not part of ECCT's services.

Since the contract was silent as to a projection as to the number served and the number of units of service for each type of service, it is not possible to assess whether the level of services was sufficient for the resources in the contract. Also, it was not possible to assess the degree to which individual client/families/children/teacher received specific dosages of services. Nonetheless, based upon available data, it would appear that ECCT engaged high numbers of at-risk families, served under-served populations (90% Latino, 75% Spanish-speaking) and provided the range of services identified in the contract.

Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?

From the report that ECCT provided to the County at the end of the year, the following impacts were claimed.

As a result of on-going mental health consultation, teachers at 4 childcare programs have demonstrated greater ability to understand and respond to the social-emotional needs of children in their centers. For 8 of the children provided case consultation, teachers were observed in a pre- and post-test assessment using the Arnett Caregiver Interaction Scale, which measures the relationship between teacher and child. In seven cases, teachers showed increased responsiveness and sensitivity to the children (the eighth showed no difference). In no case was a teacher rated in the lowest quadrant of this four-point rating scale and a total of five teacher-child interactions were rated in the highest quadrant during the post-test: in two of these cases, this rating represented a move from the second highest quadrant into the highest quadrant.

As a result of mental health consultation services, 29 families have increased their capacity to understand their child's behaviors and to respond effectively to their social-emotional needs. This increased capacity is noted in the parent surveys (results below) and also in informal comments made by parents in noting their satisfaction in working with the consultant. On the survey, parents included comments that indicate they enjoyed the work with the consultant, writing "she helped us to understand how to relate with my son" and "she helped me with other phone numbers of other people who helped me." Parents and teachers also noted differences in children's behaviors: the ECCT consultant was able to observe these differences in pre- and post-test assessments using the Devereux Early Childhood Assessment Clinical Form (DECA-C), which measures behaviors related to risk and resilience in preschool children. Over the course of the past program year and 6-12 months of working with the teachers and parents, for the six children for whom it was possible to complete a pre- and post-test assessment, statistically significant increases in protective factors were observed in three children and statistically significant decreases in behavior problems were observed in one of these three and also in one additional child. Additionally, 8 families have received referrals to additional services in the community.

Parents receiving child-parent psychotherapy services who reported symptoms of maternal depression at the onset of treatment currently report fewer symptoms and greater capacity to manage and understand their own mental health needs. Parents receiving child-parent psychotherapy services have reported gains in their understanding of their children's needs and behaviors, and in their ability to respond effectively to these needs. These clients complete pre and post test assessments using multiple measures, including the Parenting Relationship Questionnaire (PRQ), the Child Behavior Checklist (CBCL), the Parenting Stress Index (PSI), and the Keys to Interactive Parenting Scale (KIPS). Scores on the PRQ and PSI measures at the outset of treatment on average reflect low levels of attachment, involvement, discipline practices, and parenting confidence along with high levels of relational frustration and parenting stress. While these areas are not always the focus of clinical treatment, ECCT reported that clinicians saw consistent improvements, or at least stable scores in these domains. It is also common to see a high level of concern for child behavior, and lower scores on the KIPS which is a parent-child interaction observational scale. ECCT typically sees improvements or at least stable scores on the CBCL and the KIPS as well at the close of services. See below for a more detailed analysis of the CBCL and PRQ assessments.

Families with resource needs have been supported with appropriate linkages and referrals to access services such as food, housing, childcare and early education, legal and mental health services. Families with parenting and school readiness concerns have received relevant Parent Education services to support parents in better meeting their children's social-emotional needs and taking advantage of teachable moments. In the past, attendance at ECCT Parent-Child Activity groups was overwhelming, with more than 25 children plus their caregivers in consistent attendance. To better meet the needs of the community, ECCT leveraged its relationship with StarVista's Learning Together in order to create a second group. The result is that ECCT now facilitates robust, complementary groups running recurrently on consecutive days, one dedicated to children aged 3 and under, and the other focused on children ages 4 and 5.

One measure of the impact of the ECCT program on child behaviors is gleaned through a review of pre-post test data on the Child Behavior Checklist (CBCL), a 100-item forced choice list of problem behaviors where a parent is asked to identify if that behavior is not true, somewhat true or very true as relates to their child. The 100-item checklist is disaggregated to produce scaled scores for each of 15 domains of behavior, including:

Emotionally reactive	Anxiety-Depression;
Somatic complaints;	Withdrawn;
Sleep problems;	Attention problems;
Aggressive behavior;	Affective problems;
Anxiety problems;	Pervasive development problems
ADHD;	Oppositional disorder;
Internalizing problems; and	Externalizing problems.

In addition a global score is produced for Total Problems. For each domain and for Total Problems, are produced with ranges denoting "clinical," "borderline" and "normal." While the PRQ Scale that follows the CBCL has specific numeric delineations for determining clinical and borderline status, the specific point totals determining these descriptors varies slightly based upon the age of the child and the specific domain being assessed. As a result, in Table III, there are instances where on one domain a 69 is deemed 'normal' and in another it is 'borderline.' In Table III below, "clinical" scores are identified by a screened cell and bold number, "borderline" is indicated by a bold number. While the N for the CBCL was quite low, the trends indicated in Table III are entirely positive. In 19 instance where a child was indicated as having a clinical level deficit, significant improvement was made with only one exception (Client # 3 in relation to being withdrawn) and in this instance there was no change. Indeed, in 17 of the 19 instances, the child's improvement was sufficient to remove them from a 'clinical' deficit level. In addition in all seven instances where a child's behavior was identified as 'borderline' sufficient improvement was observed to move that behavior from borderline to normal. Finally, when examining the average change between pre and post-tests for each of the fourteen behaviors, thirteen of fourteen showed reductions from pre to post test with only one (Somatic behavior) showing a very slight increase. What's more, the behaviors that had the highest score in the pre-test and that had the most children exhibiting clinical deficit levels were the behaviors that showed the most marked improvement (Emotionally reactive, Anxiety-depression, Withdrawn, Aggressive behavior, and Pervasive development problems). So while the N is low for this summary, the trends are entirely positive and suggest that children are benefiting from ECCT interventions. See Table III on the following page.

Table III: Child Behavior Checklist Pre-Post Test Summary														
	#1		#2		#3		#4		#5		# 6		Ave	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Emotionally reactive	73	59	70	62	69	55	55	51	62	55	50	50	63.17	55.33
Anxiety-Depression;	66	56	69	52	66	51	51	52	52	52	56	50	60	52.17
Somatic complaints;	50	50	53	53	62	65	50	50	53	58	53	50	53.50	54.33
Withdrawn;	76	60	82	70	70	70	56	60	56	50	67	50	67.83	60.00
Sleep problems;	50	50	56	53	51	51	50	50	53	53	51	50	51.83	51.17
Attention problems;	67	62	50	50	73	57	57	57	53	53	50	50	58.33	54.83
Aggressive behavior;	82	59	68	59	86	72	66	59	52	55	50	50	67.33	59.00
Affective problems;	67	52	60	51	60	51	50	63	67	67	56	51	60.00	55.83
Anxiety problems;	63	54	67	54	60	56	50	54	52	54	51	50	57.17	53.67
Pervasive development problems	79	63	82	72	74	66	66	59	54	51	59	50	69.00	60.17
ADHD;	67	64	52	51	67	60	57	52	54	54	50	50	57.83	55.17
Oppositional disorder;	73	59	67	59	70	64	55	51	51	52	50	52	61.00	56.17
Internalizing problems; and	70	56	73	62	70	62	51	53	58	53	12	29	55.67	52.50
Externalizing problems.	72	60	63	56	83	69	65	59	52	50	39	37	62.33	55.17
Total Problems	73	59	69	57	73	63	57	57	56	57	46	32		
Change	-14		-12		-16		0		+1		-14		-55	
Ave Change													-9.1	

StarVista also used the Parenting Relationship Questionnaire (PRQ), a 45 item forced choice question that examines five domains of the parent child relationship:

Attachment;
Involvement;
Relational Frustration;
Discipline practices;
Parent Confidence; and

For all domains, T-scores can be classified into the following ranges: 10-30 (lower extreme), 31-40 (significantly below average), 41-59 (average), 60-69 (significantly above average), and 70+ (upper extreme). Parents who "improved" had scores that increased and moved them into a higher range. Parents who "maintained normal" had scores that remained average or above average. Parents who "maintained clinical" had scores that remained below average. Parents who "declined" had scores that decreased and moved them into a lower range.

As Table IV below illustrates, average scores for the five parents completing the pre-post test increased in four of the five domains with increases highly significant in three domains (attachment, discipline and involvement). Across all five domains there were twice the number of increases (12) as declines (6). It is also worth noting that there were 16 instances of improvement or maintaining in a normal range and only nine instances of decline or maintaining in a clinical status. While the N is very low, the trend line is consistently positive.

