COUNTY OF SAN MATEO
HEALTH SYSTEM
BEHAVIORAL HEALTH & RECOVERY SERVICES

SAN MATEO COUNTY
MENTAL HEALTH SERVICES ACT (MHSA)

PROGRAM AND EXPENDITURE PLAN TO SPEND REALLOCATED MHSA FUNDS

May 2, 2018

*Pursuant to Assembly Bill 114 and Department of Health Care Services (DHCS) Info Notice No. 17-059

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Proposition 63, the Mental Health Services Act (MHSA), was approved by California voters in November 2004 and provided dedicated funding for behavioral health services by imposing a 1% tax on personal income over one million dollars translating to about $25.5 million average for San Mateo County annually in the last five years through Fiscal Year (FY) 2016-17.

MHSA emphasizes transformation of the behavioral health system, improving the quality of life for individuals living with behavioral health issues and increasing access for marginalized communities.

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

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

MHSA provides funding for Community Program Planning (CPP) activities, which includes stakeholder involvement in planning, implementation and evaluation. In San Mateo County, MHSA dollars are virtually everywhere in the BHRS system and highly leveraged. MHSA funded programs and activities are grouped into "Components" each one with its own set of guidelines and rules.

Community Services & Supports (CSS)

Prevention & Early Intervention (PEI)

Innovation (INN)

75%

20%

5%

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

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

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

For a full list of MHSA funded programs by component, visit the San Mateo County MHSA website at www.smchealth.org/mhsa.

ASSEMBLY BILL 114

MHSA legislation requires local Counties to revert (return) funds to the State that have not been spent within the required 3-year time frame for the primary MHSA programs. Due to a lack of guidance on amounts subject to reversion and a process to revert funds, a one-time legislation (AB 114) was enacted allowing Counties to submit a plan by July 1, 2018 for expending their respective funds that are subject to reversion by June 30, 2020. The legislation provides additional provisions that establish a balanced approach to MHSA reversion for both past and future funds including:

- Notification of funds subject to reversion and appeal instructions will be provided.
- Reallocated funds must be spent in the same component (i.e. Prevention, and Early Intervention, Innovation, etc.) originally allocated to.
- The 3-year reversion time frame for innovation funds will commence upon approval of the project plans; minimizing the reversion risk for funds while awaiting approval.
- For funds moving forward, reversion guidelines will be provided in the near future.

SAN MATEO COUNTY IMPACT

San Mateo County Behavioral Health and Recovery Services (BHRS) received notice on December 28, 2017 through Department of Health Care Service (DHCS) Information Notice 17-059 that $2,888,006 is subject to reversion for the MHSA Innovation (INN) component. As of the notice, the San Mateo County MHSA Revenue and Expense Report (RER) for FY 16/17 had not been submitted to DHCS, which meant that FY 14/15 funds subject to reversion were not included. A second notice was received on May 3, 2018 with the adjustment. The current amounts subject to reversion are 1) $3,846,214 in INN, pending an expenditure adjustment in FY 15/16 of -$13,669; and 2) $423,610 in Workforce Education and Training (WET), a one-time funding allocation received in FY 06/07 with a 10-year reversion period.

As of original posting of this reversion plan, San Mateo County expected to submit AB 114 Reversion Plans for three components. Based on DHCS second notice of unspent funds subject to reversion, we will only submit INN and WET reversion plans. All identified reversion funds will be captured in our plan, thus preserving these funds for San Mateo County's needs.

Enclosure 1   5/2/2018

Department of Health Care Services
MHSA Funds Subject to Reversion by Fiscal Year by Component

San Mateo	CSS	PEI	INN	WET	CFTN	Total
FY 2005-06	$ -					$ -
FY 2006-07	$ -			$ 423,610		$ 423,610
FY 2007-08	$ -	$ -			$ -	$ -
FY 2008-09	$ -	$ -	$ 1,048,126			$ 1,048,126
FY 2009-10	$ -	$ -	$ 246,912			$ 246,912
FY 2010-11	$ -	$ -	$ 793,069			$ 793,069
FY 2011-12	$ -	$ -	$ -			$ -
FY 2012-13	$ -	$ -	$ -			$ -
FY 2013-14	$ -	$ -	$ 786,230			$ 786,230
FY 2014-15	$ -	$ -	$ 958,208			$ 958,208
Total	$ -	$ -	$ 3,832,545	$ 423,610	$ -	$ 4,256,155

$ -	No Funds Subject to Reversion
	ARER expenditure data is not complete

STAKEHOLDER INPUT

San Mateo County has a local planning structure to engage a broad and diverse San Mateo County stakeholder community. The MHSA Steering Committee makes recommendations to the planning and services development process and 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 helps prioritize strategies for potential funding that then move forward to the Mental Health and Substance Abuse Recovery Commission (MHSARC) for a 30-day public comment period, public hearing and final recommendations to the San Mateo County Board of Supervisors (BoS) for approval before submitting any plans or updates to DHCS.

MHSARC members are all members of the MHSA Steering Committee, commissioners are involved in MHSA planning activities providing input and receiving regular updates as a standing agenda item on the monthly MHSARC meetings. The Steering Committee meetings are open to the public and include time for public comment, including a means for submission of written comments. The MHSA Steering Committee is 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 (education, healthcare, criminal justice, among others).

COMMUNITY PROGRAM PLANNING PROCESS (CPP)

In December 2016, a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan was kicked off by the MHSARC. Planning was led by the MHSA Manager and the Director of BHRS and staffed by the Office of Diversity and Equity.

Phase 1. Needs Assessment → Phase 2. Strategy Development → Phase 3. Plan Development

Input for Phase 1. Needs Analysis and and Phase 2. Strategy Development was sought from 31 diverse community groups and vulnerable populations to include perspectives of different backgrounds and interests including geographical, ethnic, cultural and social economic, providers and recipients of behavioral health care services and other sectors, clients and their family members.

Additionally, over thirty key interviews were conducted with MHSA funded program contacts including managers and contract agencies. A Pre-Launch session was held with

clients/consumers hosted by the Peer Recovery Collaborative, a collaborative of peer-run agencies including California Clubhouse, Heart and Soul and Voice of Recovery.

Over 270 participated in two key public meetings, the CPP Launch Session on March 13, 2017 and the CPP Prioritization Session on April 26, 2017. 156 demographic sheets were collected and of these 37% identified as clients/consumers and family members, 36 stipends were provided. The majority of participants at these two public meetings (64%) represented central and south geographical areas of the county. There are institutional barriers to accessing and attending centrally located public meetings (trust, transportation, cultural and language, etc.). In an effort to address this, two additional Community Prioritization Sessions were conducted in East Palo Alto and the Coastside.

San Mateo County AB 114 Reversion Plans were developed based the comprehensive CPP process described above. Specific CPP activities for each component are included in the respective AB 114 Reversion Plans.

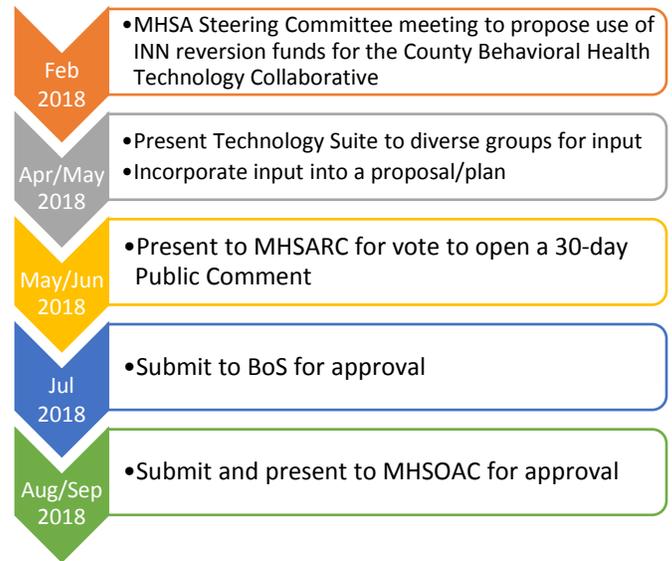## AB 114 REVERSION PLAN – INNOVATION (INN)

Purpose: to pilot technology based -interventions that support behavioral health and wellness and are intended to; increase access to mental health care; promote early detection of mental health symptoms; and predict the onset of mental illness.

Rationale: On February 16, 2018 the MHSA Steering Committee met and reviewed the AB 114 legislation and requirements. A focus on technology-based interventions was prioritized for the AB 114 Reversion Plan given the following:

- **Un-met need** - technology-based interventions to support isolated adults and transition age youth was prioritized as part of the 2014-17 CPP process and a comprehensive Innovation project development process. Due to capacity and challenges with the technology vendor's ability to pilot their apps with more acute clients, we did not pursue formal approval for the projects.
- **Opportunity** - Los Angeles and Kern Counties proposed a collaborative approach to counties statewide to bring technology-based solutions to behavioral health. Specifically, a Technology Suite of mobile apps was being developed and include:
  - Peer chat and digital therapeutics
  - Virtual evidence-based therapy using an avatar
  - Utilizing passive smartphone data for early detection and intervention

San Mateo County will join the County Behavioral Health Technology Innovation Collaborative, which will allow the development of behavioral health technology interventions that are adapted to meet unique San Mateo County community needs and leverage economies of scale for planning, implementation and evaluation. INN projects require a comprehensive process to develop a plan that meets the INN legislation and guidelines. In an effort to ensure the technology interventions are meaningful, accessible and relevant a comprehensive stakeholder engagement process was initiated in mid-April and will continue through mid-May.

A preliminary INN plan and budget was presented to the MHSARC on May 2, 2018, the MHSARC voted to open to 30-day public comment and conduct a public hearing at close of the public comment period, at which all community input and public comment will be discussed and incorporated into the INN plan as appropriate. See Appendix A. San Mateo County Innovation Plan, public comments received will be updated after the closing of the public comment period on June 6, 2018 and the final plan will be posted on the MHSA website, www.scmhealth.org/mhsa after approval by the State of California Mental Health Services Oversight Committee (MHSOAC).

Feb 2018
- MHSA Steering Committee meeting to propose use of INN reversion funds for the County Behavioral Health Technology Collaborative

Apr/May 2018
- Present Technology Suite to diverse groups for input
- Incorporate input into a proposal/plan

May/Jun 2018
- Present to MHSARC for vote to open a 30-day Public Comment

Jul 2018
- Submit to BoS for approval

Aug/Sep 2018
- Submit and present to MHSOAC for approval

Total funding amount: $3,846,214, pending expenditure adjustment in FY 15/16 of -$13,669

By joining the County Behavioral Health Technology Innovation Collaborative, San Mateo County is agreeing to contribute to a statewide pool of INN funds. CalMHSA, a Joint Powers of Authority, will serve as a fiscal intermediary and in a project management role to facilitate contracting with technology vendors, support a shared evaluation, and maximize planning outreach and marketing. The budget is divided into four main components:

Core Technology	Future Technology	Local Programming	Statewide Marketing & Evaluation
$992,578*	**$1,465,591***	**$1,046,500**	**$367,498**

*subject to change pending final negotiations with vendors

Core Technology development includes technology vendor fees (start-up, development, licensure, etc.), subject-matter experts and overhead. This will fund the development of all three generic apps 24/7 peer chat; wellness avatar and use of smartphone passive data.

Future Technology development will be reserved for customization and additions to the generic apps. Subject matter expert(s) will work with the vendors to assure apps are effectively maintained as well as advanced per County needs and goals.

Local Programming category allows us to keep funding locally (outside of what we contribute to CalMHSA) to implement the strategies needed to support culturally responsive implementation and can include training of staff and peer workers, contracting with peer/family support agencies and agencies/groups serving monolingual Spanish and Chinese communities and local outreach and marketing efforts and materials.

Statewide Marketing & Evaluation is statewide promotion at strategic access points and marketing within school systems, social media, public locations, etc. Data collection, analysis and performance monitoring will also be managed by CalMHSA.

Local Fund budget breakdown

Local Funds Items/Personnel	Cost	Total Amount	Budget Justification
Peer and Family partner specialists	150,000/year x 2 years	$300,000	Contract(s) to support peer end-users, face-to-face support services to users, outreach and training of BHRS staff and network providers.
Spanish and Chinese community specialists	$100,000/year x 2 years	$200,000	Contract(s) to support peer end-users, face-to-face support services to users and outreach.
Older Adult peer and family partners	$100,000/year x 2 years	$200,000	Contract(s) to support peer end-users, face-to-face support services to users and outreach.
Youth peer workers	$100,000/year x 2 years	$200,000	Contract(s) to support peer end-users, face-to-face support services to users and outreach.
Local Communications and Marketing	$5,000 / year x 2 years	$10,000	Social media boosts ($500), printing ($500), SamTrans/CalTrain Adcards ($3000), Daily Journal/EPA Times ($400), incentives ($600) / year
Planning and administration	15% of operating x 2 years	$136,500	Coordination of staff training, planning, approval and request for proposals processes, market and development, final reports
	TOTAL	**$1,046,500**	

County Behavioral Health Technology Collaborative budget breakdown
Vendor rates are in the process of being negotiated and subject to change

		Relative Size Unit:		% of Experts:		Total INN Budget:	
Tech Suite Budget:	2,825,667		3.34		5.00%		3,872,167

Total Expenses for Desired Duration of Innovation Project (per annual budget below)

	Overhead	Experts	Vendor #1 (7 Cups)	Vendor #2 (Mindstrong)	Vendor #3 (CBT/EBP)	Future Apps	Evaluator	Otrch & Mktg	Local Funds
Start-Up			$100,227	$83,522	$33,409	$116,931	$116,931	$33,409	
Development			100,227	100,227	33,409	100,227	0	50,113	
Licensure			100,227	100,227	66,818	167,045	100,227	66,818	
Other	141,283	133,000				1,081,388			1,046,500
Total	$141,283	$133,000	$300,681	$283,976	$133,636	$1,465,591	$217,158	$150,340	$1,046,500

$2,825,667 Total Budgeted Amount per new fee schedule (no local funds)

Expenses	FY17/18	FY18/19	FY19/20	FY20/21	FY21/22	FY22/23	Innovation Total	% of Total
CalMHSA Overhead (5%)		$ 141,283	$ -	$ -			$ 141,283	5.0%
Experts		$ 46,000	$ 46,000	$ 41,000			$ 133,000	4.7%
Vendor #1								
Start-Up Fee		$ 100,227	$ -	$ -			$ 100,227	
Development Fund		100,227	-	-			100,227	
Licensure Fees (75% in 18/19, 25% in 19/20)			50,113	50,113			100,227	
Vendor #1 Subtotal		$ 200,454	$ 50,113	$ 50,113			$ 300,681	10.6%
Vendor #2								
Start-Up Fee		$ 83,522	$ -	$ -			$ 83,522	
Development Fund		100,227	-	-			100,227	
Licensure Fees			50,113	50,113			100,227	
Vendor #2 Subtotal		$ 183,749	$ 50,113	$ 50,113			$ 283,976	10.0%
Vendor #3								
Start-Up Fee		$ 33,409	$ -	$ -			$ 33,409	
Development Fund		33,409	-	-			33,409	
Licensure Fees			33,409	33,409			66,818	
Vendor #3 Subtotal		$ 66,818	$ 33,409	$ 33,409			$ 133,636	4.7%
Future Apps/Vendors								
Start-Up Fee		$ 116,931	$ -	$ -			$ 116,931	
Development Fund		100,227	-	-			100,227	
Licensure Fees			83,522	83,522			167,045	
Local Customization		360,463	360,463	360,463			1,081,388	
Vendor #4 Subtotal		$ 577,621	$ 443,985	$ 443,985			$ 1,465,591	51.9%
Vendor #5: (Evaluator)								
Start-Up Fee		$ 116,931	$ -	$ -			$ 116,931	
Development Fund		-	-	-			-	
Licensure Fees (75% in 18/19, 25% in 19/20)			50,113	50,113			100,227	
Vendor #5 Subtotal		$ 116,931	$ 50,113	$ 50,113			$ 217,158	7.7%
Vendor #6: (Outreach & Marketing)								
Start-Up Fee		$ 33,409	$ -	$ -			$ 33,409	
Development Fund		50,113	-	-			50,113	
Licensure Fees			33,409	33,409			66,818	
Vendor #6 Subtotal		$ 83,522	$ 33,409	$ 33,409			$ 150,340	5.3%
Subtotals								
Start-Up Fee		$ 484,430	$ -	$ -	$ -	$ -	$ 484,430	17.1%
Development Fund		384,203	-	-	-	-	384,203	13.6%
Licensure Fees		-	300,681	300,681	-	-	601,362	21.3%
Local Customization		360,463	360,463	360,463	-	-	1,081,388	38.3%
Vendor Subtotals		$ 1,229,096	$ 661,144	$ 661,144	$ -	$ -	$ 2,551,383	90.3%
TOTAL EXPENSES		$ 1,416,380	$ 707,144	$ 702,144	$ -	$ -	$ 2,825,667	100.0%

Purpose: to continue the current WET plan budget through FY 17/18, which includes implementation of targeted recommendations from the 10-Year WET Impact & Sustainability Report released February 2018, see Appendix B.

Rationale: WET was designated one-time MHSA allocation to Counties with a 10 year reversion. $3,437,600 was allocated to San Mateo County. BHRS is prepared to sustain the most effective and impactful elements of this component. Continued investment in WET is critical to supporting BHRS' strategic initiatives and priorities, and for creating a system of care that is responsive to MHSA core values of building community collaboration, cultural humility, consumer and family driven services, a focus on wellness, recovery, and resilience, and an integrated service experience. To prepare for sustainability of WET, an independent consultant was hired to support a comprehensive CPP process for WET and included the following:

- Survey for Staff, CBO Partners, Contractors
- Survey for Cultural Competency Stipend Intern Program Participants
- Interviews of Cultural Competency Stipend Intern Program Participants
- Survey for Lived Experience Academy Participants
- Interviews of Lived Experience Academy Participants
- Listening Session with the Lived Experience Education Workgroup (LEEW)World Café with the Workforce Development and Education Committee

Materials reviewed also included the LEEW Enhancement report, training logs, pre/post-tests and evaluations collected at trainings, budgets, WET and MHSA plans and annual updates, etc. A WET 10-year Impact & Sustainability Report was published in February 2018, which included impact analysis and a vision for WET and recommendations based on a comprehensive stakeholder input process.

According to a letter provided to CBHDA by the California Department of Mental Health, WET funds received in FY 06/07 and FY 07/08 revert on 2017 and 2018 respectively. In the DHCS Info Notice No. 17-059, we were informed that WET funding allocated in FY 07/08 expired FY 16/17 as it includes the year when funding was made available. Given this discrepancy we will use unspent funds to complete the FY 17/18 WET program plan implementation.

Total funding amount: $ 423,610

BHRS Workforce Education & Training FY 17/18 Budget

Workforce Staffing and Support • WET Coordinator ($126,025) • Program Specialist ($59,133) • Office Specialist ($48,526)	$233,610
Trainings for System Transformation • Cultural Humility • SOGI • Harm Reduction/Motivational Interviewing • Family Therapy • Trauma-informed Care • Cognitive Behavioral Therapy • Recovery 101 • ASIST • Law & Ethics (Behavioral Health) • Managing Assaultive Behavior • Dialectical Behavior Therapy • Provider Vicarious Traumatization/Self Care/Wellness Trainings • Training Logistics (space rentals, etc.)	$100,000
Trainings by/for Consumers/Family Members • Voices of Recovery-WRAP • Human Trafficking • HEI Training Support • Peer Worker 101 • Advocacy Training • Provider Vicarious Traumatization/Self Care/Wellness Trainings • Conferences/Trainings	$55,000
Behavioral Career Pathways/Financial Incentives • CSIP/ODE Stipends • Lived Experience Scholarship • BHRS Clinical Internship Planning & Implementation • APA Continuing Education (CESA application)	35,000
Total	**$423,610**

30-DAY PUBLIC COMMENT & UPDATES TO THE PLAN

Pursuant to Assembly Bill 114 and Department of Health Care Services Info Notice No. 17-059, the San Mateo County Program and Expenditure Plan to Spend Reallocated MHSA Funds was posted on the San Mateo County website and presented to the MHSARC on May 2, 2018. The MHSARC voted to open to 30-day public comment and conducted a public hearing on June 6, 2018 at close of the public comment period. Following are the key updates made to the proposed plan and public comments received during the 30 day public comment period. The final steps before commencing implementation of the plan include a presentation to the Board of Supervisor for adoption of the plan and to the Controller to certify expenditures, within 90 days of posting of the plan on May 2nd. For the INN component plan, a final approval by the State of California Mental Health Services Oversight Committee (MHSOAC) is required.

Key updates to the plan:

- Adjusted reversion amounts and budgets for INN and WET components
- Removed PEI reversion plan, no PEI dollars are subject to reversion
- Clarified WET reversion plan to include use of unspent funds for FY 17/18 expenditures
- Added Appendix A: *San Mateo County Innovation Plan: Increasing Access to Behavioral Health Services and Supports Utilizing a Suite of Technology-Based Behavioral Health Interventions*
- Added Appendix B: *10-Year WET Impact and Sustainability Report*

Public comments received:

This section to be updated following the closing of the 30 day public comment period and public hearing on June 6, 2018. The responses to the technology questions will also be updated, before requesting BoS approval, based on any additional information we receive from technical assistance providers and counties that are beginning implementation of the innovation.

MHSARC Opening of the 30-Day Public Comment Period (5/2/18)

Q: Behavioral Health/Mental Health has very strict legal protection in CA as far as what records can be subpoena and HIPAA, what's being looked at to capture these apps in that type of legal protection? The more you change the language from mental health the more you'll have the argument against those legal protections. What is being considered in that regard?

A: We are talking to CalMHSA as the technical assistance and project management entity and we will ask how HIPAA shows up, what does that look like, what data can you have and not

have. They are free applications and they are not supposed to replace clinical treatment so there might be different legislation attached to that because it is not treatment.

Q: Let me clarify…thinking less along the lines of HIPAA and more along the lines of…Let's say you're in a car accident and you can subpoena someone's medical record if you're the plaintiff but you can't get the mental health records but you can subpoena a Fitbit and you can subpoena Facebook. What type of protections would there be around these types of apps that would prevent the information (which is extremely sensitive) and mental health related in order for them to fall under that legal protection?

A: We will ask CalMHSA and other counties Los Angeles County and Kern County, which have started implementation, how they are addressing this issue.

Q: I'm assuming the app will be available on the app store and google play. How would people get access to it and is it open to the public for use?

A: it's free and its open to the public. I don't know where it can live yet, wherever folks can get apps.

Q: Question regarding the chat. Is that like Facetime and is there a limit? Because I speak only Chinese and will I understand the other participants? I don't want people to see me, how does that work? Is there an age limit for groups, are they only for adults, how do they verify the age? Can a 10-year-old pretend to be 30? Do we see the people in the group or is it typing?

A: If we don't have an answer to your question, we will catalog it. We will never answer a question that we don't have the answer to. It's typing, more like text messaging on the online platform. Most of the groups are broken down by age. I don't know how they would verify age of someone using the service. You also asked about language availability and that is something we have heard throughout the county making sure there's language availability in the threshold languages also cultural relevance/sensitivity and we will pursue Chinese translation for any prioritized apps by the Chinese monolingual community.

Q: Is there an entry level age? Does someone have to be 18 or older to use because if you drop it down to youth it becomes even more dicey as far as privacy goes.

A: We've heard some parents raise concerns about their young children having access to being on the internet too much and not being able to monitor their time/activity. That was one of the recommendations is that the county decide the age threshold.

Q: Who controls the content that's built on this, that's so complicated to do. Are you building on something that's already in place?

A: Yes, we are building on something that's in place as far as the three technology interventions available for customization. We also have the opportunity to develop new apps and will work with the vendors on this. This question has come up at previous meetings. While we don't have the full answer right now, it's important that we are asking these questions because these are questions we will bring up when we begin working with the vendors. The County has not selected a vendor.

Comment: Our technology requires that we get in front of this, early intervention. As you look at age thresholds it might be appropriate that you consider that we have people as young as 14 in our program.

Response: Thank you, we will take that into consideration for customization of the app.

Q: Is Noni [avatar for virtual-based therapy] available 24 hours?

A: Yes, the website is available 24 hours, 7 days a week. That's one of the reason for doing this app is to have something available 24 hours for people who are isolated. With the live Peer Listeners being nationwide, there's always someone to talk to on the app.

Q: How are the Peer Listeners screened who are doing that job? How they screened? How are they trained? How are they monitored?

A: The Peer Listeners go through a training and also if the Peer Listener is not a fit for someone, they can speak with someone else.

Q: Will the 24/7 service link to a help access line?

A: That has been a request from this community. That consideration will be raised so that it can be a prioritized feature of the app.

Q: How is this going to work for people who are isolated, especially if they don't have iPhones or computers? Has the county thought of providing all of that? Because that will be a challenge for some folks.

A: The county will need support around how to reach folks who are isolated. Some suggestions have been to go to places where people are. Not the places you think they, go to the places you know they are. This might not be the best way to engage everyone. If you are someone who doesn't have access to the internet or a smart phone, it might not be the best fit for you. It's just one of many options.

Comment: Maybe law enforcement and emergency responders can roll it out to people. They see people that others don't.

Response: Thank you, we will add that to the implementation considerations.

Q: You talked about an evaluation process, what does that like?

A: The part of the evaluation process that is in the plan is around gathering data, either doing focus groups or surveys. One suggestion was to put a survey in the app so people can interact and say how it is working for them so that data can come back. Additionally, as part of the statewide collaborative, an evaluation consultant has been identified and will support evaluation plan and tool development.

Q: With Wellness tools, does that include pharmacy integration? Is there a way for it to link into have you picked up your meds or reminder to pick up your meds, as well as taking and refilling the meds?

A: This is a consideration we can take into the process of customizing this app

Q: Will the chat box have EBP type tools?

A: This is a consideration we can take into the process of customizing this app

APPENDIX A: SAN MATEO COUNTY INNOVATION PLAN

San Mateo County MHSA Innovation Plan
Increasing Access to Mental Health Services and Supports
Utilizing a Suite of Technology-Based Behavioral Health Interventions

I. Project Overview

1). Primary Problem

a) *What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community.*

b) *Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.*

With a population estimate of approximately 764,797, San Mateo County is one of the larger suburbs on the San Francisco Peninsula. Santa Mateo County is also home to a diverse range of races and ethnicities.[1] White residents comprise the largest proportion of residents (39.5%), followed by Asian or Pacific Islander (27.8 %) and Hispanic or Latino residents (24.8%). More than 46% of the County population five years of age and older spoke a language other than English at home; of this population, 45% spoke English less than "very well," according to the 2011-2015 Census estimates. As of January 1, 2015, San Mateo County's threshold languages are Spanish, Chinese (Mandarin and Cantonese) and Tagalog.

It is important to note the diversity of the County because each community experiences different culturally-specific challenges in their ability to access the mental health services they need. During San Mateo County's FY 17-20 Mental Health Services Act (MHSA) Three-Year Community Program Planning (CPP) process and through a series of stakeholder meetings held in April and May of 2018, stakeholders voiced a need for new approaches to connect and engage mental health consumers to services and supports, especially for isolated consumers, transition-age youth and underserved racial and ethnic communities. Specifically, the Spanish and Chinese monolingual communities within San Mateo have been identified as un, under, and inappropriately served groups and prioritized through the CPP process. Some of the identified barriers to accessing mental health services for these diverse communities include stigma of mental illness, geographic isolation paired with transportation challenges, and services not being culturally relevant and/or linguistically accessible. Additionally, the MHSA CPP process revealed that these persistent barriers also make service engagement and participation particularly difficult for transition-aged youth (TAY) and older adults with more severe symptoms that may result in isolation.

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[1] https://datausa.io/profile/geo/san-mateo-county-ca/#category_age

Los Angeles and Kern Counties initiated a collaborative approach that invites counties statewide to bring technology-based solutions to behavioral health, forming the County Behavioral Health Technology Collaborative. Given that San Mateo County's Behavioral Health and Recovery Services (BHRS) prioritized technology innovations in 2014 and reinstated this priority in the most recent FY 17-20 planning process, San Mateo County joined the County Behavioral Health Technology Collaborative. This project plans to utilize technology-based services and supports to increase access and linkages that have never been tested by a collaborative effort among county public mental health systems.

The purpose of this innovation concept is to:
- Create and advance a suite of technology-based mental health solutions to detect, recognize, and acknowledge mental health symptoms in a timely manner;
- Reduce stigma associated with mental health issues while increasing access to care;
- Increase purpose, belonging, and social connectedness of individuals served; and
- Analyze and collect data from a variety of sources to improve mental health needs assessment and service delivery.