Table IV: Parenting Relationship Questionnaire (PRQ)

Domain / Client	Attach		Discipl.		Involve.		Confid.		Frustration	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
1	*40*	55	61	58	52	49	*26*	39	89	57
2	*33*	33	56	54	*34*	44	43	19	73	60
3	*37*	48	*35*	54	*27*	32	*30*	36	67	70
4	44	38	*31*	47	*34*	40	52	38	53	56
5	50	64	*39*	52	42	66	64	67	*4*	53
Ave	40.8	47.6	44.4	53	37.8	46.2	43	39.8	57.2	59.2
# Improved	3		3		2		2			2
# Maintained Normal			1		1		1			1
# Maintained Clinical	1				2					
# Declined	1		1				2			2

What is not captured in the table is that a total of 17 parents took the pre-test with just under 30% of these parents (5) also took the post-test. What's of more concern, is that among the 12 who did not take the post-test, only three did not register at least one score in the significantly below average or in the lower extreme range. What's more, half of these parents had at least one score in the extreme low range with three having two domains scored in the extreme low. Finally, half of the 12 had at least three domains where they exhibited significantly low or extreme low scores. This suggests that at least twelve parents with significant parenting challenges were not administered the post-test. Indeed, if you average the scores for all pre-test parents, five of the six lowest scores never took the post-test.

Despite the limited number of pre and post-tests on these assessments, the data that was available strongly suggests that the ECCT is having a positive impact on the children and families being served.

Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?

As has been noted elsewhere, ECCT has not managed to collect large numbers of pre-post test assessments and this occurred in relation to satisfaction surveys as well, particularly in relation to parent satisfaction with only six surveys collected from among the 29 families who received consultations. In relation to Childcare Worker satisfaction ECCT did a much better job with 15 surveys returned from among the 20 teachers receiving consultations.

Table V summarizes parent responses. Six statements were asked about specific areas of program services with parents asked to rate how effective ECCT delivered each component. The statements asked of parents were:

- Q-1. How effective was the consultant in supporting your relationship with your child?
- Q-2. How effective was the consultant in increasing your understanding of your child's behaviors and needs?
- Q-3. How effective was the consultant in helping you think about your child's experience in daycare/pre-school?
- Q-4. How effective was the consultant in assisting the teachers to adapt and/or respond to your child's needs?
- Q-5. How effective was the consultant in supporting your relationship with your child's teachers?
- Q-6. The Consultant was involved in finding additional services for me or my child.

While the N is low, the results clearly suggest a very high level of satisfaction among parents with no rating lower than effective and with responses to the first three statements being unanimously Very Effective. What's more, parents responding to open ended questions about whether and how the program could better meet their needs provided more detail about how important the program was to them.

Response	Q1	Q2	Q3	Q4	Q5	Q6
Very Effective	100.00%	100.00%	100.00%	83.33%	83.33%	50.00%
Effective	0.00%	0.00%	0.00%	16.67%	16.67%	50.00%
Somewhat Effective	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Not at all Effective	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
NA	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Totals	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Among parent comments: "Sarah has been a huge help in providing the necessary steps. I would recommend her services to everyone very highly." And, "She has helped us learn to relate better to our son." And "Sarah is a person who cares about both the wellbeing of the children and of our family. Thank you for your help." When asked for any suggestions for how the program could be improved, no specific suggestions were made and parents instead commented again on how good the program was and how much it had helped.

A satisfaction survey was also administered with childcare workers with whom the ECCT consultant worked, generally in relation to a specific child. As above, a series of 17 statements in relation to program services were provided with respondents asked to indicate the level of effectiveness of each service component. The statements were:

Q1 How effective was the consultant in helping you accomplish what you wanted

Please answer the following questions if the consultant was involved in discussion about an individual child

Q2	How effective was the consultant in increasing your understanding of the child's experience and feelings?
Q3	How effective was the consultant in contributing to your willingness to continue caring for the child?
Q4	How effective was the consultant in contributing to your ability to handle this child?
Q5	How effective was the consultant in helping you in your relationship with this child's family?
Q6	How effective was the consultant in contributing to your understanding of the family's situations and its effects on the child's current behavior?
Q7	How effective was the consultant in helping to relieve some of the pressure in responding to the family's needs?
Q8	How effective was the consultant in helping to find services that the child and family need?
Q9	How effective was the consultant in helping you apply what you learned about the child to other children?

Please answer these questions about your program:

Q10	How useful was the consultant in helping you to think about children's development and behavior?
Q11	How useful was the consultant in helping you to think about curricula planning?
Q12	How useful was the consultant in helping you to think about your classroom environment?
Q13	How useful was the consultant in helping you to think about classroom management?
Q14	How useful was the consultant in helping you think about parent involvement?
Q15	How useful was the consultant in helping you to think about staff relationships?

As someone who has used Early Childhood Mental Health Consultation:

Q16	Overall, how would you rate the quality of services provided by the consultant?
	If you rated "fair" or "poor," what suggestions would you offer to improve services?
Q17	Would you recommend the Early Childhood Mental Health Consultation Program to others who need help with similar concerns?
Q18	Are there any other comments you would like to make about the services you received?

As Table VI reveals, satisfaction levels were extremely high among the Childcare Workers. On Questions 1-9 which focused on the consultant's effectiveness, only one of sixteen respondents scored services lower than effective. In relation to Q10-17, ratings were almost as high for questions 10-17 with the only Q-11 being the only instance in which the respondent indicated "somewhat useful" on a question related to helping with curricula planning. Open-ended responses asking respondents to identify areas where the program could be improved did not result in a single suggestion. However, there were 16 different narrative responses with every one entirely positive. A sampling: "The Consultant has also helped me a lot in speaking about my own personal issue. She is very interested in helping everyone and is always at the center and available." And "The consultant provides excellent support in all areas including, challenging behaviors, parents,

staff relationship and classroom management." And "It is so nice to have someone to look forward t talk to when you need it. I feel comfortable knowing that I can trust Sarah and the she cares and does it positively and professionally."

Table VI: Childcare Worker Satisfaction Part 1

Response	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9
Very effective	60.00%	66.67%	66.67%	53.33%	66.67%	53.33%	46.67%	46.67%	40.00%
Effective	40.00%	33.33%	33.33%	46.67%	33.33%	46.67%	46.67%	33.33%	60.00%
Somewhat effective	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.67%	0.00%	0.00%
Not at all effective	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Not applicable	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	13.33%	0.00%
Unanswered	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.67%	0.00%

Table XX: Childcare Worker Satisfaction Part 2

	Q10	Q11	Q12	Q13	Q14	Q15		Q16		Q17
Very useful	60.00%	40.00%	46.67%	60.00%	40.00%	60.00%	Excellent	66.67%	Yes	93.33%
Useful	40.00%	40.00%	40.00%	26.67%	53.33%	40.00%	Good	33.33%	No	0.00%
Somewhat useful	0.00%	13.33%	6.67%	6.67%	6.67%	0.00%	Fair	0.00%		0.00%
Not at all useful	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	Poor	0.00%		0.00%
Not applicable	0.00%	6.67%	6.67%	6.67%	0.00%	0.00%	Not applicable	0.00%		0.00%
Unanswered	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	Unanswered	0.00%	Unanswered	6.67%

Taken together, it is clear that even with the low N on the parent survey, both parents and teachers are highly satisfied with the ECCT program.

Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?

The ECCT is funded to serve the geographically isolated, low-income, rural community of Coastside. More specifically, it is supposed to target under-served families where either child behaviors raise concerns of emotional or psychological risk or where parenting practices raise concerns. A measure of the degree to which ECCT has successfully engaged families where the parent-child relationship is less than ideal can be seen from the PRQ discussed under EQ # 2 above. As can been seen, every one of the five parents taking both the pre and post test had at least one domain that was significantly below average and as described in the analysis below the table, of the 12 parents who only took the pre-test nine of the twelve had at least one domain with a significantly below average score. The program's impact is further underscored by the results of the CBCL. Again, while the numbers of pre-and post-test results is lower than would be desired, the results were very strong. Lastly, satisfaction surveys of both parents and childcare workers indicate an exceedingly high level of satisfaction indicating the programs' being responsive to the needs of the targeted population. Clearly the program is targeting and engaging families at very high risk and with better data collection practices, it would be possible to assess the level of services accessed by each child and family, but it seems clear that while data collection practices could be strengthened, the program is responsive to the targeted population and targeted

community needs, with one exception. While not evident from data presented to the evaluator, in structured discussions with StarVista leadership, they shared that the North County ECCT team has not become the cornerstone of early childhood mental health services in its community that has been achieved by the Coastside team. This issue is discussed in EQ # 7.

Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?

The vision, mission and values of San Mateo County Behavioral Health & Recovery Services stress empowering individuals to direct their own recovery process. BHRS stresses the adoption of culturally competent treatment approaches and through its MHSA planning processes, a further focus has been placed upon implementing evidence-based practices that have demonstrated the capacity to support client wellness and recovery. From the perspective of prevention, BHRS has also described the journey towards a transformed system requiring that programs:

- move "upstream" to primary prevention strategies;
- partner with other health prevention efforts to focus on wellness and recovery;
- achieve desired outcomes; and
- integrate efforts to support sustainability;

What's more, San Mateo's MHSA plan clearly described the priority of intervening early and identified stress, PTSD, and use of alcohol and drugs as factors where early intervention were most important, particularly in relation to individuals from historically underserved populations.