San Mateo County saw this Innovation project as an opportunity to leverage the subject matter expertise, app development management and collaborative learning approach with the goal to reach mental health consumers not currently connecting with the public mental health system with apps that are responsive to specific cultural and linguistic needs, as well as connecting consumers who find it challenging to receive or access mental health services in traditional office settings. Specifically, the County sought the opportunity to leverage technology to 1) reach and engage four priority populations with mental health services and supports, and 2) reduce the burden of transportation by providing alternative methods for engaging in recovery and wellness activities that do not require travelling to a physical location, such as an office or clinic.

2). What has been done elsewhere to address your primary problem?

a) *Describe the methods you have used to identify and review relevant published literature regarding existing practices or approaches. What have you found? Are there existing evidence-based models relevant to the problem you wish to address? If so, what limitations to those models apply to your circumstances?*

b) *Describe the methods you have used to identify and review existing, related practices in other counties, states or countries. What have you found? If there are existing practices addressing similar problems, have they been evaluated? What limitations to those examples apply to your circumstances?*

Across the state and nation, the broader mental health community has designed, implemented, and evaluated a number of initiatives that seek to address issues that impact service engagement and participation for youth, older adults, and culturally and linguistically isolated

communities. Despite a multitude of investments to implement cultural-specific mental health practices that reduce disparities; grow a bilingual/bicultural mental health workforce that is reflective of communities being served; and transcend the barriers of transportation, geography, and the reliance on in-person services; disparities in service access and participation remain persistent issues to be addressed.

San Mateo County opted in to the County Behavioral Health Technology Collaborative led by Los Angeles and Kern Counties, which aims to bring interactive technology–based mental health solutions into the public mental health system through a highly innovative set or "suite" of mobile apps. Los Angeles and Kern Counties have conducted a review of the field of mental health and found that utilizing a suite of technology-based mental health services has never been used in a public mental health care setting or in a multi-county collaborative setting. Because the use of technology-based interventions in mental health is an emerging field, there are many opportunities to pilot these innovative approaches to close gaps in the existing literature and knowledge about promising practices, including:

- Practices for mitigating limitations in access to technology or internet service for low income consumers;
- Practices to integrate technology-based interventions into existing in-person/community based mental health services with providers;
- Negotiating use of technology while complying with data security and HIPAA requirements of a public mental health system; and
- Launching a county-wide technology intervention suite tailored to meet the needs of the County's unique target populations.

San Mateo County's specific investments seek to leverage the multi-county collaborative efforts and further seek to understand the extent to which the "tech suite" engages and supports the four identified priority populations. This contribution may support other counties across the state to consider if technology-based solutions may support engagement in recovery and wellness with other un, under, and inappropriately served groups beyond the four identified by San Mateo County. By opting in to the County Behavioral Health Collaborative, San Mateo County has learned from counties taking the lead in incorporating emerging research into their pilots of innovative technology solutions. The Collaborative shared information with the County about the breadth and capabilities of technology options available. The County then conducted preliminary literature reviews to identify practices and approaches in the research on technology-based interventions. While platforms and interventions differ, and the specific options chosen will be informed by input gathered during the CPP, emerging research suggests that technology-based interventions have the potential to increase access to mental health services and support ongoing recovery for consumers not already engaged in services.

At this time, there appear to be no other public mental health systems using a collaborative model to roll out suites of innovative technology-based interventions to consumers, and as a result, there is no information about this delivery model in the literature. The lack of information presents an opportunity for the proposed pilots to add to the knowledge of utilizing technology-based practices in a public mental health system context. Additionally, the National Institute of Mental Health (NIMH) has identified several gaps in research that require additional investigation. Regarding whether these interventions are effective, NIMH points out that some recently-developed technology-based interventions are not yet supported by scientific evidence that they work or that they are as effective as traditional methods. There is also a lack of information about which apps work best for different populations based on their needs. Addressing HIPAA and other data security concerns are a high priority and best practices in this area are still being developed.

3). The Proposed Project

Describe the Innovative Project you are proposing. Note that the "project" might consist of a process, the development of a new or adapted intervention or approach, or the implementation and/or outcomes evaluation of a new or adapted intervention. See CCR, Title 9, Sect. 3910(d).

Include sufficient details so that a reader without prior knowledge of the model or approach you are proposing can understand the relationship between the primary problem you identified and the potential solution you seek to test. You may wish to identify how you plan to implement the project, the relevant participants/roles, what participants will typically experience, and any other key activities associated with development and implementation. Provide a brief narrative overview description of the proposed project.

a) *Identify which of the three approaches specified in CCR, Title 9, Sect. 3910(a) the project will implement (introduces a practice or approach that is new to the overall mental health system; makes a change to an existing practice in the field of mental health; or applies to the mental health system a promising community-driven practice approach that has been successful in non-mental health contexts or settings).*

b) *Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply to mental health a practice from outside of mental health, briefly describe how the practice has been applied previously.*

Project Purpose
The purpose of this project is to determine if a suite of technology-based mental health apps will 1) connect transition-age youth in crisis, older adults experiencing isolation, and the Spanish and Chinese monolingual communities to in-person services; 2) improve access to mental health services and supports; and 3) improve wellness and recovery outcomes for those who engage with the mobile apps.   The project aims to connect, increase access to and engagement with mental health services and supports for individuals who are struggling to connect with

traditional mental health supports (for a myriad of reasons) through increasingly familiar technology devices, like smart phones, tablets, and computers.

Project Description

San Mateo County and its collaborative county partners will utilize a suite of technology-based mental health services and solutions. Through active online engagement, this project will identify those in need of mental health services and offer innovative techniques and approaches to engagement in recovery and wellness activities. This project also serves to reduce the stigma associated with mental health treatment by using virtual engagement strategies. The County plans to adopt interventions within the three domains that are part of the collaborative technology suite depending on specific needs as identified by the four target groups.

- **Online Peer Chat and Support Groups:** Online Peer Chat and Support Groups utilize online chat capability designed to engage, educate, assess and intervene with individuals experiencing symptoms of mental illness. Though research on online peer chat and support has increased in recent years, many researchers concluded that there is an overall lack of evidence on the effectiveness of online peer chat on consumer outcomes in general and among different subpopulations. However, existing research suggests that people with serious mental illness who accessed online peer support experienced greater social connectedness and learned strategies for coping with daily challenges of living with mental health issues. Online peer support was also found to show promise as an intervention to assist consumers in gaining insight about their situation and developing a sense of empowerment and hope.

- **Virtual Therapy Using an Avatar:** This range of apps offers virtual manualized evidence-based interventions delivered via an avatar powered by artificial intelligence (AI), such as mindfulness exercises and cognitive behavioral or dialectical behavior interventions delivered in a simple, intuitive fashion. For apps within this category of interventions, research varies widely depending on how the intervention was designed and the mental health issues consumers were experiencing at the time of evaluation. For example, some virtual therapy models are specifically designed to support consumers with anxiety disorders. Interventions also vary along a spectrum of automation from providing therapy services where a clinician is represented as an avatar, to an avatar completely driven by AI with no human involvement. While some research suggests that avatar-based mental health interventions are promising, researchers view this as a nascent area of research and call for additional studies.[2]

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[2] Rehm, C. I., Foenander, E., Wallace, K., Abbott, J.-A. M., Kyrios, M., & Thomas, N. (2016). What Role Can Avatars Play in e-Mental Health Interventions? Exploring New Models of Client–Therapist Interaction. Psychiatry. https://doi.org/10.3389/fpsyt.2016.00186
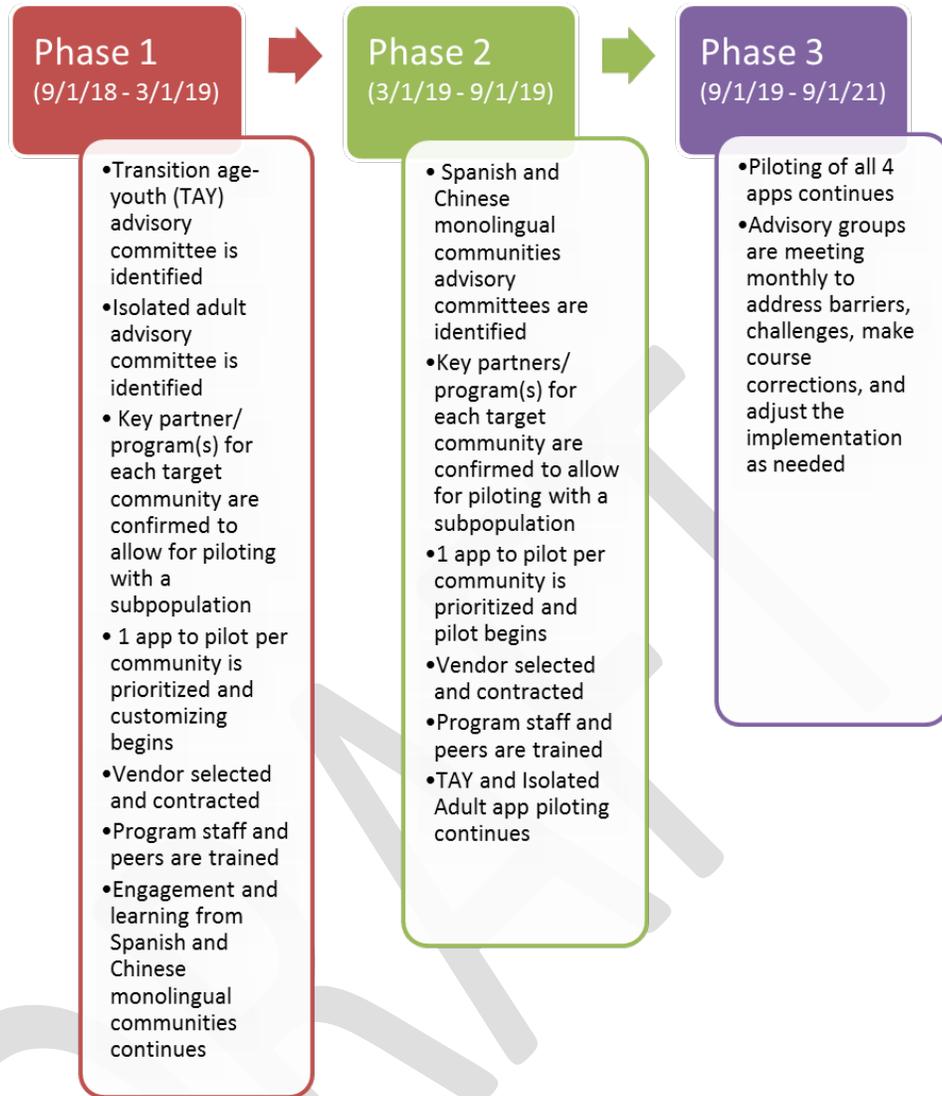
- **Digital Phenotyping:** The proposed plan includes an interactive approach to digital phenotyping where the technology is able to monitor cell phone usage (passive data) and interact with the user through a pop-up chat function to promote increased user understanding of thought and feeling states. Web-based analytics then inform targeted communications and recommend interventions. Digital phenotyping can detect subtle social or behavioral red flags consumers experience between outpatient appointments and evaluations, which may indicate early onset of serious symptoms. For example, decreased communication, motor activity, or changes in speech or sleep patterns may be a harbinger of relapse for some consumers. Preliminary research has found that using digital phenotyping in a mental health context shows promise as a method to identify symptoms early and prompt intervention before consumers escalate to crisis or psychiatric relapse, thus averting the disruption, cost, and potential tragedy associated with repeat crises.[3]

Project Implementation

San Mateo County will take a measured and client-centered approach to the implementation of these technological apps, as described below. Based on initial findings from the Innovation CPP Process, the following is a suggested phased approach to app development and customization based on readiness (key stakeholders engagement, current programs and infrastructure to support implementation) from each of the target communities.

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[3] Onnela, J.-P., & Rauch, S. (2016). Harnessing Smartphone-Based Digital Phenotyping to Enhance Behavioral and Mental Health. Neuropsychopharmacology, 1691–1696. https://doi:10.1038/npp.2016.7

Phase 1
(9/1/18 - 3/1/19)

- Transition age-youth (TAY) advisory committee is identified
- Isolated adult advisory committee is identified
- Key partner/ program(s) for each target community are confirmed to allow for piloting with a subpopulation
- 1 app to pilot per community is prioritized and customizing begins
- Vendor selected and contracted
- Program staff and peers are trained
- Engagement and learning from Spanish and Chinese monolingual communities continues

Phase 2
(3/1/19 - 9/1/19)

- Spanish and Chinese monolingual communities advisory committees are identified
- Key partners/ program(s) for each target community are confirmed to allow for piloting with a subpopulation
- 1 app to pilot per community is prioritized and pilot begins
- Vendor selected and contracted
- Program staff and peers are trained
- TAY and Isolated Adult app piloting continues

Phase 3
(9/1/19 - 9/1/21)

- Piloting of all 4 apps continues
- Advisory groups are meeting monthly to address barriers, challenges, make course corrections, and adjust the implementation as needed

1. <u>Conduct outreach and recruitment for Tech Suite Advisory Committees.</u> This project will convene an advisory committee per target community composed of mental health consumers, family members, community members, culturally specific providers, and mental health providers to help design and oversee the Tech Suite implementation rollout and evaluation. The County will work to identify key stakeholders within each community for recruitment, and reach out to these parties communicating a clear vision, purpose, and role for group members with explicit time commitment and expectations.

2. <u>Identify and customize most appropriate apps to respond to specific needs of San Mateo target communities.</u> Initial findings from the Innovation CPP process suggest that some apps may be better suited to support and address key issues with each community. For example, Youth expressed discomfort with "serious" mental health support and suggested that youth would be more open to trying apps they perceived as "low-key" and casual. Some youth were interested

in less intensive apps that are useful for one-time stress reduction (such as an app that provides prompt for breathing exercises to navigate through moments of panic or anxiety). Given this specific input, the Virtual Therapy app may be most appropriate. However, for transition age youth in crisis (target population), the app should be able to connect youth to local crisis line and other resources. Further considerations brought up during the CPP process is that the County will need to develop a crisis response plan and communicate it clearly to all using the apps so that youth will connect with crisis services when needed. Lessons learned from other counties involved in the Collaborative will also help customize Tech Suite apps specifically for a San Mateo County user audience.

3. <u>Create a strategic approach with Tech Suite Advisory Committee to access points to expose individuals to technology-based mental health solutions, including:</u>
   o Engaging the school systems, including colleges and universities, to promote use of services and supports
   o Partnering with those providing services and supports to at-risk Transition Aged Youth, including working with mental health providers, social workers, and foster-care advocates who frequently interface with young adults
   o Leveraging social media, public websites and other media to promote use of technology-based services
   o Working with mental health organizations (National Alliance for Mental Illness) and culturally-specific community health workers (Promotores), the LGBTQ Center, peer-based community learning centers, and local support groups to promote use of technology-based services
   o Collaborate with those providing services to older adults at risk for isolation, including working with senior apartment complexes, senior centers, and faith-based organizations who outreach to seniors
   o Work with local public locations, including agencies, libraries and other resources to promote technology-based use
   o For isolated people and those who are not engaged in services fully or at all, it will be important to conduct outreach in places they already go to and with people they already interact with such as faith based communities; salons/barber shops; grocery stores; Laundromats, libraries, hospitals/Clinics/Primary health care facilities; case workers; law enforcement and first responders, etc.

4. <u>Identify peer/family specialists to conduct training of BHRS staff and community partners</u>. This will provide an overview training to BHRS providers, contracted providers, peers specialists, and other key stakeholders on how to access the apps, HIPPA implications, and crisis roles and responsibilities. Trainings will be structured to provide a didactic overview of materials, discussion, and a space for demonstrations of the apps. Program staff and peers will be ready to support clients in use of apps and clinical integration as relevant.

5. <u>Early phase of evaluation plan is completed</u>. This will include the initial prep phase and developing of tracking processes to support daily monitoring of activities, challenges and identification of any needed course corrections.

6. <u>Information security is in place, implement technology-based mental health interventions designed to engage, educate, assess, and intervene with individuals experiencing symptoms of mental illness.</u> San Mateo will roll out the technology suite for transition age youth and isolated seniors first. Customized services will include:
    o   Virtual peer chatting with trained and certified peers with lived experience
    o   Virtual support communities for populations including those experiencing behavioral health-related symptoms and family members of those with mental illness
    o   Virtual chat options for parents of children and adults receiving behavioral health care
    o   Virtual interventions like mindfulness exercises and Dialectical Behavior Therapy (DBT)
    o   Referral process for those requiring additional in-person services or supports through the San Mateo Behavioral Health and Recovery Services System of Care.

7. <u>Data collection and analysis of outcome evaluation of all elements of the project, including:</u>
    o   Increased wellbeing of those utilizing services
    o   Reduced duration of untreated/undertreated mental illness
    o   Increased ability for users to identify cognitive, emotional and behavioral changes and actively address them
    o   Increased quality of life, measured objectively and subjectively by both the user and by indicators such as activity level, employment, school involvement, etc.

Qualifications for Innovative Project
In accordance with the three specified approaches in CCR, Title 9, Section 3910 (a), this project:
Introduces a new approach or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention.

Why is this Innovative?
This project will use technology-based services and supports to engage populations not previously engaged through outreach and education efforts. While private industry technology-based services have been used in public health institutions, technology-based services and supports to increase access and linkages have never been tested by multiple public mental health departments across several counties.

Why is this an appropriate approach for San Mateo?
San Mateo County plans to use technology as a means of reaching and engaging those with mental health issues, which may be particularly appropriate and helpful for unserved and underserved populations, which were previously unidentified through culturally-relevant platforms.

4). Innovative Component

Describe the key elements or approach(es) that will be new, changed, or adapted in your project (potentially including project development, implementation or evaluation). What are you doing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

a) *If you are adapting an existing mental health model or approach, describe how your approach adds to or modifies specific aspects of that existing approach and why you believe these to be important aspects to examine.*

b) *If you are applying an approach or practice from outside of mental health or that is entirely new, what key aspects of that approach or practice do you regard as innovative in mental health, and why?*

Through the utilization of technological apps, this project seeks to engage mental health consumers in mental health services, promote social connectivity with peers, and mitigate the barriers of stigma for culturally specific communicates by creating culturally responsive options to mental health services. This Tech Suite Innovation Project is a County priority, because the MHSA process identified that despite various approaches to outreach there are still underserved populations struggling to engage in services. These specific populations were identified as: (1) isolated older adults, (2) Transition Aged Youth in crisis, (3) Latino mental health consumers, and (4) Chinese mental health consumers. Mental health issues can be compounded by symptoms and experiences of isolation. Consumers who struggle to connect to in-person traditional services either because of mental health stigma, transportation barriers, or other difficulties still deserve venues to get help. Over the years, technology has advanced and can be customized to meet the needs of these isolated community members.

This project seeks to test out use of a set of technology tools to provide alternative mechanisms for support to individuals who may need mental health care and to reach these individuals for whom San Mateo has not been successful in identifying or engaging through methods that are relevant to these specific populations. This project will strengthen and expand the County's use of peer support and culturally responsive technology apps through a virtual service delivery that has never been used by BHRS before.

5). Learning Goals/Project Aims

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the spread of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the spread of effective practices.

a) *What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?*

b) *How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?*

The Tech Suite pilot is intended to provide an opportunity for the County to reach **three main learning goals**:

1. Does the availability and implementation of technology-based mental health apps connect transition age youth in crisis, older adults experiencing isolation, and the Spanish and Chinese monolingual communities to in-person services;

2. Does engaging with the apps promote access to mental health services and supports?

3. Does engaging with the apps effectively promote wellness and recovery?

The County prioritized these goals in order to respond to the needs identified through the various community planning initiatives it has conducted and to utilize MHSA Innovation funding to expand access to mental health services for unserved and underserved community members. Learning within the field of technology-based mental health interventions is developing as the technology emerges and people are beginning to use it and provide feedback. These learning goals guide the County in contributing to the knowledge in this nascent field of research and practice.

6). Evaluation or Learning Plan

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. What observable consequences do you expect to follow from your project's implementation? How do they relate to the project's objectives? What else could cause these observables to change, and how will you distinguish between the impact of your project and these potential alternative explanations?

The greater the number of specific learning goals you seek to assess, generally, the larger the number of measurements (e.g., your "sample size") required to be able to distinguish between alternative explanations for the pattern of outcomes you obtain.

In formulating your data collection and analysis plan, we suggest that you consider the following categories, where applicable:
   a) *Who are the target participants and/or data sources (e.g., who you plan to survey to or interview, from whom are you collecting data); How will they be recruited or acquired?*
   b) *What is the data to be collected? Describe specific measures, performance indicators, or type of qualitative data. This can include information or measures related to project*

implementation, process, outcomes, broader impact, and/or effective dissemination. Please provide examples.

c) *What is the method for collecting data (e.g. interviews with clinicians, focus groups with family members, ethnographic observation by two evaluators, surveys completed by clients, analysis of encounter or assessment data)?*

d) *How is the method administered (e.g., during an encounter, for an intervention group and a comparison group, for the same individuals pre and post intervention)?*

e) *What is the preliminary plan for how the data will be entered and analyzed?*

Target Population

The target participants include those who were identified as unserved or underserved during the FY 17-20 Mental MHSA Three-Year CPP and through a series of stakeholder meetings held in April and May of 2018: isolated older adults, transition-age youth in crisis, and residents who primarily speak Chinese or Spanish. The Tech Suite will be evaluated using a mixed methods approach to meet the learning goals.

Learning Goal 1: Does the availability and implementation of technology-based mental health apps connect transition age youth in crisis, older adults experiencing isolation, and the Spanish and Chinese monolingual communities to in-person services? The evaluation will use quantitative analysis to describe the extent and level of engagement with the apps among the target populations.

Learning Goal 2: Does engaging with the apps promote access to mental health services and supports? Qualitative data will be used to better understand what is effective at promoting engagement or what can be improved to improve engagement.

Learning Goal 3: Does engaging with the apps effectively promote wellness and recovery? Qualitative analysis will be used to provide context for quantitative findings and develop an understanding of consumers' experience and perspectives on using the apps and whether the apps supported their wellness and recovery. Quantitative data may be gathered through consumer surveys administered through the apps.

Data sources to support the evaluation will include:

- **Participant Survey:** The County will gather qualitative data through surveys on the apps that invite consumers to rate their wellness and recovery.
- **Focus Groups and Interviews:** The County will gather qualitative data through a process of interviews and focus groups with the target populations about their experience using the apps and their perspective on the extent to which they engaged in the apps and the apps supported their wellness and recovery.
- **App Usage Data:** Evaluation data will be gathered through the apps about who is engaging in services through the apps and their level of engagement to understand if the Tech Suite is effectively engaging the target participants.

The Tech Suite Advisory Committee will inform and oversee the evaluation process. The committee will be composed of stakeholders required by MHSA as well as representatives from the target population communities. The Advisory Committee will meet quarterly to have opportunities to review and engage with the data.

7). Contracting

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

BHRS Managers are assigned contract management responsibilities and meet with contractors on a monthly basis initially and as things rollout on a quarterly basis to discuss progress, challenges and support needed. The MHSA Manager with support from an MHSA planner oversee all MHSA program evaluation and work with evaluation contractors on a regular basis.

II. Additional Information for Regulatory Requirements

1). Certifications

Innovative Project proposals submitted for approval by the MHSOAC must include documented evidence of County Board of Supervisors review and approval as well as certain certifications. Additionally, we ask that you explain how you have obtained or waived the necessity for human subjects review, such as by your County Institutional Review Board.

a) *Adoption by County Board of Supervisors. Please present evidence to demonstrate that your County Board of Supervisors has approved the proposed project. Evidence may include explicit approval as a stand-alone proposal or as part of a Three-Year Plan or Annual Update; or inclusion of funding authority in your departmental budget. If your project has not been reviewed in one of these ways by your Board of Supervisors, please explain how and when you expect to obtain approval prior to your intended start date.*

b) *Certification by the County mental health director that the County has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act (MHSA). Welfare and Institutions Code (WIC) 5847(b)(8) specifies that each Three-Year Plan and Annual Update must include "Certification by the county behavioral health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements."*

c) *Certification by the County mental health director and by the County auditor-controller if necessary that the County has complied with any fiscal accountability requirements, and that all expenditures are consistent with the requirements of the MHSA. WIC 5847(b)(9) specifies that each Three-Year Plan and Annual Update must include "Certification by the county behavioral health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and*

*that all expenditures are consistent with the requirements of the Mental Health Services Act."
Of particular concern to the Commission is evidence that the County has satisfied any fiscal
accountability reporting requirements to DHCS and the MHSOAC, such as submission of required
Annual Revenue and Expenditure Reports or an explanation as to when any outstanding ARERs
will be completed and filed.*

d) **Documentation that the source of INN funds is 5% of the County's PEI allocation and 5% of the
CSS allocation.**

To be updated after Board of Supervisors approval

2). Community Program Planning

*Please describe the County's Community Program Planning process for the Innovative Project,
encompassing 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.*

During San Mateo's FY 17-20 MHSA Three Year Planning Process, the Department gathered input at
existing County meetings and targeted input sessions, through online surveys, and through formal
public comment. In the spring of 2017, San Mateo hosted two public meetings, a CPP Launch
Session and a CCP Prioritization Session. Over 270 participants were in attendance, and 156
demographic sheets were collected; 37% identified as clients/consumers and family members.
Participants represented groups set forth in the MHSA legislation, including homeless individuals,
law enforcement, mental health consumers and family members, mental health providers, health
and social service providers, and individuals with disabilities. The racial and ethnic diversity of the
community was reflected in the planning process, see Appendix 1.

From these community engagement activities, San Mateo County learned about the specific
populations being un/underserved as (1) isolated older adults, (2) transition aged youth in crisis
(TAY), Latino mental health consumers, and Chinese mental health consumers.

In April and May of 2018, San Mateo began a Community Planning Process that included 14
community meetings aimed to (1) inform community members about proposed the Technology
Suite INN plan and (2) seek input and feedback from stakeholders to incorporate into the final plan.
Stakeholders received background information about the Innovation Projects and the Mental Health
Services Act to ensure their ability to meaningfully participate. See Appendix 2 for all materials
developed for stakeholder engagement. The stakeholder groups included were:

AB 114 Innovation Plan Community Forum Schedule

Session	Date	Time	Location
Coastside CSA	17-Apr	8:30am	225 S Cabrillo Hwy. Halfmoon Bay, 1st Floor Conference Room
Peer Recovery Collaborative	17-Apr	12:00pm	210 Industrial Road San Carlos, Suite 102
Northwest/Northeast CSA	17-Apr	3:30pm	725 Price St Daly City
Youth Commission	26-Apr	6:30pm	Closed session
Family Partners & Peer Workers	30-Apr	2:00pm	Closed session
Monolingual Spanish	1-May	6:00pm	802 Brewster Ave Redwood City
Older Adults	2-May	10:00am	2000 Alameda de las Pulgas, San Mateo, Room 208
MHSARC – Public Comment	2-May	3:00pm	225 37th Ave. San Mateo, Room 100
South County	3-May	10:00am	Friendship Center, 802 Brewster Ave, Redwood City
Central CSA	3-May	3:30pm	2000 Alameda de Las Pulgas, San Mateo, Room 201
Diversity and Equity Council	4-May	11:00am	609 Price Ave. Redwood City, Room 107
BHRS Management	8-May	9:00am	Closed session
Monolingual Chinese	8-May	11:00am	2000 Alameda de las Pulgas, San Mateo, Room 208
East Palo Alto CSA	10-May	1:00pm	2415 University Ave , East Palo Alto, Community Room

Feedback from the initial five stakeholder meetings included the following. Stakeholders expressed an interest in utilizing technology to help these isolated communities, and made suggestions broken down in the following categories.

Outreach and Engagement
- Tailor outreach and educational materials about the apps to specific target populations.
- Develop materials that can be advertised on bus stops, television, tabling events, and sent out in mailers.
- Incentivize/ leverage partnerships with monolingual communities, community colleges, schools, peer mentors, case managers, hospitals, Institute on Aging, primary care health providers, and other key stakeholders that can support outreach.
- Include representatives from these diverse target populations in outreach and engagement planning and application implementation.
- Ensure outreach and educational materials are accessible and available in the County's threshold languages

Access and Inclusion for Underserved Populations
- Services should be available in all threshold languages.
- Provide training for consumers who are less tech savvy.