Childcare Consultation. By making early childhood mental health consultation available to more childcare providers, the ECCT team reaches individuals who have the potential to be a long-term support for families at risk and in distress at an early point in the developmental process, magnifying the impact of their work over years.

Child-parent psychotherapy is reaching families with infants and toddlers, very early in their development and providing parents with parenting tools that should benefit the child over the course of their development, as well as with any future children that the family may produce.

Community Outreach and Case Management. The ECCT community outreach worker is also able to identify and connect with family/friend/neighbor providers that may not have been previously known to the resource and referral agency and facilitate their connection to ongoing supports.

Taken together it is clear that ECCT is collaborating with other community providers, engaging families and children 'upstream' and are achieving the desired results from their services. While ECCT's data collection could be improved, it is clear that this vital service is appreciated by parents and childcare workers and is consistent with SMC BHRS vision and values.

Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?

Transition of Childcare Staff. The second half of this year marked a challenging time for the Coastside centers served by the ECCT. Staffing changes at all four centers in February led to feelings of instability and mistrust among teaching staff, parents, and children. One center in particular saw over half of their teachers change in the course of three weeks (including one classroom in which all

three teachers were new to the class). Such changes impact children attending the center significantly as they lose a reliable and consistent connection with an adult with whom they have developed trust and respect and the new staff saw major changes in the behaviors of the children following these staffing shifts. Similarly, parents reported feeling anxious about leaving children with new faces and frustrated in not knowing which staff was permanent and which were substitutes. Turnover in childcare staff involved in consultations means that resources poured into building the capacity of a specific childcare worker has been wasted while also requiring that the new worker receive training. This turnover also impedes the evaluation as a childcare worker may have identified a challenging child behavior, begun to work with the ECCT Consultant and then leave in midstream without the opportunity to do a post-consultation observation. Turnover in the childcare industry is endemic and simply makes the work of the ECCT more challenging.

Transition in ECCT Team Members. In the coming program year, ECCT is anticipating several shifts among ECCT staff. The current consultant in the ECCT Program, Sarah Dobkin, will be transitioning to the role of Program Manager of the ECMHC Program. As such, a new consultant will be introduced at one of the center-based programs while Ms. Dobkin will continue to provide services at the other three. Ms. Dobkin has worked closely with the new consultant to ensure a smooth transition of the work in this center. The current Program Director of the ECMHC Program, Kristin Reinsberg, will transition to a new role as the Training Director of the Early Childhood and Family Services Department, of which the ECCT is a part. Ms. Reinsberg's experience and expertise in developing and facilitating ECMH trainings within the ECMHC Program over the past ten years will provide a strong foundation that will benefit the Department and help to further strengthen StarVista's presence in San Mateo County as a leader in early childhood mental health services. Ms. Reinsberg and Ms. Dobkin will continue to be work closely together over the next program year to help ensure a smooth and stable transition.

ECCT's North County clinician, Anyella Clark, will also be leaving and a new clinician will begin working in this region in the coming months. All the clinician's clients have been referred to appropriate services and one will be continuing work with the new clinician once she begins. Finally, the ECCT Community Outreach Worker/Parent Educator on the Coast, Edgar Villafaña, will be shifting his time also. He is beginning to complete practicum hours and will be a mental health clinician trainee as part of StarVista's Learning Together 20 hours per week. To cover the other 20 hours allocated to the Community Worker position, Learning Together Parent Educator, Maria Elena Schurr, who has in the past led playgroups and worked with families on the coast, will be picking up the additional hours. While a strong core staff remain, these transitions will not be easy to manage.

Almost without exception, every agency evaluated this year has been impacted by staff transition. While each agency manages these transitions differently, it may be worthwhile exploring a more systemic solution, perhaps involving use of MHSA Workforce Education & Training funding.

Clarify ECCT Role and Scope of Responsibility in Kicking Off Kindergarten. As described above under EQ # I, ECCTs becoming involved in Kicking Off Kindergarten was very well received, but also encountered challenges that resulted in some inefficiencies with teachers expecting the ECCT to support students with either behavioral problems or academic problems. Academic problems are simply not part of ECCT's clinical expertise and so children were referred to ECCT who could not be served. sNew, collaborative projects frequently encounter these kinds of challenges and suggestions are included under EQ # VII below.

Data collection. With 83 clients the ECCT delivers three distinct strategies (child-parent psychotherapy; mental health consultation with child care providers; and case management/parent education (including parent-child activity groups) each employing different clinical tools that can produce pre and post test results. So the N for any given strategy is never going to be large. Families exiting the program do not always leave in a predictable timeframe and hence many post-tests are not obtained. However, given that the average client sustains program involvement for an average of over 200 days with that involvement typically including weekly sessions, a larger N is possible. The low number of pre- and post-tests has been identified as a barrier to the development of a robust evaluation, but it is also a barrier to ECCT conducting internal program improvement efforts. With larger N's and more valid findings, ECCT leadership would be able to identify specific areas where improvement in teacher, parent or child outcomes is occurring and where it is not. This information is invaluable in strengthening and focusing staff supervision and training. Aside from the number of parents, children and teachers who complete pre and post tests, a data system that easily allows for ECCT managers and the evaluator to analyze the relationship between involvement in specific program components and the level of that involvement with child, teacher and parent outcomes would also enhance both program improvement and program evaluation. In the structured interview, ECCT leadership acknowledged that it would be beneficial to collect data more methodically and to use it in a cycle of inquiry focused on program improvement. Current practice is that data is primarily used for clinical purposes, meaning that the individual clinician or consultant uses client-level data in support of work with the individual client and data is not aggregated to analyze trends in client outcomes. ECCT leadership felt that the program is already stretched thin, with a large geographic service area and a waiting list and so the choice faced is to devote more resources to data collection and program improvement at the expense of maintaining service levels.

North County Engagement/Penetration. In dialog with ECCT leadership, they shared that while not apparent from the data presented under EQ # I, ECCT has done a much better job of becoming integrated into the Coastside community than it has in North County. A number of strategies were discussed to improve penetration in the North County community, discussed under EQ # 7, below.

Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

The ECCT is clearly a well-managed, effective program that is of great benefit to the Coastside and North County communities it serves, nonetheless as with most any program, there are opportunities to improve operations and achieve still greater benefit. Recommendations identified in this evaluation are identified below.

Staff transitions. Two manifestations of turnover impacted the ECCT, turnover within the childcare programs they served and staff transition within StarVista. From what was reported by leadership, transitions among the ECCT, were handled proactively and effectively. While turnover among the staff at the childcare providers served by ECCT is certainly not something ECCT could prevent, it might be possible to create a kind of training for new staff at these centers that introduces them to managing challenging behaviors. In an early childhood program I evaluated ten years ago, the early childhood mental health team developed a video library of consultations and classroom demonstrations that were available both to new staff at each site as well as to more veteran teachers. Certainly such an initiative would require additional resources, but perhaps a grant or even funding from MHSA Workforce Education & Training could subsidize the project.

Clarification of ECCT roles and responsibilities in the context of the Kick-Off to Kindergarten program. ECCT leadership felt that there were a couple options to explore to ensure that this collaboration works more smoothly in the future. First, it seems important that ECCT continues to discuss the role of the ECCT and the work that it can and cannot do with several involved parties, starting with the director of the summer program. It will also be necessary to speak with teachers and their support staff (school secretaries and translators) who may be contacting parents directly to examine their understanding of why parents are being referred to the ECCT and what services the ECCT will be able to provide to families. If time allows, ECCT staff could be available to think with teachers and others about how to talk to parents about the referral.

Second, as discussed above, ECCT feels teachers may benefit from reviewing what they can expect in terms of behavior and academic performance from children entering kindergarten. If ECCT continues to collaborate with the school district around this program, it will be important to know that teachers (in particular those who may be less familiar with kindergartners) are provided with more background about what are realistic expectations for children entering the program, especially those who have had little or no preschool experience. There is an abundance of highly digestible research covering realistic developmental and behavioral expectations for kindergartners and sharing this information with teachers would reduce teacher referrals for developmentally appropriate behaviors while providing teachers with information about how better to manage those behaviors. Sharing this information would also strengthen the relationship between the ECCT and the teaching faculty.

Data Collection. While there are certainly resource issues in expanding data collection practices, there are some relatively low-cost strategies that could result in more useful data and create procedures for using that data in program improvement activities.

> *Use a tickler system* to notify clinical staff when a client has been engaged in service for 3 or 6 months and schedule post-tests at this time rather than waiting for a client to indicate their plan to exit the program. This practice would not just serve the evaluation and program improvement efforts, but would also serve a clinical purpose, as it would inform the clinician as to client improvement and areas where improvement has not occurred.
>
> *Development of a database system that aligns participation (units of service) with assessment data.* With such a database, ECCT leadership could analyze what program strategies and treatment dosages elicit the biggest impact on outcomes. Is there a threshold level of engagement and program participation that is necessary to achieving positive outcomes?
>
> *Include a database 'tag' that would identify clients by the ECCT team that serves them.* This would allow ECCT to more easily compare engagement in services between ECCT teams.
>
> *Expand use of satisfaction surveys.* There were many missed opportunities for administering satisfaction surveys: 1) during school-based training surveys could be administered with teachers participating in the training; 2) parent satisfaction surveys could be incorporated into the fabric of child-parent psychotherapy with surveys used after 3-4 months of treatment; 3) teacher satisfaction surveys should be continued as 15 of the 20 teachers involved in consultations in 2013-14 were surveyed, eliciting important information.
>
> *Create a very few data reports.* Starting with only a very few data reports showing participation levels and one or two outcome reports, establish a quarterly or semi-annual cycle of inquiry process where ECCT teams review these reports and discuss their clinical or

programmatic implications. Through this kind of process, an organization will quickly identify the benefit to this practice and either find internal resources to sustain the work or seek outside resources to support them.