- Consider ensuring boundaries of youth and young adult's utilization of technology [when in-person supports are needed].
- Learn from other counties in the collaborative how to reach older adults who may be difficult to reach.
- Consider providing a stipend to give consumers without a smartphone or computer device they can use to access the app services, or internet for those who are not currently connected.
- Consider utilizing current peers specialists for virtual services delivery.
- Leveraged technology to help bring people out of isolation, such as connecting consumers with helpful resources like WRAP and personalized outreach.
- Coordinate with mental health open houses to help people become familiar with the in-person options the community has to offer.
- Provide transit to isolated individuals to support them becoming involved in mental health resources beyond the apps.
- Allow apps to be available to anyone in San Mateo (regardless of enrollment in traditional services).

Crisis
- Develop protocols for how to support mental health consumers if application detects strong language that may indicate a crisis or venting.
- Consider mechanisms to trigger law enforcement or 911 dispatcher when necessary, and determine decision-making authority and conditions that should trigger a phone call.

Evaluation
- Consider doing an initial pilot with smaller groups.
- Develop a questionnaire to measure success within the application.

Using the Apps
- Provide choices and options for consumers to be able to change peer listeners to find someone they feel the most comfortable speaking with.
- Develop the Personal Wellness Avatar application to learn information and adapt to the individual's needs, and refine the interventions it offers to consumer son an ongoing basis.

San Mateo County continued to gather feedback about the implementation of the Tech Suite apps and integrate the feedback from community into overall approaches to the plan. See Appendix 3 for a summary of notes. The key adjustments made to the plan based on the final feedback where:
1. A phased approach to implementation and piloting one app with a small subpopulation, given that there are four target communities;
2. Adjusted the target population based on this smaller pilot
3. Added a learning goal related to connecting individuals to in-person services, stakeholders felt strongly that the apps are not to replace human interaction and commented their concern that technology can potentially further isolate individuals.

3). 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 (The Service Need).

a)   Increase access to mental health services to underserved groups

The primary purpose of this project is to i***ncrease access to mental health services for the four specified underserved populations***, (1) isolated older adults, (2) transition aged youth (TAY) in crisis, (3) Latino mental health consumers, and (4) Chinese mental health consumers.

4). MHSA Innovative Project Category

Which MHSA Innovation definition best applies to your new INN Project (select one):
a)   Introduces a new mental health practice or approach.

The MHSA innovation best applicable to this project is the ***introduction of a new mental health practice or approach***.

5). Population

a)   If your project includes direct services to mental health consumers, family members, or individuals at risk of serious mental illness/serious emotional disturbance, please estimate number of individuals expected to be served annually. How are you estimating this number?

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. In some circumstances, demographic information for individuals served is a reporting requirement for the Annual Innovative Project Report and Final Innovative Project Report.

c)   Does the project plan to serve a focal population, e.g., providing specialized services for a target group, or having eligibility criteria that must be met? If so, please explain

The specific target groups for San Mateo County Innovation Project are:

- Isolated older adults
- Youth in crisis, and
- Residents who primarily speak Chinese or Spanish.

Total number of individuals served

For the past three years, San Mateo County MHSA Outreach Collaboratives meaningfully engage an average of 3% of their respective geographic areas, 1% are referred to mental health or substance use services, often through a warm hand-off. The Outreach Collaboratives employ a promotores/health navigator model of outreach and we would expect to utilize the same outreach model for these special populations and thus expect the same reach for a county-wide approach. We will determine appropriate numbers of individuals to be served once the key program partner is identified for the smaller pilot. In the meantime, population wide estimates are provided below. These will represent the potential reach of full-fledged programming.

- Age-specific populations – in the general population there are 208,000 older adults 55+ in San Mateo County; 1% of this is 2,080. 55-69 year olds account for the majority of adults that receive specialty mental health services. In San Mateo County FY 15-16, there were 29,614 adults age 45-64 and 19,161 adults 65+ eligible for specialty mental health services. 1% of the older adult eligible population is 488. For transition aged youth (15-24) population is 82,700; 1% of this is 827. In San Mateo County FY 15-16, there were 944 youth age 12-17 and 378 youth age 18-20 eligible for specialty mental health services. 1% of this is 13.

- Cultural-specific populations - 1% of the County's Latino population of 66,600 is 700 individuals. It is possible that 2% of the population is receiving mental health services, and ½ of those community members are likely not getting the mental health supports that they need. Similarly, for the Chinese community 1% of the County's Chinese population of 25,000, which is 250 individuals. It is possible that 2% of the population is receiving mental health services, and ½ of those community members are likely not getting the mental health supports that they need.

- Medi-Cal enrollees - BHRS served 5% (5,826) of the average unduplicated Medi-Cal enrollees. This Innovation project intends to serve 1,165 target for beneficiaries in the system through staff and/or peer introductions.

6). MHSA General Standards

Using specific examples, briefly describe how your INN 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 INN Project, please explain why.
a) *Community Collaboration*
b) *Cultural Competency*
c) *Client-Driven*
d) *Family-Driven*
e) *Wellness, Recovery, and Resilience-Focused*
f) *Integrated Service Experience for Clients and Families*

This San Mateo Innovation Plan is informed and reflective of the MHSA legislation key components listed above.

- **Community Collaboration:** The need for new approaches to services was derived from a collaborative community stakeholder process, and this project will seek to work with community members through the Tech Suite Advisory Committee to ensure San Mateo stakeholders will continue to inform the implementation of this Innovation Plan.

- **Cultural Competency:** Technology supports will have the capability to engage and address underserved communities who need a more culturally responsive approach.

Additionally, San Mateo will involve diverse stakeholders in the development of these apps to ensure they are culturally competent.

- **Client/Family Driven:** The proposed apps are self-directed and customized by the consumers and family members, which ensures their ability to be client and family driven.
- **Wellness, Recovery, and Resilience-Focused:** Through virtual peer chat and online communities, users can access individuals with lived experiences that are modeling recovery. Additionally, these apps include recovery-orientation platforms that remind consumers of self-care practices, and specific skills like mindfulness exercises.
- **Integrated Service Experience for Clients and Families:** One possibility for these apps is the ability to connect consumers and family members to service providers, which would support an integration of mental health services.

7). Continuity of Care for Individuals with Serious Mental Illness

Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals when the project ends.

Individuals experiencing serious mental health issues will receive services from this proposed project. The Technology Application Suite is intended to support self-directed recovery efforts, but not interrupt the continuity of care already provided by the County.

8). Innovation Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement

a) *Explain how you plan to ensure that the Project evaluation is culturally competent.*
b) *Explain how you plan to ensure meaningful stakeholder participation in the evaluation.*

San Mateo County will utilize two mechanisms to ensure the project evaluation is culturally competent and employs meaningful stakeholder participation. First, the County will convene an Evaluation Steering Committee that will inform and oversee the evaluation process. The committee will be composed of stakeholders required by MHSA as well as representatives from the target population communities. The Steering Committee will meet quarterly to have opportunities to vet the data and evaluation methods. Secondly, in alignment with MHSA guidelines, the County will ensure that the Steering Committee members reflect the County's cultural diversity. With diverse cultural representation and an ongoing, proactive approach to sharing information and gathering feedback from the Steering Committee, the project evaluation process will be culturally competent. The Steering Committee will also reflect the diversity of stakeholder perspectives, including consumer, County, and CBO providers. Additionally, the Steering Committee's involvement during the evaluation process will provide opportunities for stakeholders to meaningfully engage in the evaluation by providing feedback and direction regarding the evaluation methods and findings, and sharing information from their respective communities with the evaluators.

9). 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 INN 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?

> Data analytics and evaluation coupled with local qualitative data, will inform sustainability at the conclusion of this project. Factors that will be taken into consideration include user satisfaction, outcomes, and overall effectiveness of the suite of apps. If deemed successful, if funding allows and if stakeholders (through the MHSA Three-Year Community Program Planning process) prioritize the continued funding of this program, continuation of the project or its components may be funded by MHSA.

10). Communication and Dissemination Plan

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

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

KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

> As this project is a multi-county collaboration, we are partnering with CalMHSA to conduct an evaluation about successful practices and lessons learned. Those results will be disseminated for all counties (e.g. list serves) and throughout the stakeholders (standing meetings) providing oversight for this project. Program participants may choose to opt in to provide feedback through surveys, which will be included in the communication regarding results. **Keywords:** Some possible keywords or phrases that could be used to help find this project are: *therapy apps, online peer support, and mindfulness exercises, and wellness activities.*

11). Timeline

> a) *Specify the total timeframe (duration) of the INN Project: <u>3</u>Years <u>0</u> Months*
> b) *Specify the expected start date and end date of your INN Project: <u>September 2019</u> Start Date <u>June 2021</u> 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*
>> i. *Development and refinement of the new or changed approach;*
>> ii. *Evaluation of the INN Project;*
>> iii. *Decision-making, including meaningful involvement of stakeholders;*
>> iv. *Communication of results and lessons learned.*

Phase I: Application Development	Phase II: Community Outreach & Education	Phase III: Implementation and Evaluation
Finalize participation agreement – Sep 2018	Request for Proposals to select and award contracts for outreach and marketing– Sept 2018	Peer specialist to train BHRS providers – Nov 2018
Launch first cohort of Advisory Committees to discuss expectations, timeline, etc. - Sep 2018	Training of Peer specialists, outreach workers – Oct 2018	Health Navigators are at strategic entry points in the community to support individuals with the app – Nov 2018
Launch meeting with subject matter experts and vendors to discuss adaptations, support needed – Sep 2018	Launch meeting with marketing vendor to discuss scope of work – Oct 2018	Develop qualitative data collection plan to supplement statewide evaluation indicators– Jan 2019
Identify indicators and evaluation plan – Sep 2018	Approve and refine marketing plan – Nov 2018	
	Begin second cohort of Advisory Committees	
Milestones: Apps ready for Launch	**Milestones: Community Awareness of Apps**	**Milestones: Mental Health Consumer and Families utilizing Apps and Data are being collected**

12). Budget Narrative

Total funding amount: $ 3,872,167

By joining the County Behavioral Health Technology Innovation Collaborative, San Mateo County is agreeing to contribute to a statewide pool of INN funds. CalMHSA, a Joint Powers of Authority, will serve as a fiscal intermediary and in a project management role to facilitate contracting with technology vendors, support a shared evaluation, and maximize planning outreach and marketing. The budget is divided into four main components:

Core Technology	Future Technology	Local Programming	Statewide Marketing & Evaluation
$992,578*	**$1,465,591***	**$1,046,500**	**$367,498**

*subject to change pending final negotiations with vendors

Core Technology development includes technology vendor fees (start-up, development, licensure, etc.), subject-matter experts and overhead. This will fund the development of all three generic apps 24/7 peer chat; wellness avatar and use of smartphone passive data.

Future Technology development will be reserved for customization and additions to the generic apps. Subject matter expert(s) will work with the vendors to assure apps are effectively maintained as well as advanced per County needs and goals.

Local Programming category allows us to keep funding locally (outside of what we contribute to CalMHSA) to implement the strategies needed to support culturally responsive implementation and can include training of staff and peer workers, contracting with peer/family support agencies and agencies/groups serving monolingual Spanish and Chinese communities and local outreach and marketing efforts and materials.

Local Fund budget breakdown

Local Funds Items/Personnel	Cost	Total Amount	Budget Justification
Peer and Family partner specialists	150,000/year x 2 years	$300,000	Contract(s) to support peer end-users, face-to-face support services to users, outreach and training of BHRS staff and network providers.
Spanish and Chinese community specialists	$100,000/year x 2 years	$200,000	Contract(s) to support peer end-users, face-to-face support services to users and outreach.
Older Adult peer and family partners	$100,000/year x 2 years	$200,000	Contract(s) to support peer end-users, face-to-face support services to users and outreach.
Youth peer workers	$100,000/year x 2 years	$200,000	Contract(s) to support peer end-users, face-to-face support services to users and outreach.
Local Communications and Marketing	$5,000 / year x 2 years	$10,000	Social media boosts ($500), printing ($500), SamTrans/CalTrain Adcards ($3000), Daily Journal/EPA Times ($400), incentives ($600) / year
Planning and administration	15% of operating x 2 years	$136,500	Coordination of staff training, planning, approval and request for proposals processes, market and development, final reports
	TOTAL	**$1,046,500**	

Statewide Marketing & Evaluation is statewide promotion at strategic access points and marketing within school systems, social media, public locations, etc. Data collection, analysis and performance monitoring will also be managed by CalMHSA.