North County Penetration. In the interview with ECCT leadership a couple of strategies were identified to address ECCT's not achieving the degree of community integration in North County as has been achieved in Coastside. Starting with looking inward, an internal retreat involving staff from both teams. During the retreat each team could describe community engagement strategies that had proven effective in their community and the challenges that they encountered. Through such a process the North County team could consider adoption of strategies that had been successful in Coastside. After the retreat, ECCT team leaders could then turn outward, working through the North County Community Service Area could seek to introduce proposed engagement strategies, listen to CSA member perceptions about reasons why the North County team has not been as engaged as in Coastside and together develop a plan for increased engagement.

ECCT leadership has been extremely receptive and reflective throughout the evaluation process, acknowledging where data collection practices could be improved and open in revealing areas where they felt improvement in program could occur (e.g. Kick-Off to Kindergarten and North County penetration). In this context, the evaluator is confident that evaluation findings will be received and used constructively for the benefit of the communities that the ECCT targets.

Section V Demographic Summary

The data below will be reported with different programs having customized reports if their programs have unique features that would benefit from separate reporting. For example, if a program:

- Offered its programs in different communities; or
- Offered the same program at a school to different students in the first semester than the second; or
- Delivered two or more very different program components, e.g. consultation to school professionals and direct service to children and/or families.

Table I: Demographic Summary					**Source of Data**
Total Unduplicated Served					
Gender		**Clients**	**Program Staff**		
	#	%	#	%	Childcare staff served by the ECCT are 95% female as is common in the industry.
Male	54	65%	7	87.5%	
Female	29	35%	1	12.5%	
Other					
Age	#		%		
Children 0-15	83				Children served were all below 4 years old.
Transition Age Youth 16-24					
Adult (25-59)			8---100%		
Older Adults 60+					

Table I: Demographic Summary					Source of Data
Families (can include families with children or TAY)					
Ethnicity	**Clients**		**Program Staff**		
	#	%	#	%	
Caucasian	4	5%	3	37.5%	
Latino	73	90%	4	50%	
African American	1	< 1%	1	12.5%	
Mixed	3	3.6%			
Other	1	< 1%			
Middle Eastern	1	< 1%			
Native American	0	0 %			
Multi-Ethnic					
Other					
Home Language	**#**	**%**	**#**	**%**	
English			8	100%	All staff speak English, but all but one is bilingual as per below.
Spanish			6	75%	
Other			1	12.5%	Portuguese
Mandarin					
Underserved Pops Served	**#**	**%**	**#**	**%**	No data collected on this.
LGBT					
Blind/Vision Impaired					
Deaf/Hearing Impaired					
Veterans					
Homeless					

Program Components Table and discussion are on the next page.

Section VI Program Components:

The information in Table II will be used to report to MHSA as part of the statewide evaluation. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator.

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.		
	Yes	**No**
II-1) Access for Underserved Populations	**X**	
Details: Clearly ECCT serves an under-served population (90% Latino) in a significantly under-served community (Coastside).		
II-2) Outreach for Early Recognition of Need	**X**	
Details: Very early identification of behavioral conditions.		
II-3) Access or Linkages to Care	**X**	
Details: Coastside has such limited resources, the ECCT operates as a kind of one-stop shop for		

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.		
young parents and child care programs, but it also collaborates with school districts, CPS, and Coastside MH, among other providers.		
II-4) Reduction of Stigma		
Details: Not a major focus. But the ECCT's placement in the community, in childcare settings, provides an easy point of access to both services and information about mental health, making it easier for community members to learn more about mental health issues, become more informed and to unlearn the stigma commonly associated with the condition.		
II-5) Screening for Needs	**X**	
Details: As is evidenced by this report, ECCT relies upon a battery of validated assessment tools to identify and clarify child behavioral needs.		
Program Activities	**Yes**	**No**
II-6) Addressing Trauma	X	
Details: Trauma is one of the most important factors contributing to family crisis and parenting challenges. One of the ECCT tools is specifically designed to identify trauma (Parent Stress Index).		
II-7) Specific Risk Factors	X	
Details: The ECCT considers all risk factors in play that might contribute to infant toddler behavioral conditions and works with family and pre-school to accommodate and address those factors.		
	Provide specific details very briefly. 1-3 sentences per line.	
II-7) Indicate the location where program activities occur (identify places where services occur	Office located at the Cabrillo Unified School District main office. Childcare centers are Moonridge Head Start, Moonridge Early Head Start, Half Moon Bay Head Start, Coastside Children's Program.	
II-8) Specify the roles for Peers (mentors Outreach, Peer education, other)…Please specify.	Not a program component.	
II-9) Specify the sectors with which you collaborate on this program (housing, criminal justice, public health, education, child welfare)	ECCT collaborates extensively with primary care, education, CPS, and mental health systems and providers in Coastside.	

Section VII Program Alignment with SMC MHSA PEI Priorities:

Providers will mark Y for Yes for any community need or priority population addressed. In the space provided, please explain how these needs or populations were served. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator during which time a discussion will occur to amplify and provide details or examples.

Table III: Alignment with SMC MHSA PEI PRIORITIES				
	Children & Youth	**TAY**	**Adult**	**Older Adult**
1-PEI Key Community Needs				
1-A) Disparities in Access to Mental Health Services:	**X**	**X**	**X**	
Details: Underserved community with program targeting the most under-served population in that				

Table III: Alignment with SMC MHSA PEI PRIORITIES				
community (Latino). Many participant parents are TAY.				
1-B) Psycho-Social Impact of Trauma	**X**	**X**	**X**	
Details: Trauma is a major factor in early childhood behavioral issues. The PSI revealed very traumatic incidents that would impede normal child development.				
1-C) At-Risk Children, Youth and Young Adult Populations	**X**	**X**	**X**	
Details: By virtue of living in a geographically isolated community, serving low-income families, and targeting families subject to high levels of trauma all are evidence of the ECCTs addressing at-risk families and children.				
1-D) Stigma and Discrimination				
Details: Not a focus.				
1-E) Suicide Risk				
Details: While parents under stress due to early childhood behavioral concerns is a risk factor for suicidal ideation, this is not a focus of the program.				
2- PEI Priority Populations				
2-A) Trauma Exposed Individuals	**X**	**X**	**X**	
Details: See above.				
2-B) Individuals Experiencing Onset of Serious Psychiatric Illness	**X**			
Details: While early onset of serious psychiatric conditions is not common among infants and toddlers, identification of behavioral issues early and provision of tools to promote healthier development is a focus of the program.				
2-C) Children and Youth in Stressed Families	**X**	**X**	**X**	
Details:				
2-D) Children and Youth at Risk for School Failure	X			
Details: Early childhood behavioral issues predict later school failure and the program provides both teachers and parents with tools to build the resilience of toddlers and infants experiencing behavioral issues				
2-E) Children and Youth at Risk of or Experiencing Juvenile Justice Involvement				
Details: While certainly children who ultimately fail in school and while early childhood behavioral issues predict later school failure, the focus of the program is not prevention of juvenile justice involvement and does not target juveniles experiencing justice involvement				

Section I Agency & Program Description
I.A. Description of Program Services

Formerly known as Youth and Family Enrichment Services, StarVista came into being when Youth and Family Assistance and Family and Community Enrichment Services merged in 2003. StarVista offers counseling, prevention, early intervention and education resources and services to more than 34,000 people throughout San Mateo County every year. One of its programs is the Crisis Intervention and Suicide Prevention Center, a program comprised of a 24 hour phone Hotline and a Youth Intervention Team that works primarily through schools countywide offering both crisis intervention services when a student is in crisis, training for school personnel and prevention education for thousands of middle and high school students. The Center is staffed by:

- Program Director (part-time, only 4 hours allocated per week),
- Volunteer Coordinator (full-time),
- Clinician (full-time),
- One Americorps member (receives a stipend, Full-time),
- A Program Development Coordinator (30 hrs., funded through CalMHSA),
- Four overnight workers (each working less than 25 hours per week), and
- A cadre of approximately 60 community volunteers who staff the hotline and Teen Chat Line.

StarVista Hotline

StarVista manages and supports 41 Crisis Line Volunteers and 19 youth volunteers for its Teen Crisis Chat room. The Chat Room is a facilitated discussion forum for youth to get support, discuss the issues they are facing. If someone is in crisis or needs individual support, they have access to a private chat feature where they can communicate with a peer counselor 1-on-1. The hotline is staffed 24-7 and is accredited by the American Association of Suicidology. AAS accreditation validates service delivery programs that are performing according to nationally recognized standards. Achieving AAS accreditation involves submitting a detailed report to the AAS and hosting a one or two day site visit during which an AAS. Once accreditation is achieved, agencies must submit an annual report verifying their continued compliance with AAS standards. Each agency is revisited and reaccredited every five years. StarVista is required to attend a minimum number of Annual AAS conferences, and pay yearly dues. Achieving AAS accreditation ensures the County that an outside, expert eye has examined StarVista operations and has met all AAS standards related to:

- Administrative operations and organizational structure;
- Screening, Training and Monitoring Crisis Workers;
- General Service Delivery System;
- Services in Life-Threatening Crises;
- Ethical Standards and Practice;
- Community Integration; and
- Program Evaluation.

The Crisis Line program is overseen by the Volunteer Coordinator and a licensed clinician. The use of volunteers for crisis lines is routine throughout the State. A study, California Suicide Prevention Hotline Survey Report, conducted by the California Department of Mental Health found that 90% of hotlines surveyed deployed primarily volunteers with an average of 60 volunteers per

crisis center with the volunteers trained and supervised by paid clinical staff. This is precisely the model utilized by StarVista.

Before taking a shift on the phone lines, each volunteer a 30-hour training that takes place over the course of 4 weeks. Guest speakers with specialized expertise come from other community based organizations to provide most of the training. The training covers a number of crisis related topics including:

- Active Listening
- Suicide Risk & Assessment
- Alcohol and Drugs
- Sexual Abuse,
- Domestic Abuse
- Parenting
- Working with Youth
- LQBTQ Issues
- Child and Elder Abuse and
- Training in managing difficult cases.

In addition, training covers how to complete required paper and provides volunteers opportunities to role-play with each other. Once volunteers complete the training sequence, each volunteer picks up two observation shifts (each shift is 4 hours), where they listen in on experienced Crisis Line counselors fielding calls. After they do two observation shifts they sign up for two active shifts where they pick up the lines with an experience volunteer guiding them and offering them feedback. Suring the training, staff offers ongoing evaluations and constructive feedback. If the volunteer feels like they need more observation or active shift we offer additional support and training.

Volunteers also receive support from staff during the week. StarVista usually has a staff member present from 9:00 am - 7:00 pm on weekdays. Staff is available to debrief, offer support, information and feedback. After-hours, the Hotline is operated by paid StarVista overnight staff. The Volunteer Coordinator is also on site weekdays and is able to monitor and gauge if a volunteer needs support. For non-weekday hours, StarVista provides a 24-hour back up line that is available for support if there is no staff at the office. Through this line, volunteers can reach a StarVista LCSW to debrief or consult after a difficult call. Volunteers are also able to flag difficult calls in the StarVista database or write incident reports and get feedback on a specific call. When calls escalate - volunteers can check in with staff to see what steps need to be taken. Staff can also help with initiating emergency rescue/services e.g. welfare check, tracing calls, filling CPS reports and follow up calls to callers who need additional support.

StarVista evaluates each volunteer twice a year during which staff observes volunteer shifts and provides constructive feedback. Nineteen youth volunteers work in the Chat Room with a StarVista staff member supervising them at all times. Chat room supervisors offer support and guidance to other teens Monday and Thursday from 4:30pm to 9:30pm and during the summer on a varied schedule. It provides teens an opportunity to engage in group chats to discuss more general issues of concern, while also allowing for private 1-1 chats with a peer counselor.

Youth Intervention Team

As part of this contract, StarVista also operates a Youth Intervention Team housed at the Crisis Intervention and Suicide Prevention Center. The Team is led by the Prevention Program Director and Prevention Center Clinical Supervisor and supported by an unlicensed intern. The team responds to requests from schools, providing crisis intervention services to youth (which can include short-term counseling for youth in crisis), consultation and training to school staff, and provision of referrals for youth and families as clinically indicated. The YIT also provides educational presentations for middle school and high school students focused upon identifying signs of suicide risk in youth, suicide prevention strategies, and to de-stigmatize behavioral health conditions. The Team can make referrals to the mental health system through the ACCESS Team. As a member of the BHRS Community Response Team, StarVista attends related meetings and trainings, and is available to respond to community crises, although even in the event of a community crisis like the San Bruno fire, the Crisis Team tends to operate mostly from affected schools.

I.B. Research Basis for Approach

The clearest measure of crisis hotline intervention effectiveness would be a follow‐up study of all crisis callers to determine whether they continued to have suicidal thoughts after calling the crisis hotlines, or in the worst case scenario, died by suicide. These studies, however, are difficult to conduct given the sheer volume of individuals who call the crisis hotlines, privacy concerns, and the difficulty in extracting follow‐up contact information when an individual is in crisis. The best proxy of crisis hotline effectiveness in saving lives can be found in a 2007 study by Gould and Kalafat, et al.[1] – this study found that seriously suicidal individuals reached out to telephone crisis services and that significant decreases in suicidality were found during the course of the telephone sessions, with continuing decreases in hopelessness and psychological pain in the following weeks. In addition, anecdotal evidence by crisis center staff who were interviewed for the survey showed that callers responded positively to the counseling and the resources provided to them for after‐care.

I.C. Target Population, Number Served and Sites

The target population for Hotline is anyone who is experiencing crisis and as described below, clients call for a wide range of reasons with varying levels of crisis from being at extreme risk of suicide, to seeking resources and supports for a wide variety of reasons. Volunteers at the Hotline report also having 'regular' callers who call frequently and come to rely upon volunteers to provide support. Volunteers reported that in most instances, these callers are very isolated socially and their contacts are critically important to them. The YIT targets middle and high school youth throughout the County and responds to youth in crisis or at risk of suicide and provides education to middle and high school youth throughout San Mateo County. Since psychological crises cross all class and ethnic boundaries, the program does not target specific populations and neither the Hotline nor the YIT collect demographic data on callers or those where a crisis intervention occurs.

[1] Gould MS, Kalafat J, et al. (2007). An Evaluation of Crisis Hotline Outcomes Part 2: Suicidal Callers. Suicidal and Life‐Threatening Behavior, 37(3): 338‐352

Section II Evaluation Process

The evaluation plan was developed in June-July 2013 through a series of meetings with Director of Wellness and Recovery Services, Stephanie Weisner and Director of the Crisis Intervention Suicide Prevention Center, Julie Kinloch. Plans were made to provide data on the number of hotline calls and the number of school and community interventions where Crisis Center clinicians provided support during immediate crises or in the aftermath of school or community trauma. To measure satisfaction with the program and to get a view of the perceived impact that the crisis hotline had on callers, a survey was developed for volunteers. A separate survey of callers was also conducted, along with an online survey for school personnel involved in StarVista crisis interventions. Finally, structured interviews were conducted with:

- Julie Kinloch, Program Director;
- Sarah George, Clinical Directors; and
- Two school counselors.

Early in evaluation design discussions it became clear that pre-post test assessments, such as those used in most of the PEI programs, were unrealistic as neither the crisis hotline program nor the school-community intervention services sustained long-term involvement with clients. The contract for Crisis Hotline services did not delineate specific numbers of anticipated calls, trainings, or school-community interventions. Nonetheless, with the data above, it was possible to assess the scope of services delivered, the satisfaction with services from the perspective of the school, those calling the hotline, and the volunteers who staff it. So while pre-post tests were not practical, a view of the impact of services was gleaned from these data sources. Lastly, as data was being reviewed, discussions with the Clinical Director resulted in opportunities to better assess the impact of crisis intervention services in 2014-15 via the use of an online survey that will remain open throughout the year and be used to enable school personnel to describe its experience with the crisis intervention team, their satisfaction with its operations, and their perceptions as to the impact the interventions have had on the student(s) in crisis, school personnel supporting those students and the general school community.

Section III Evaluation Findings

There are seven evaluation questions that frame the evaluation of the Prevention & Early Intervention programs supported with Mental Health Services Act funds.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to the contract funding the program?
Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?
Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?
Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?
Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?
Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?

Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

The review of StarVista data leaves little doubt that both program components, the Crisis Hotline and the Youth Intervention Team has operated with a high level of efficiency and positive effectiveness, responding to crisis calls on the Hotline 24-7 every day of the year and responding every school request for crisis support promptly. The impact of both services components is also clear. While tracking the long-term outcomes of Crisis Hotline services is identified in the research as being impractical without a very expensive evaluation, an exceedingly high percent of Hotline volunteers surveyed indicated that they felt that they had had a very important and positive impact upon callers who were in crisis. In addition, the California Suicide Prevention Network (CSPN) conducted two months of random surveys of Crisis Hotline callers and this data also describes callers as being highly satisfied with the hotline services, that the services had been positive and that they would utilize the service again if they had problems.