SAN MATEO COUNTY TECH SUITE BUDGET

Tech Suite Budget:	2,825,667	Relative Size Unit:	3.34	% of Experts:	5.00%		Total INN Budget:	3,872,167

Total Expenses for Desired Duration of Innovation Project (per annual budget below)

	Overhead	Experts	Vendor #1 (7 Cups)	Vendor #2 (Mindstrong)	Vendor #3 (CBT/EBP)	Future Apps	Evaluator	Otrch & Mktg	Local Funds
Start-Up			$100,227	$83,522	$33,409	$116,931	$116,931	$33,409	
Development			100,227	100,227	33,409	100,227	0	50,113	
Licensure			100,227	100,227	66,818	167,045	100,227	66,818	
Other	141,283	133,000				1,081,388			1,046,500
Total	$141,283	$133,000	$300,681	$283,976	$133,636	$1,465,591	$217,158	$150,340	$1,046,500

$2,825,667 Total Budgeted Amount per new fee schedule (no local funds)

Expenses	FY17/18	FY18/19	FY19/20	FY20/21	FY21/22	FY22/23	Innovation Total	% of Total
CalMHSA Overhead (5%)		$ 141,283	$ -	$ -			$ 141,283	5.0%
Experts		$ 46,000	$ 46,000	$ 41,000			$ 133,000	4.7%
Vendor #1								
Start-Up Fee		$ 100,227	$ -	$ -			$ 100,227	
Development Fund		100,227	-	-			100,227	
Licensure Fees (75% in 18/19, 25% in 19/20)			50,113	50,113			100,227	
Vendor #1 Subtotal		$ 200,454	$ 50,113	$ 50,113			$ 300,681	10.6%
Vendor #2								
Start-Up Fee		$ 83,522	$ -	$ -			$ 83,522	
Development Fund		100,227	-	-			100,227	
Licensure Fees			50,113	50,113			100,227	
Vendor #2 Subtotal		$ 183,749	$ 50,113	$ 50,113			$ 283,976	10.0%
Vendor #3								
Start-Up Fee		$ 33,409	$ -	$ -			$ 33,409	
Development Fund		33,409	-	-			33,409	
Licensure Fees			33,409	33,409			66,818	
Vendor #3 Subtotal		$ 66,818	$ 33,409	$ 33,409			$ 133,636	4.7%
Future Apps/Vendors								
Start-Up Fee		$ 116,931	$ -	$ -			$ 116,931	
Development Fund		100,227	-	-			100,227	
Licensure Fees			83,522	83,522			167,045	
Local Customization		360,463	360,463	360,463			1,081,388	
Vendor #4 Subtotal		$ 577,621	$ 443,985	$ 443,985			$ 1,465,591	51.9%
Vendor #5: (Evaluator)								
Start-Up Fee		$ 116,931	$ -	$ -			$ 116,931	
Development Fund		-	-	-			-	
Licensure Fees (75% in 18/19, 25% in 19/20)			50,113	50,113			100,227	
Vendor #5 Subtotal		$ 116,931	$ 50,113	$ 50,113			$ 217,158	7.7%
Vendor #6: (Outreach & Marketing)								
Start-Up Fee		$ 33,409	$ -	$ -			$ 33,409	
Development Fund		50,113	-	-			50,113	
Licensure Fees			33,409	33,409			66,818	
Vendor #6 Subtotal		$ 83,522	$ 33,409	$ 33,409			$ 150,340	5.3%
Subtotals								
Start-Up Fee		$ 484,430	$ -	$ -	$ -	$ -	$ 484,430	17.1%
Development Fund		384,203	-	-	-	-	384,203	13.6%
Licensure Fees		-	300,681	300,681	-	-	601,362	21.3%
Local Customization		360,463	360,463	360,463	-	-	1,081,388	38.3%
Vendor Subtotals		$ 1,229,096	$ 661,144	$ 661,144	$ -	$ -	$ 2,551,383	90.3%
TOTAL EXPENSES		$ 1,416,380	$ 707,144	$ 702,144	$ -	$ -	$ 2,825,667	100.0%

Appendix 1

Community Program Planning (CPP) Process

San Mateo County is committed to engaging a diverse group of stakeholders using a Community Program Planning (CPP) process to ensure that communities that are experiencing mental health and substance abuse issues are heard in each phase of the process. Input is gathered at existing County meetings, targeted input sessions, online surveys, and through formal public comment. During the FY 17-20 Three Year Planning Process, San Mateo County hosted two public meetings, the CPP Launch Session on March 13, 2017 and the CPP Prioritization Session on April 26, 2017. Over 270 participants were in attendance, 156 demographic sheets were collected and of these 37% identified as clients/consumers and family members. 36 stipends were provided to consumers/clients and family members for their input.

Participant Demographics

Participant Demographics help us understand how far our CPP efforts reach when engaging San Mateo County's diverse communities.

CPP Participant Demographic Sheets Collected			
156			
Male	59	**Female**	97
Age		**Age**	
16-25	3	**16-25**	3
26-59	36	**26-59**	63
60+	20	**60+**	31
Veteran Status			
3		3	

Race   **Ethnicity**

Race legend:
- American Indian/Alaska Native
- Asian
- African-American / Black
- Caucasian / White
- Native Hawaiian
- Other Pacific Islander
- Decline to state
- Other

Ethnicity legend:
- Central American
- Mexican
- South American
- Carribean
- African
- Eastern European
- Middle Eastern
- European
- Chinese
- Filipino
- Asian Indian/South Asian
- Japanese
- Korean
- Other
- Decline to state

Sexual Orientation

- 3%
- 6%
- 3%
- 13%
- 75%
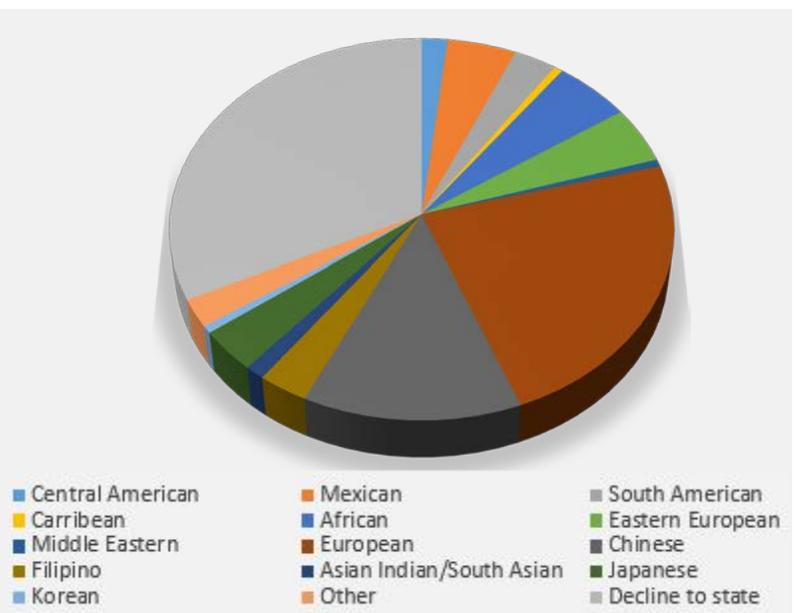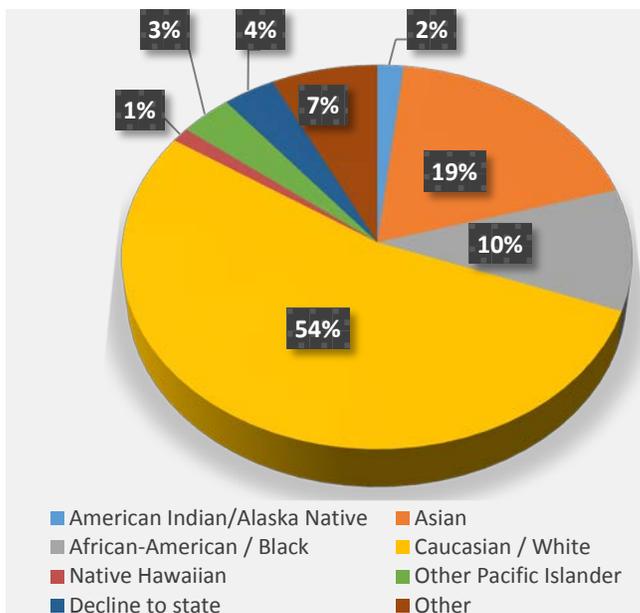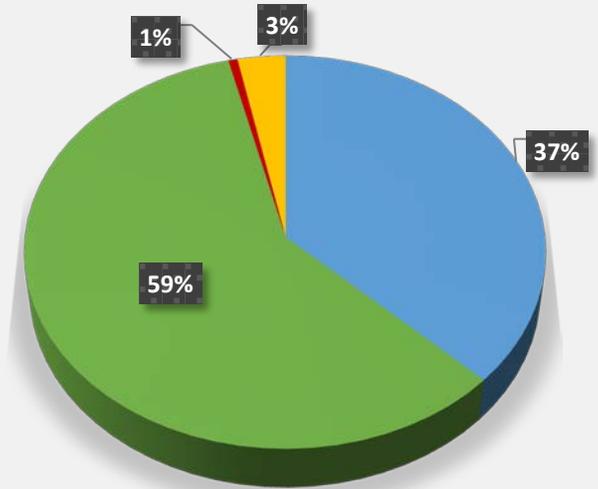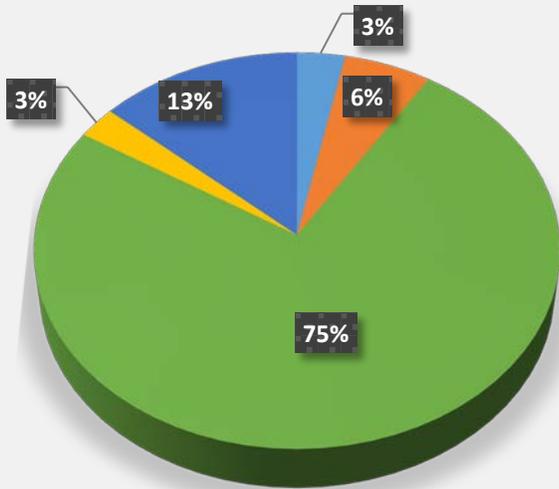
Legend: Bisexual | Gay/Lesbian | Heterosexual | Queer | Decline to state

Gender Identity

- 1%
- 3%
- 37%
- 59%

Legend: Male | Female | Transgender | Decline to state

Represented Groups

- 2%
- 1%
- 8%
- 14%
- 18%
- 13%
- 15%
- 10%
- 19%

Legend:
- Homeless
- Law Enforcement
- Behavioral Health Consumer/Client
- Family Member of a Consumer/Client
- Provider of Behavioral Health Services
- Provider of Health and Social Services
- Decline to state
- Disability
- Other

Represented Service Areas*

- 9%
- 7%
- 42%
- 8%
- 22%
- 4%
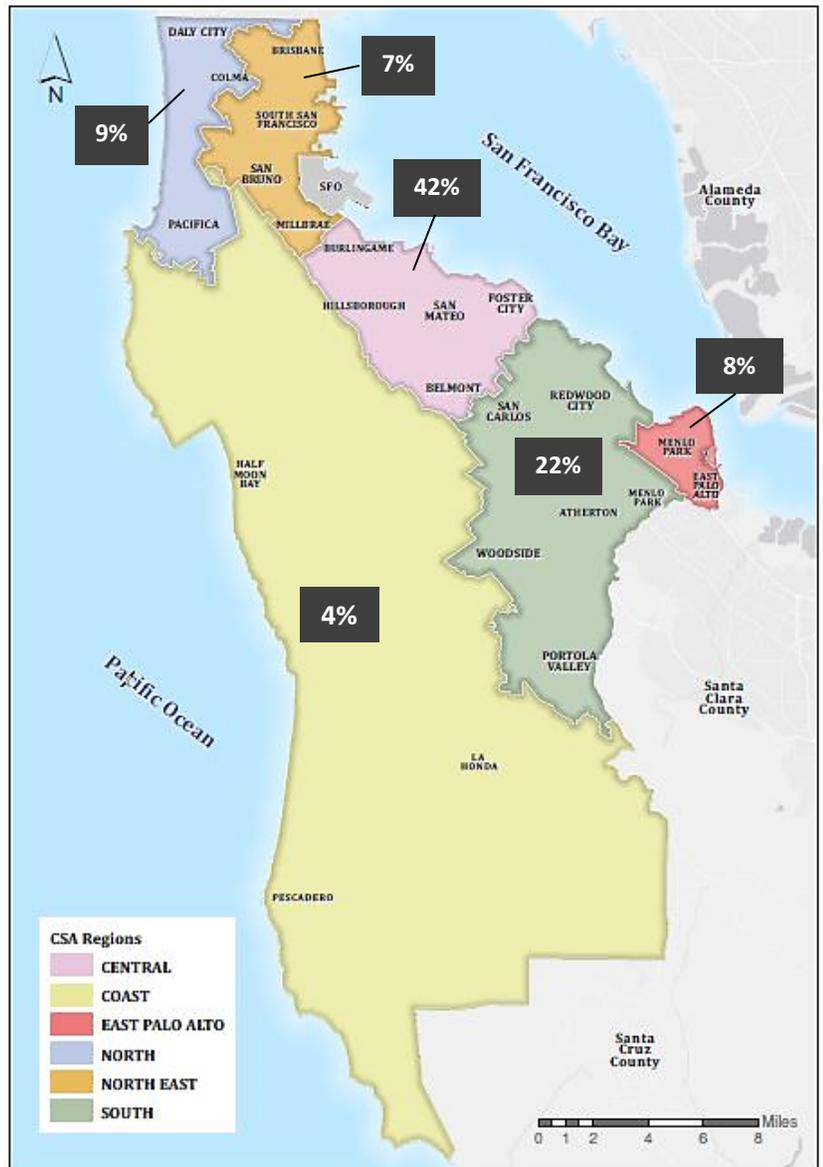
CSA Regions
- CENTRAL
- COAST
- EAST PALO ALTO
- NORTH
- NORTH EAST
- SOUTH

*There are institutional barriers to accessing and attending centrally located public meetings (trust, transportation, cultural and language, etc.). In an effort to account for this, two additional Community Prioritization Sessions were conducted in East Palo Alto and the Coastside. In the future, we will add a community session in north county as well.