StarVista also provided specific data on the scope of school training and school interventions delivered during the program year. While there was no stipulation in the contract delineating an objective for the numbers of schools served, it is clear that the YIT responded promptly to all calls and delivered training to many schools and intervened in 28 crises at schools where a student was either in immediate risk of suicide or where a school was grieving over the loss of a student. While there was less quantitative data supporting the impact of these services, a survey of school personnel and interviews with other personnel where YIT services were delivered make it clear that these services are both highly valued and respond to situations where there really is no other option for schools in crisis to obtain immediate intervention or consultation to support students in crisis. Through the evaluation process, StarVista and the evaluator identified ways in which more data could be obtained from schools via an online survey that would be posted and open all program year. As a part of end of an intervention process, the crisis team intern or clinician would ask the school contact person to complete the brief survey. While this would provide yet another form of data validating the impact of StarVista's Crisis Intervention and Suicide Prevention Center, even without it there is ample evidence of it effectiveness and impact of Center and of the satisfaction of those served by the Center. Each evaluation question is discussed separately below.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to its contract?

To answer Evaluation Question # 1, the evaluator was provided data on the number of crisis calls fielded by month, the number of crisis interventions conducted at schools, and the number of trainings provided throughout the year. Since there were no projected numbers to be served referenced in the contract, the analysis below does not reflect a comparison with a contract-specified projected productivity totals.

In terms of crisis calls, Table I provides the number of crisis calls fielded by month. As can be seen, just under 15,000 calls were received during the program year, with an average of almost 1250 calls per month. As a point of comparison, Contra Costa County has a population of 1.05 M residents, almost 50% more residents than live in San Mateo County (718,000). Contra Costa County's countywide crisis line receives 1150 calls per month, 100 fewer calls than does StarVista.[2]

[2] California Suicide Prevention Hotline Survey Report, Office of Suicide Prevention, California Department of Mental Health, January 2011.

The variation in call volume evident in Table I is the result of an agreement with Santa Clara County's Contact Care, a Bill Wilson Center program. Through this agreement StarVista and Contact Care back up each other's calls. For example, there are times at each Crisis Line where gaps in availability of volunteers require the other Crisis Line to cover calls for each other. This ensures continuity of crisis support at all times.

Table I: Crisis Calls	
Month	Calls
July '13	1657
Aug '13	1369
Sept. '13	1312
Oct. '13	1279
Nov. '13	1093
Dec. '13	990
Jan '14	1328
Feb. '14	1184
Mar. '14	1257
Apr. '14	1275
May '14	1275
June '14	946
Total	14,965
Ave.	1247

In addition to operating a Crisis Hotline, the Crisis Center also operated a Teen Chat Room that operated Monday through Thursday from 4:30-9:30 and on a more irregular schedule during the summer. This Chat Room was staffed by up to 19 teen volunteers, supervised by a StarVista clinician. Chat Room Peer Counselors provided 159 private chats and the Chat Room website had 546,570 hits. According to the Clinical Director, 'chats' are declining somewhat as they are being supplanted with teen preference for texting. StarVista is exploring how to develop texting chats to better respond to how teens want to communicate.

The Crisis Center also provides crisis intervention and training in suicide prevention, largely in response to calls from schools throughout the County. Based upon data provided by StarVista, the Crisis Center provided the following training and education services.

Suicide Prev. Presentation for Middle and High School Students.

- 61 1-hour presentations
- 2494 students served
- 14 school sites served
- 9 districts served

Presentations by Sarah George for Student Personnel to Recognize signs of suicide risk in students, how to respond:

- 2 presentations
- 2 sites
- 56 school personnel served

Other community suicide prevention presentations conducted by Sarah George:

- 4 presentations
- 120 people served (community service providers..mental health, probation, etc)

Presentations for Crisis Center Volunteers by Sarah George.

- 2 Continuing Ed. for Crisis Center Volunteers (10 people served)
- 15 1-hr. segment of Crisis Center Volunteer training series for 32 volunteers.

In addition, the YIT conducted interventions in response to crisis calls from schools where students were believed to be at imminent risk of suicide.

- 14 onsite at schools
- 7 over the phone consults

Other School Based Interventions

- 14 interventions at one school for Post-suicide support and in this instance, the intervention team identified a close friend of the suicide victim who was also manifesting signs of suicidal ideation and the team intervened providing ongoing support to the student and school personnel. This student has stabilized.

- 7 at one school for students self-identifying as needing to talk after a school bullying program event.

While there were no service levels projected in the StarVista contract, the data above reflects a program that is consistently responsive to all demands for its services and that the Crisis Center staff and volunteers of the Hotline, Teen Chat Room, and crisis intervention team delivered services both efficiently and effectively.

Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?

As summarized in Section I.B., evaluating outcomes from crisis hotlines is an extremely difficult challenge, far beyond the scope of this evaluation. While it would be desirable to track future caller suicide rates, use of psychiatric emergency services or other crises services, or utilization of services to which the caller was referred by the phone counselor, these measures would require a very elaborate evaluation design. Further, the real purpose of a hotline is to provide immediate, short-term support in moments of significant personal crisis, not to provide an ongoing therapeutic intervention where reduction of utilization of crises services might be a realistic impact. In assessing the hotline's impact, the evaluation has examined caller survey data since the questions involved in the survey directly relate to the degree to which the caller felt helped by their conversation with the phone counselor. StarVista is part of the California Suicide Prevention Network (CSPN), which represents a cross-section of Crisis Centers in the state of California who collaborated in the identification and development of a common set of call center metrics. Ten crisis centers agreed to have a determined period of time, a "survey season", where callers were given the option to answer a satisfaction survey. Callers were transferred to an Interactive Voice Response System (IVR) to answer three questions, with the option to leave a voice message. The first survey season was in December 2013 (D-13) with an N of 32. The second survey season took place in March 2014 (M-14) with an N of 17. The aggregated results for StarVista can be found below (N=75). Data from this survey is collected by CSPN and so is entirely independent. As can be seen from the table below, callers were extremely satisfied with their experience contacting the hotline with 77% (D-13) to 80% (M-14) of respondents indicating that they felt connected to the counselor, 78% (D-13) to 87% M-14) finding the call helpful, and 81% (D-13) to 88% (M-14) indicating they would call the Hotline again if they had a problem. While the change in satisfaction levels was not great, in all three areas surveyed, satisfaction levels increased from December 2013 to March 2014 survey administrations.

Table II: California Suicide Prevention Survey. December 2013 (N=32) and March 2014 (N=75)

Question	Very Unlikely		Unlikely		Neutral		Likely		Very Likely	
	D-13	M-14	D-13	M-14	D-13	M-14	D-13	M-14	D-13	M-14
How likely are you to call again if you need help.	6%	3%	3%	1%	9%	8%	3%	7%	78%	81%
	Very Disconnected		Not Connected		Neutral		Connected		Very Connected	
How connected did you feel to the counselor	3%	4%	6%	3%	13%	13%	16%	24%	61%	56%
	Very Unhelpful		Unhelpful		Neutral		Helpful		Very Helpful	
How helpful was this call in reducing your distress?	3%	0%	3%	1%	16%	12%	13%	16%	65%	71%

A volunteer satisfaction survey provided another measure of the Hotline's impact as questions in this survey asked volunteer phone counselors to describe the level of crisis of callers

and the degree to which they felt they had had a positive impact on the caller and helped resolve the crisis. The results of this survey are discussed under EQ #3.

StarVista also operates a mobile Youth Intervention Team that responds to calls from schools throughout the County. Three sources of data were used to assess the impact of the team: 1) results from an online survey completed by two school administrators; 2) interviews with a school administrator; and 3) a structured interview with the intervention team's clinical supervisor which elicited detailed descriptions of how the team has operated and where it has had a significant impact.

"The Crisis Counselor really helped the girl have an outlet and get some counseling. StarVista also consulted with us and assessed her likelihood of self-harm. We created a plan to support her. As a result, and she finished the year well."

While the survey of school personnel was completed by only two staff members from different schools, the responses to the Likkert Scale forced choice questions elicited unanimous satisfaction with the services with both respondents indicating that intervention services were effective, that the team went beyond providing immediate crisis support, and with both respondents strongly agreeing that the YIT was critical to defusing a crisis situation. Responses to open-ended questions elicited a more detail about the impact of the team. See above left and below right for quotes excerpted from these open-ended questions.

"YIT service was crucial because we reached out when other on-site mental health support was unavailable. YIT made it possible for a few of our students to receive support on site that they probably wouldn't have otherwise. We are very grateful for the partnership in assessing and sometimes providing short-term counseling."

To probe a bit more deeply into how the YIT operated, a structured interview with Clinical Director Sarah George was conducted. She described a number of crisis situations that illustrated the impact of the program. In one instance, Hoover Middle School in Redwood City, a YIT intern worked with a girl with suicidal ideation for several months. During this work, the girl acknowledged cutting herself and as the work with the intern helped stabilize the girl, she suggested starting a group for others who have issues with cutting. A peer group was established where self-esteem building exercises, peer discussions, and the introduction of alternatives to cutting were introduced, e.g. friendship building, involvement in art projects, and other positive activities. This example illustrates not just how an StarVista intern helped an individual girl, but how she turned that outcome into a peer-driven initiative that benefited many other girls.