MHSA Info Sheet   Updated 3/2017

Appendix 2

SAN MATEO COUNTY INNOVATION PLAN TECH SUITE

INN Plan Development

April - May 2018

Agenda

Introduction

Background

Overview of the Tech Suite

Community Input

Next Steps
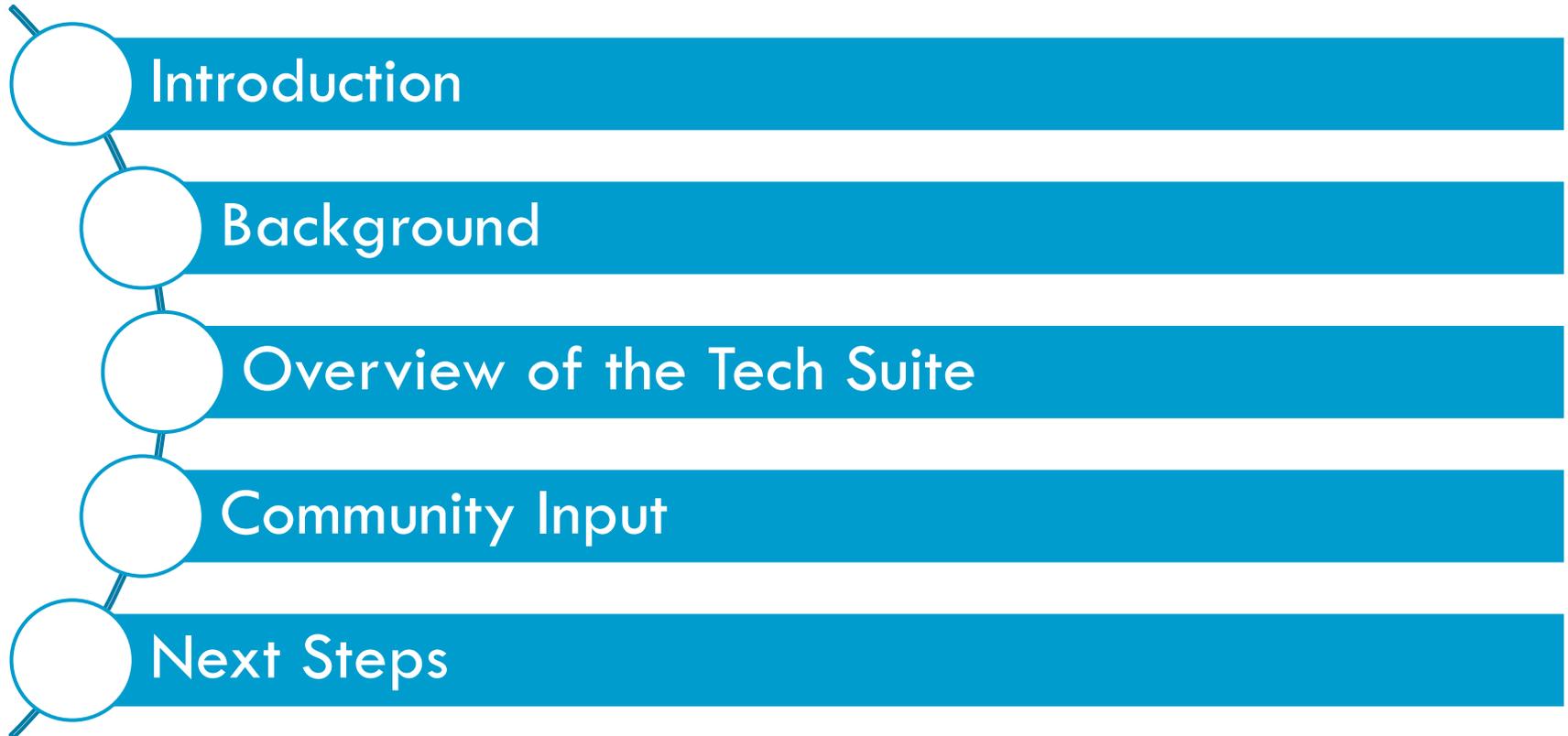
Introduction

About RDA: RDA is working with San Mateo County to develop its Tech Suite Innovation Plan.

Check-in: Please share your name and stakeholder affiliation.

Goals

Share information about the Tech Suite
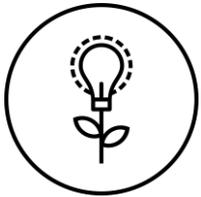
Respond to questions and concerns

Gather feedback about how to refine the plan to meet San Mateo County's unique needs

Discuss implementation considerations to refine how the plan is rolled out

RDA

MHSA Innovation Overview

The Mental Health Services Act (MHSA) sets aside funding for counties to promote innovative projects to meet mental health needs in new ways. Innovation projects…

❑ Have never been done before or are modified to happen in a new setting

Need identified	Community program planning	INN plan posted for 30 days	Public Hearing	Board of Supervisors Approval	MHSOAC Approval

Current Status

Need Identified

San Mateo County's 2014 MHSA Plan identified need for tech innovations for youth in crisis and isolated adults and older adults

Opportunity

Los Angeles and Kern Counties formed the *County Behavioral Health Technology Collaborative* to bring technology-based solutions to behavioral health

San Mateo County Opts In

San Mateo County opted-in to the Collaborative

Community Input (Today!)

San Mateo solicits community input to help shape the technology suite

County Behavioral Health Technology Collaborative: Multi-county collaborative with several pre-qualified vendors ready to provide a variety of apps for mental health support.

Tech Suite Description

The Tech Suite is a collection of innovative apps from different vendors that support wellness and recovery.

The apps are designed to:

❑ Engage people who are disconnected from services

❑ Remind clients to engage in wellness and recovery

❑ Increase socialization through online platforms

❑ Support ongoing mental health recovery

Tech Suite Benefits

Large scale impact

Support ongoing recovery

Provide expanded and increased access

Tech Suite

Connect people to mental health services

Alleviate fear and stigma around access

Detect and prevent serious mental illness
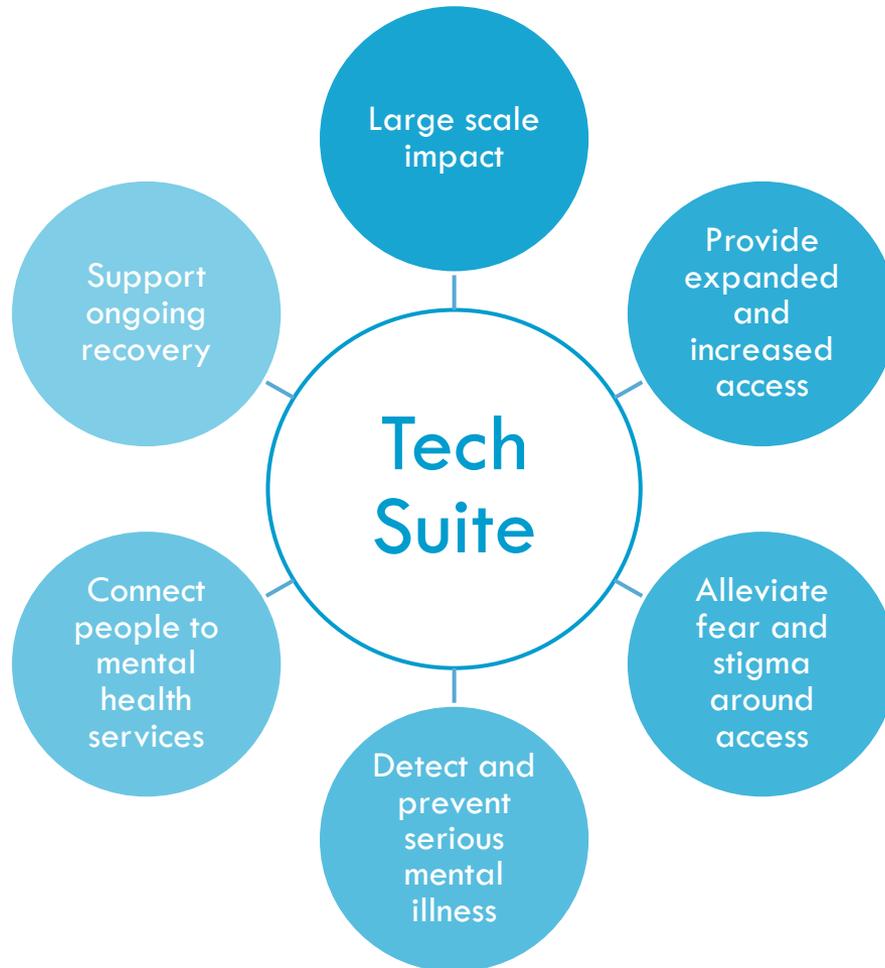
- ❑ Utilizes commonly used devices like smartphones to expand access to services

- ❑ Makes it easy for youth to connect mental health services

- ❑ Promotes connection for isolated adults and older adults

- ❑ Increases language accessibility (Apps can be modified to provide services in clients' preferred language)

RDA

Overview of Tech Suite Components

Tech Suite Interventions

Outreach
to connect
people to
tech suite
services

24/7 Peer Chat and Online Support Apps
• Chat with trained peer mentor or peer groups

Personalized Wellness Avatar
• Scripted mindfulness exercises and behavioral therapy interventions

Wellness Apps
• Analyzes cell phone data and recommends interventions
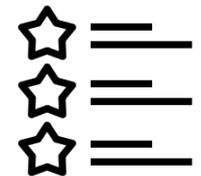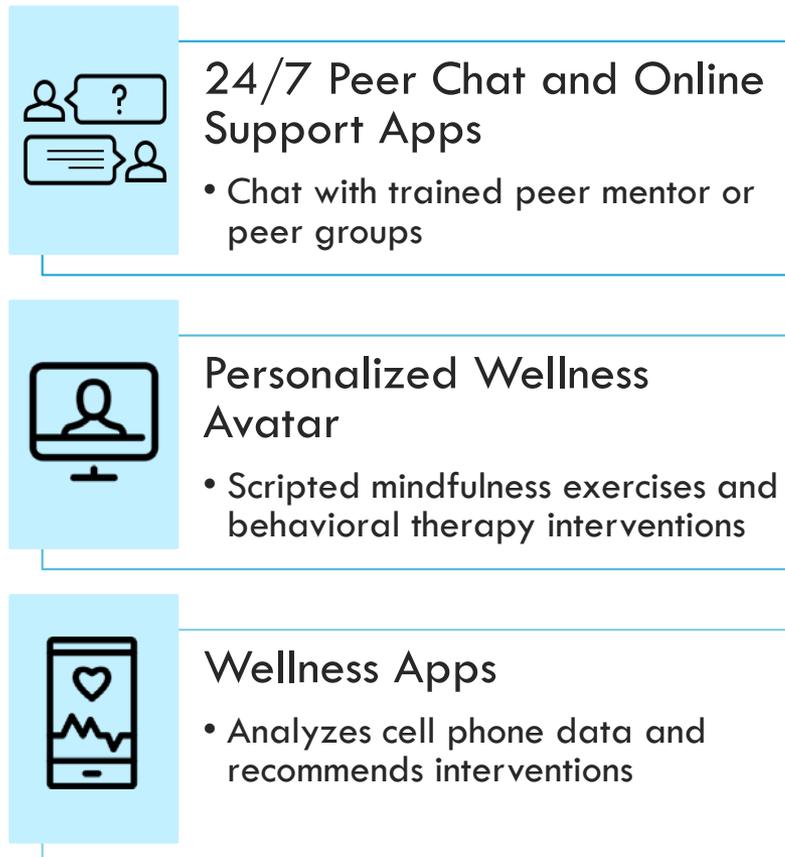
Evaluation
to determine
effectiveness
and adjust
services

24/7 Peer Chat and Online Support

Clients or their loved ones can chat with support groups or peers with lived experience, online or via text

How do they work?

- Anyone can join an online chat group with trained peer listeners on topics such as depression or anxiety
- Individuals can chat one-on-one with a peer with similar lived experience
- Family members of people with mental health issues can engage in support groups online

Who can these apps benefit?

- Youth and clients comfortable with text and chat
- Isolated individuals
- Individuals who prefer anonymity or have fear/stigma around seeking support
- Clients with limited access to in-person support groups/peer support

Personalized/Wellness Avatar

Clients can sign up to receive reminders to engage in wellness activities such as mindfulness exercises

How do they work?

❑ Clients can sign up to receive regular notifications about wellness activities to support their recovery and wellbeing

❑ Clients can interact with an online avatar that recommends wellness activities based on how their interact with the app

Who can these apps benefit?

❑ Youth and clients comfortable with communicating by text

❑ Isolated individuals

❑ Individuals who prefer anonymity or have fear/stigma around mental health

❑ Clients with limited access to in-person support groups/peer support

Wellness Apps

Clients can give permission to use their cell phone data to identify changes in behavior that might identify the need for additional support

How do they work?

- Clients can opt in to allow the app to identify patterns in their text behavior that may indicate changes in mental health

- The app interacts clients with via text or chat to increase their understanding of their thoughts and feeling states

Who can these apps benefit?

- Individuals who prefer to interact with virtual technology

- Isolated individuals

- Individuals who need ongoing recovery support

Community Input

What questions do you have about the Tech Suite components or planning process?

What would you want the County to consider before implementing these innovative interventions?

What are the needs that these apps can help meet? What components do you think would be most helpful to you/your community/ the community you serve?
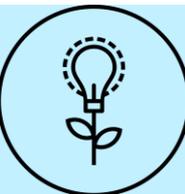
What do you want to learn from the pilot process?

Next Steps

April/May • Gather community feedback and input

May • Post plan for 30-day public comment period

June • Mental Health Board public hearing

June • Board of Supervisors for approval

July • Submit to MHSOAC for approval

Thank you!

For further information, please contact:

Kelechi Ubozoh, Senior Associate
kubozoh@resourcedevelopment.net

Descripción del paquete tecnológico de innovación

Los Servicios de Salud del Comportamiento y Recuperación del Condado de San Mateo (San Mateo County Behavioral Health and Recovery Services, BHRS) están probando un proyecto piloto de innovación de la Ley de Servicios de Salud Mental (Mental Health Service Act, MHSA) que reúne intervenciones basadas en la tecnología diseñadas para ayudar a la salud mental y el bienestar con el uso de dispositivos como los teléfonos inteligentes. Las aplicaciones varían según el proveedor y se dividen en tres categorías: chat y apoyo en línea con iguales, avatar de bienestar personalizado y aplicaciones de bienestar.

Componentes del paquete tecnológico

Componente del paquete tecnológico	¿Qué es esta aplicación?	¿Cómo funciona?	¿Por qué es útil?
Chat y apoyo en línea con iguales	Conecta a los clientes o consumidores y a sus seres queridos con grupos de apoyo en línea o con iguales.	La aplicación de chat con iguales y apoyo en línea les brinda a los clientes, consumidores y a sus seres queridos una variedad de opciones de apoyo con iguales en línea (por ejemplo, texto, chat grupal).	• Aumenta el acceso de aquellos que prefieren permanecer en el anonimato. • Proporciona servicios en el idioma preferido del cliente o consumidor. • Promueve la conexión para los jóvenes y los adultos aislados.
Avatar de bienestar personalizado	Enlaza a los clientes o consumidores a actividades de bienestar personalizadas a través de un avatar.	Los clientes o consumidores pueden escoger recibir instrucciones y recordatorios para involucrarse en el bienestar de acuerdo con sus preferencias.	• Incrementa el acceso de los clientes o consumidores que tienen acceso limitado a servicios presenciales, que evitan los servicios presenciales debido al estigma o que prefieren el anonimato.
Aplicaciones de bienestar	Utilizan los datos del teléfono celular para brindar una red segura de apoyo para alguien.	Los clientes o consumidores pueden dar permiso a una aplicación para que use los datos del teléfono celular para recibir recordatorios de actividades de bienestar o compartir datos seleccionados con su proveedor actual.	• Sugiere actividades de bienestar con base en los datos recolectados. • Les avisa a los proveedores de salud mental si un cliente o consumidor necesita más ayuda.