In another instance, the team was called when a student was demonstrating clear suicidal intentionality. While the team was en route, the school also called the police. The officers had been well-trained in behavioral health interventions and were able to triage with the StarVista team and school counselor. From conversations with the student, it was clear he had the intent to take a gun, enter a neighborhood with gang presence and by drawing his weapon, ensure that he was killed by gang gunfire. All agreed that the student required emergency hospitalization and the StarVista counselor worked with the school's Marriage and Family Therapist to develop a plan for the student to return to school once he had stabilized.

The last example described by Ms. George involved a school where a popular student had committed suicide. The intervention team worked with the school counselor and teachers to brief them on how best to manage the school's grief and how to identify students at risk of suicide. The team also set up an ad hoc drop-in, grief counseling center in the library and spoke with scores of

students individually and in groups. Through this process, the school realized that one of the best friends of the suicide victim was himself in severe crisis. In individual counseling with the SV clinician, it was clear that this student had a high degree of suicidal ideation. After ten days of counseling, the student stabilized considerably and returned to school.

To obtain another independent view of the effectiveness of the StarVista team, the evaluator spoke with a counselor at a local middle school who had called upon StarVista's crisis services many times, referring parents to the parent hotline, students to the Teen Chat Line, and calling for crisis intervention support numerous times. The counselor described one instance with a high-achieving boy who was seriously depressed and experiencing suicidal thoughts. The counselor called upon the Crisis team and an intern came to the site, met with the student, confirmed the counselor's assessment, and conferred with the counselor to develop a treatment plan. For two months, the intern continued to come to the site weekly to meet with the student and the counselor until the crisis had been stabilized. The Counselor noted that now a year later, the student continues to meet with her weekly, is doing well in school and is developing skills for managing his depression. The counselor noted another time when a younger student was also depressed and also exhibiting signs of suicidal ideation. Again, the counselor called upon StarVista and again an intervention specialist met with the student, confirmed the diagnosis and met with the counselor to develop a treatment plan. The counselor also indicated that every year she and others at the site have been trained by StarVista in identification of students at-risk of suicide and in strategies for implementing school-wide suicide prevention strategies. Above left is a quote from the structured interview conducted by the evaluator.

> "StarVista is a critical service to our school community. A community nearby has been experiencing a number of youth suicides among high-achieving students and it creates a context in which suicide seems to be almost a normalized response to crisis or depression. It is a great concern at our school and I know at others in the area. StarVista's training, crisis intervention and hotline services are all critically needed. They are very good at what they do, they respond very quickly, and they make a big difference."
>
> Middle School Counselor

Lastly, the YIT also provides prevention education sessions to over 2500 middle and high school students. After each presentation, students take a post-test survey. Results from the survey disclosed that 93.3% of respondents correctly answering two questions pertaining to myths about suicide. More than 90% responded that they were more aware of available resources after the presentation. Clearly, these presentations are meeting their goal of dispelling myths about suicide and helping students

Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?

Certainly the caller and school personnel satisfaction data described above provide evidence of high satisfaction with both the hotline and the Youth Intervention Team services. This satisfaction is further affirmed through the structured interviews. Another online, anonymous satisfaction survey was administered with Hotline volunteers responsible for answering crisis calls. Twenty volunteers responded to the survey and their responses both offered a better picture of the role volunteers played and provided clear evidence of their satisfaction with their role, the support provided by paid staff, and their perceived impact on clients. Open-ended questions also provided a number of excellent suggestions for how the program could be improved.

The survey revealed that 50% of the respondents had been volunteers for 1-3 years with 10% having been volunteers for over 10% and 10% more being volunteers over three to ten years. Taken together this suggests a significant level of stability and satisfaction among the volunteer corps. Sixty-five percent of respondents indicated spending over ten hours per month as volunteers. When asked how often they felt they had helped callers, 65% of respondents indicated either almost always or most of the time they felt they had helped, with 35% indicating some of the time and with no volunteers indicating rarely or almost never. Given the difficult role that volunteers play and the high degree of crises they encounter, this appears a very high percentage to feel confident in their impact. While 15% of respondents felt that most calls were from people in immediate and extremely urgent crisis, 75% responded that the majority of calls were seeking support for a serious situation, but not an urgent, immediate crisis. In terms of the degree to which volunteers felt prepared for their role, 70% of respondents strongly agreed and the remaining 30% somewhat agreed with the statement that "SV's training prepared me very well for the work I do" and an even higher percentage (85%) strongly agreed that "SV staff provide excellent support whenever I feel challenged by a call or situation" with the remaining 15% indicating that they somewhat agree. Taken together this represents an extremely high level of satisfaction and a high proportion of volunteers indicating confidence that they are having an impact. The quote above aptly captures the sentiments of the many other extremely positive comments made by volunteers in response to an open-ended question about what how the program could be better. The only remotely negative comments were that the carpet be replaced or cleaned and two conflicting comments, one indicating that volunteers should be allowed to remain on the line longer with callers with complex challenges or needs for referral to other services while another volunteer indicated that there should be stricter guidelines to limit longer calls, particularly during high demand hours. In addition to the above, there were a number of constructive suggestions worthy of consideration including:

"The training was extremely helpful. It covered a myriad of call types we receive. Also when you receive a very emotional call or a critical call, the staff are so supportive and reassuring, often standing beside you to put a hand on your shoulder or write notes about other services to offer or to provide background if the caller is a frequent caller. This is priceless support that makes all the difference."

- One asking if their line could be transferred to their cell phone so they could continue to work after their shift,
- Another asking if there could be supplemental training in response to volunteer requests,
- One volunteer requested that StarVista overlap shifts so volunteers could develop a deeper connection with each other and perhaps share partial shifts,
- Two volunteers indicated that phone numbers for resources and referrals sought by callers should be updated with the second reference specifically noting that some of the housing and mental health services were not as helpful as would be desired,
- Another volunteer wondered if a button on the computer could be installed to enable the caller to automatically call the phone company for an emergency trace and perhaps connect with police so the volunteer didn't have to be looking for a number during an extreme crisis, and lastly
- A volunteer suggested that StarVista should consider including recordings of real calls in the training, supplementing the role play practice.

The large number of positive comments about staff support, training and volunteer camaraderie along with the thoughtful, constructive suggestions above, are indicative of a well-managed program that despite operating in extremely stressful contexts, has achieved a very positive moral among the volunteers.

Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?

StarVista provided significant and varied forms of highly affirmative data verifying the degree to which the Hotline program responded to the needs of both the volunteers and callers in crisis. Volunteers felt well-trained and callers felt that they were heard and supported by those volunteers. While there was less evidence from the schools and none from those directly served by the Youth Intervention Team, the survey and interviews with school personnel and the interview with the clinical director provided ample evidence that this program was also meeting the needs of the intended population. EQ # 6 and 7 provide suggestions as to how the intervention program could gather more data on school personnel satisfaction with both training and intervention support.

Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?

The vision, mission and values of San Mateo County Behavioral Health & Recovery Services stress empowering individuals to direct their own recovery process. BHRS stresses the adoption of culturally competent treatment approaches and through its MHSA planning processes, a further focus has been placed upon implementing evidence-based practices that have demonstrated the capacity to support client wellness and recovery. From the perspective of prevention, BHRS has also described the journey towards a transformed system requiring that programs:

- move "upstream" to primary prevention strategies;
- partner with other health prevention efforts to focus on wellness and recovery;
- achieve desired outcomes; and
- integrate efforts to support sustainability;

What's more, San Mateo's MHSA plan clearly described the priority of intervening early and identified stress, PTSD, and use of alcohol and drugs as factors where early intervention were most important, particularly in relation to individuals from historically underserved populations. The hotline and intervention programs clearly promote wellness and recovery, provide services, supports and referrals to individuals in extreme crisis. While the crisis intervention and hotline are not classically preventive or 'upstream' as they serve clients who have reached extreme crisis, both programs target youth and provide referrals to other partner health promotion supports and based upon the data presented, both programs are achieving the desired outcomes. What's more, the extensive school training of school personnel and consultations with counseling staff facilitate schools adopting suicide prevention programs and assist in identify students at risk of suicide. The school presentations to almost 2500 students also contributes to creating student bodies that are sensitive to the needs of individuals under stress and better equipping them to be supportive.

Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?

Through the evaluation process a number of factors were identified that impede StarVista from maximizing its impact.

Crisis call back-up system. StarVista had been using the Bill Wilson Center in Santa Clara to back up StarVista's system when they are over-extended. Unfortunately, the AAS requires that all back up providers also be AAS certified, as StarVista is. Bill Wilson is not AAS certified and so StarVista is in the process of engaging Bay Area certified providers to see if a back-up plan can be developed.

***Language can be a barrier*.** StarVista is part of a collaborative Bay Area Spanish speakers crisis line, and refers people to that line both via outreach and when they call the Hotline. While StarVista does have a few Spanish speaking volunteers, they are only occasionally on duty. Having a language interpretation service account has been too expensive for the StarVista budget in the past, though the Program Director indicated that with adequate funding, they would use this resource.

Out-of-date referral information. Volunteers noted that contact information for many referral resources were out of date and that callers had reported to them that some of the resources to whom they had been referred were not very useful. From experience working with hotlines in most Bay Area counties, I know that this is a very common challenge and one not easily overcome, as once any list of referrals is complete, within weeks they begin to become out of date.

Lack of automation or easy access to information and/or outside support. A couple of volunteer comments suggested that at times they become flustered when seeking referral numbers and one volunteer suggested that it would be beneficial to have automatic connections established with emergency services providers like the police or to put a tracer on calls so that the location could be identified.

Ability to balance need to address high volumes of calls with the need to stay with callers who are experiencing extreme crisis or require complex referral support. Two volunteers sited either side of this conundrum, one asking for more flexibility to stay with callers and the other asking for tighter regulations to force volunteers to get off long calls when there is also a high volume of callers.

Lack of sufficient funding. The Hotline is significantly underfunded and this impacts all of the above items. The program is funded for only four hours a week for a program manager when a full-time manager would be warranted. Developing a new back up relationships, exploring development of a texting system for the Teen Chat Room, coordinating outreach efforts to secure more bilingual volunteers, or translation options and sustaining a up-to-date referral information all require managers with time to do the research, design and outreach. StarVista simply does not have sufficient management to address these challenges as quickly or thoroughly as would be the case with more funding for management.

Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

There were very few areas in which there was any evidence of a significant need for improvement in the services delivered by the Crisis Intervention and Suicide Prevention Center, however, there is room for improvement in data collection as there were a number of ways in which the YIT could obtain data to validate program effectiveness and to identify areas where improvement might be possible.

- *Conduct more outreach to the Spanish-speaking community to expand the number of Spanish-speaking volunteers.*
- *Consider ways to better organize referral contact information so that it is more easily accessible by volunteers on the Hotline;*
- *Explore ways in which contacts with emergency services can be automated or that traces can be made via a computer connection with the phone company.*
- *Begin collecting data on the number of call referrals to other resources that are required because of Hotline inability to converse with a caller speaking another language—this data could be used to justify seeking county or private funding for the translation*
- *Expand data collection for all school based programs by:*
    - *Incorporating a protocol at the end of a school crisis intervention that directs the primary school contact to complete a brief online survey once the crisis has been reduced with open-ended questions asking what was most valuable about the intervention and how the intervention might have been implemented more effectively or what more could have been done;*
    - *Work with the evaluator to create a Crisis Intervention Incident Report that captures demographic data of students served, a checklist of services delivered, and a brief summary of the nature of the crisis and the outcome;*
    - *Survey Teen Chat Room teen volunteers as was done with hotline volunteers*
    - *Utilize a post presentation survey of students attending presentations and with teachers and school personnel participating in training, and including open-ended questions to identify how the presentations or trainings could be improved; and*
    - *Establish a procedure for entering this data into a database so that it can be used by program managers to identify areas in which programs could be improved.*

While the above recommendations could possibly improve StarVista's Crisis Intervention and Suicide Prevention Center, as the evaluation report describes throughout, this is a very well managed program that consistently meets the needs of schools and individuals experiencing high levels of crisis and where there really is no other resource other than the Crisis Center. If it were at all possible for the County to dedicate additional funding to support expansion of the program's management position OR to partner with StarVista in seeking private funding, this would significantly boost the program's capacity to continue to expand its program and fill gaps where they exist.

Section V Demographic Summary

Demographic data is not collected by any of the programs. So this table has not been completed. However, narrative is provided for the tables that summarize the degree to which a program meets MHSA and/or BHRS priorities. That information follows this incomplete table.

Demographic Summary					**Source of Data**
Total Unduplicated Served					
Gender		**Clients**	**Program Staff**		
	#	%	#	%	
Male					
Female					
Other					
Age	#		%		
Children 0-15					

Demographic Summary					Source of Data
Transition Age Youth 16-24					
Adult (25-59)					
Older Adults 60+					
Families (can include families with children or TAY)					
Ethnicity	**Clients**		**Program Staff**		
	#	%	#	%	
Caucasian					
Latino					
African American					
Asian					
Pacific Islander					
Native American					
Multi-Ethnic					
Other					
Home Language	**#**	**%**	**#**	**%**	
English					
Spanish					
Cantonese					
Mandarin					
Underserved Pops Served	**#**	**%**	**#**	**%**	
LGBT					
Blind/Vision Impaired					
Deaf/Hearing Impaired					
Veterans					
Homeless					

Program Components Table and discussion are on the next page.

Section VI Program Components:

The information in Table II will be used to report to MHSA as part of the statewide evaluation. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator.

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.		
	Yes	**No**
II-1) Access for Underserved Populations	**x**	
Details: Clearly the hotline and intervention team both serve individuals in crisis, while not explicitly targeting under-served populations, under-served populations are among those served.		
II-2) Outreach for Early Recognition of Need	**X**	
Details: Training of school personnel and prevention education to almost 2500 middle and high school students is designed to help students and school personnel identify students at risk of suicide.		

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.		
II-3) Access or Linkages to Care	**X**	
Details: Certainly one of the primary functions of the Hotline is to connect callers to resources that address their needs.		
II-4) Reduction of Stigma	**X**	
Details: School presentations reaching almost 2500 students are designed to sensitize students to how stigma impacts peers experiencing emotional challenges.		
II-5) Screening for Needs	**X**	
Details: One of the key functions of the YIT is to work with school personnel to assess the needs of students in crisis and identify and develop a plan for longer-term support, as needed.		
Program Activities	**Yes**	**No**
II-6) Addressing Trauma	X	
Details: Trauma is in play with the large majority of clients served by the Crisis Center whether this be in intervening with students at risk of suicide or fielding crisis calls on the Hotline.		
II-7) Specific Risk Factors	X	
Details: Suicidal ideation and depression.		

	Provide specific details very briefly. 1-3 sentences per line.
II-7) Indicate the location where program activities occur (identify places where services occur	The Hotline is a countywide program and the intervention team serves schools throughout the County.
II-8) Specify the roles for Peers (mentors Outreach, Peer education, other)…Please specify.	The most obvious example of a peer component is the Teen Chat Room. However, as was evident from the structured interview with the YIT Clinical Director, interventions have resulted in peer groups at one school with peers supporting peers who had been involved in self-harming activities.
II-9) Specify the sectors with which you collaborate on this program (housing, criminal justice, public health, education, child welfare)	The Hotline refers callers to services in virtually every public service sector including housing, education, and health. The intervention team is quite obviously collaborating with school sites throughout the county but is also referring students in crisis for mental health services via the Access Program.

Section VII Program Alignment with SMC MHSA PEI Priorities:

Providers will mark Y for Yes for any community need or priority population addressed. In the space provided, please explain how these needs or populations were served. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator during which time a discussion will occur to amplify and provide details or examples.

Table III: Alignment with SMC MHSA PEI PRIORITIES				
	Children & Youth	**TAY**	**Adult**	**Older Adult**

Table III: Alignment with SMC MHSA PEI PRIORITIES				
1-PEI Key Community Needs	**X**	**X**	**X**	**X**
1-A) Disparities in Access to Mental Health Services				
Details: The primary purpose of the crisis line is to defuse the personal crisis of thousands of callers of all ages who have not been able to access other services. The intervention team intervenes and supports schools in the prevention of suicide both through prevention education and direct crisis intervention.				
1-B) Psycho-Social Impact of Trauma	X	X		
Details: Intervention team presentations to 2500 students are designed to educate students about the impact of trauma and school training is designed to train school personnel in how to prevent trauma and identify its impact.				
1-C) At-Risk Children, Youth and Young Adult Populations	X	X		
Details: Both the Teen Chat Room is designed to work with other youth before they begin experience crisis and the intervention teams is designed to support youth in extreme crisis.				
1-D) Stigma and Discrimination	X	X		
Details: Intervention team presentations to 2500 students are designed to educate students about the impact of stigma and school training is designed to train school personnel in how to prevent stigma and nurture a more empathetic school community.				
1-E) Suicide Risk	X	X	X	X
Details: The intervention team intervenes directly in situations where a youth is at extreme risk of suicide and the Hotline fields hundreds of calls from individuals with suicidal ideation.				
2- PEI Priority Populations				
2-A) Trauma Exposed Individuals	X	X	X	X
Details: The intervention team intervenes directly in situations where a youth is at extreme risk of suicide and the Hotline fields hundreds of calls from individuals with suicidal ideation. Most often these crises are triggered by exposure to trauma.				
2-B) Individuals Experiencing Onset of Serious Psychiatric Illness	X	X	X	X
Details: In many instances, student suicidal ideation surfacing at the school site can represent the first evidence of the onset of serious psychiatric illness. While there is no data to verify this, it is likely that a number of Hotline calls are being triggered by the onset of a psychiatric condition.				
2-C) Children and Youth in Stressed Families	X	X	X	X
Details: Students experiencing thoughts of suicide are often feeling isolated and unsupported by families and may often be products of a highly stressed family.				
2-D) Children and Youth at Risk for School Failure	X	X	X	X
Details: Students at the level of stress where they are considering suicide are quite obviously at risk of school failure. In the structured interview with the intervention team Clinical Director, just such a situation was described with a friend of a suicide victim needing to leave school for several weeks to stabilize his own suicidal thoughts.				
2-E) Children and Youth at Risk of or Experiencing Juvenile Justice Involvement				
Details: Working with juvenile justice involved youth is not a focus of this program.				