创新技术套件概述

San Mateo 郡行为健康和康复服务 (Behavioral Health and Recovery Services, BHRS) 正在试行一项精神健康服务法 (Mental Health Services Act, MHSA) 创新项目，该项目通过使用智能手机等设备，将旨在支持心理健康和保健的基于技术的干预措施汇集在一起。这些应用程序因供应商而异，可分为三类：同侪聊天和在线支持、个性化健康头像和健康应用程序。

技术套件组成

技术套件组成	此应用程序的功能是？	如何运作？	有何助益？
同侪聊天和在线支持	将客户/消费者和其亲人与在线支持团队和/或同侪连接起来	同侪聊天和在线支持应用程序为客户/消费者及其亲人提供了多种在线同侪支持选项（例如文本、群聊）	• 帮助那些更倾向保持匿名的人士扩大获取范围。 • 以客户/消费者的首选语言提供服务。 • 促进青年和孤立的成年人的联系
个性化健康头像	通过头像将客户/消费者与个性化健康活动相连接	客户/消费者可以选择接收提示和提醒，以根据自己的喜好参与健康活动。	• 针对获取现场服务能力有限的、因受到耻辱而避免进行面对面服务的、或倾向匿名的人士，扩大其访问范围。
健康应用程序	使用手机数据为某人提供安全支持网络	客户/消费者可以授权应用程序使用其手机数据，以接收健康活动的提醒或与他们的当前提供者共享特定数据。	• 根据收集的数据提供健康活动建议。 • 如果客户/消费者需要额外支持，可通知精神健康提供者。

Innovation Tech Suite Overview

San Mateo County Behavioral Health and Recovery Services (BHRS) is piloting an MHSA Innovation project that brings together technology-based interventions designed to support mental health and wellness, using devices like smartphones. The apps vary by vendor and fall into three categories: peer chat and online support, personalized wellness avatar, and wellness apps.

Tech Suite Components

Tech Suite Component	What is this App?	How does it work?	Why is it helpful?
Peer Chat and Online Support	Connects clients/consumers and their loved ones with online support groups and/or peers	The Peer Chat & Online support app gives clients/consumers & their loved ones a variety of options for online peer support (e.g. text, chat group)	• Expands access for those who prefer to remain anonymous. • Provides services in client/consumers' preferred language. • Promotes connection for youth and isolated adults
Personalized Wellness Avatar	Links clients/consumers to personalized wellness activities through an avatar	Clients/consumers can choose to receive prompts and reminders to engage in wellness based on their preferences.	• Expands access for clients/consumers who have limited access to in-person services, avoid in-person services due to stigma, or prefer anonymity.
Wellness Apps	Uses cell phone data to provide a safety net of support for someone	Clients/consumers can give permission to an app to use their cell phone data to receive reminders for wellness activities or share selected data with their current provider.	• Suggests wellness activities based on data collected. • Alerts mental health providers if a client/consumer needs additional support.

Tech Suite Frequently Asked Questions

Peer Chat and Online Support

Will clients/consumers be able to chat with a real person?

Yes, clients/consumers will chat with real people who have lived experience and are trained to listen and provide support through chat.

Are the peers/support group moderators certified?

Depending on the app, the peer listeners and support group moderators are trained and may either be paid or volunteers.

Is it confidential?

Depending on the app and service, clients/consumers may choose to share their name or remain anonymous. Personal information is never shared with the listeners or anyone else.

How much does it cost?

Depending on the app, peer chat and online support groups are free. Some apps offer free peer chat and support groups, but may also offer additional services for a fee.

Are there peers/support groups available in other language?

Depending on the app, some services are available in multiple languages.

Therapy/Wellness Avatar

Will users be able to talk with a real person?

Depending on the app, users will be able to engage with an "avatar" that uses artificial intelligence to gather information about how they're doing and recommend wellness activities to meet their needs. The avatar will communicate with users in a way that is similar to a real person, but is a program designed to understand information they provide and suggest ways to engage in wellness, such as remembering to take medication or practicing meditation or self-care.

Will the avatar replace a human connection with a real person?

No, these apps are designed to provide users additional support when they need it, not replace other wellness activities like talking with a therapist or other professional.

How will the avatar know whether someone is in a crisis situation or connect them to additional crisis services in the community?

The avatar uses advanced technology that can analyze information they share when they interact with it to determine whether they are experiencing certain challenges or symptoms. The County will work with vendors who can modify apps to provide information about local resources.

Are there apps that provide services in other languages?

Depending on the app, some services are available in multiple languages.

Wellness Apps

How do the apps work?

Depending on the app, users can choose to allow their phone to review data about usage, such as whether they have left their home that day or the words and ideas they type in texts. The app will monitor that data to identify signs that might mean they are not feeling so great. For example, if their phone hasn't left the location of their home in over 24 hours, the app might suggest actions they can take to make sure they connect with their support network such as calling a friend. If their text behavior changes, such as if they start using different words or communicating different ideas than they usually do, the app may prompt them to check in with how they are feeling or remember to take their medication as scheduled. If they choose to do so, some apps may send this information to a provider users know and trust so the provider can check in.

What information will the app collect?

The information varies depending on the app and what options users select. Generally, apps will collect data about their phone usage, such as whether they have left their home or the words and ideas they type in texts.

Who will have access to information my phone collects?

User information will not be shared with anyone unless they choose to share it with a qualified health professional they already know.

Will the app record information about me or listen in on my phone conversations?

No, the app will not record any data users do not want it to and does not allow their phone to record conversations.

Will the government have access to my data?

No, the app will not share any information with anyone unless users want to share it with a qualified health professional they already know.

Appendix 3

Summary of Community Meeting Notes

Customization for Target Populations-Community-wide

- **Crisis.** Apps should be able to connect people to local crisis line and other resources. The County will need to develop a crisis response plan and communicate it clearly to all using the apps. Stakeholders expressed concern that people will only talk to the avatar app and will not connect with crisis services when needed. Some were concerned that law enforcement would be contacted based on certain language or behavior, while others were concerned that law enforcement would not be contacted.

- **Culture, language, and age fit.** Apps should be designed to respond to the needs of specific age groups and culture/ethnic groups. Apps should also be linguistically and culturally appropriate. Representatives from target populations should be included in the process to design the apps and the outreach/training efforts. Multimedia capability such as videos and voice recognition can provide options for people to engage in ways that are most comfortable for them.

- **Model apps for design inspiration.** Apps that people are already using or are designed for certain populations should be the design models for the tech suite (e.g. Wobot, for youth, WeChat for the Chinese community, What's App for Latino community).

- **Integrate with existing services.** Apps should integrate with existing in-person mental health services, 211, and the crisis line to the extent possible.

- **Stigma and design preferences.** Apps should use imagery and language that is upbeat, positive, and age appropriate. Language should focus on "stress," "health," and "wellness." Marketing them to the general public as something other than mental health may be helpful.

- **Data security and liability.** Data security and liability around crisis are a significant concern. The County will need to develop a plan to mitigate liability issues and manage data security. Stakeholders asked for the county to specifically consider/name who gets access to the data collected from users, how it is stored, and who is responsible. Stakeholders suggested that the apps need safeguards to protect consumers from hackers and predators.

- **Training/Certification of Peer Listeners.** Many raised questions about the qualifications, (are peers mandated reporters?) and training of peer listeners and stated a preference that peer listeners be local peer specialists that are familiar with existing resources and are representative of the County's cultural and linguistic diversity. Stakeholders suggested the peer listeners receive training on how to initiate escalation of support if someone is experiencing a crisis.

- **Substance use.** Stakeholders suggested that many mental health consumers who are isolating may be coping/ struggling with substance use issues. These apps should be inclusive of wellness approaches for substance use, and SUD providers can provide input on SUD support in app design.

Youth

- Youth stakeholders and youth advocates suggested the county partner with student/youth-run mental health organizations and advocates to select/design the apps.

- Youth stakeholders and youth advocates suggested that customization for youth include games, puzzles, and mindfulness activities. Specifically, these apps should less "text heavy" and provide more mechanisms to "swipe" and be interactive with wellness interventions.
- Considerations for apps for youth include implementing Wobot or designing an app similar to Wobot for youth (similar to avatar option) Other apps youth mentioned as potential design models were Calm and Clue.
- Some youth expressed interest in apps that provide capability to anonymously refer friends so the app can contact the referred person.
- Ease of access is important for this population, and youth suggested that a questionnaire could help people find the right service for them.
- Due to the barriers of stigma, youth suggested using language like "overall health, "wellness," "stress reduction" (esp. related to academic pressure) instead of mental health. Imagery should be positive, upbeat, "lifestyle" focused, and youth-friendly.
- This population needs a range of options for levels of support. Youth expressed discomfort with "serious" mental health support and suggested more that youth would be more open to trying apps they perceived as "low-key" and casual. Some youth were interested in less intensive apps that are useful for one-time stress reduction (such as an app that provides prompt for breathing exercises to navigate through moments of panic or anxiety).

Older Adults

- To avoid stigma, the apps should not use language like "mental health," but instead, focus on more universal issues that most older adults may face, such as connection, socializing, and loneliness. Apps and outreach materials should emphasize that aging is a universal experience and brings up issues for "all of us." Older Adults suggested the county connect with Reframing Aging at the Aging Institute for inspiration and guidance.
- Older adults emphasized that ease of access is a priority. Customization for these apps should include large font, video and voice recognition, and simple and straight-forward design.
- Navigation and training on how to use the apps will be needed for this population. This support will need to be available on an ongoing basis, or at least a few times in-person, to be most effective for older adults.
- Commission on Aging and AARP may be able to provide input to help customize the app.

Consumers

- Peer listeners should be able to provide information about existing in-person services in the local area.
- Apps should provide opportunities for online WRAP groups that could bring people together and help reduce stigma. Apps should provide information about in-person peer support events/groups/resources, and provide ongoing support to work towards goals
- Nutrition support info overlaps with mental health. Info about nutrition can be helpful.
- Apps should provide info about SSI and other benefit recertification.

Parents

- Include supportive tips and techniques for parents to respond to and support their children experiencing mental health issues, as well as local resources available. Information about techniques and local resources should be listed by age group.
- The apps may be helpful in supporting parents and helping them engage in self-care during stressful experiences navigating their children's mental health challenges; this may need to be a self-care/support app specifically designed for parents and family members.
- Apps should be able to notify multiple people in case of an emergency (e.g. if someone programs a wellness app to contact a provider, they can also program it to contact their parents to help).

- The apps could potentially be useful for pregnant mothers during and after pregnancy, particularly if they experience post-partum depression.

Monolingual Spanish-speaking community

- For people with limited literacy and/or challenges texting typing, stakeholders suggested having an option to record conversations for example "what's app" so you can have an entire conversation through a text mechanism, but without texting.
- Stakeholders suggested that because of stigma, it may be challenging to get people to use the apps. Marketing them to the general public as something other than mental health may be helpful and/or marketing app under another name may be helpful (e.g. "YouTube Health")
- Multimedia capability such as videos and voice recognition may provide options for people to engage in ways that are most comfortable for them.
- Apps should be designed in a way that looks visually happy, attractive, fun. There should be happy, attractive people of color featured in any imagery.

Monolingual Chinese-speaking community

- The County will need to expand the capacity of bilingual outreach support.
- Provide information about local resources available in Chinese.
- Consider insurance implications before linking people to services that would not be covered for them.
- Chinese communities are already using WeChat, WhatsApp, and Facebook. These are familiar and good models for design. Stakeholders suggested integration with these apps to make intake from these apps easy for clients.
- Language to use could include "wellness," "stress," and "health".
- Some people might have different perceptions of simplified and traditional Cantonese, so apps may need to be available in both.
- Visual design should emphasize physical health and not point to mental health.

Providers/CSA

- Providers suggested that it wellness teams may benefit from these methods of staying connected and monitoring client status.
- Apps should be able to provide clients info about physical wellness indicators and activities. Consider options to integrate with Fit Bit and programming in wellness activities that include physical wellness.
- Apps should be able to connect people to the 6 core service agencies: food, shelter, health, etc.
- Potential pilot groups may be:
    - TAY, age groups most likely to engage
    - Parents of young children: pre-3
    - Isolated coastal community, especially for Spanish language services using voice recognition

Implementation Considerations Communitywide

- Piloting the apps with a smaller subpopulation will help inform implementation and design that is relevant to people of different languages, ages, and cultures.
- The County will need to protect sensitive information such as immigration status. Some parents are afraid that seeking help for their children will involve CPS. Outreach to parents will need to let parents know that they will be safe using the apps and that CPS will not be notified or involved.
- For isolated people and those who are not engaged in services fully or at all, it will be important to conduct outreach in places they already go to and with people they already interact with:
    - Faith based communities
    - Salons/barber shops
    - Grocery stores
    - Laundromat
    - Libraries
    - Hospitals/Clinics/Primary health care facilities
    - Case workers
    - Law enforcement and first responders
    - Peninsula Family Services
    - 70 Strong
    - One Degree, org who recently launched "Help Me Grow" a supportive/interactive online resource center
    - Incorporate app and/or collocate (peer?) support with existing networks, see "Star Vista"
    - (Early) Head Start
    - One Stop Service Locations Jails
    - Health Plan
    - Community orgs
    - Support team, FAST

- o   Primary Care Interface Team
- o   Coastside Clinic, medical clinics, providers
- o   Families who contact the Office of Consumer & Family Affairs
- o   Core Service Agency
- o   Peer organizations such as Heart and Soul, California Clubhouse; peer support workers
- o   Community health advocates in health system → it may be challenging for them to provide support, but INN funds can support training and outreach
- o   Total Wellness
- o   Substance use providers serving co-occurring population
- o   People who distribute cellphones, they will need to be trained to help people load apps and teach clients how to use them
- The County should develop a sustainability plan to:
  - o   Prevent the service/app from disappearing on people who are using it after the 3 year implementation period after consumers have begun to use it
  - o   Keep the service free for clients after the 3-year implementation period

Youth

- Stakeholders suggested partnering with schools and the School District to support implementation, education, and outreach about the apps- This information should clarify privacy and ensure that parents don't have to know youth are using the apps. Demos should emphasize anonymity and privacy features.
- Youth also suggested partnering with student/youth-run mental health organizations and advocates to conduct outreach.
- There is some concern that some youth use their phones instead of connecting to other resources. The County should consider how to ensure that these apps are helpful for youth, without suggesting that apps could replace other services.
- Education and outreach about the apps will be necessary to ensure engagement. Engagement venues can include the list below. These venues and people may also be helpful in training people to use the apps:
  - o   Youth ambassadors
  - o   HAP-Y
  - o   Schools/teachers
  - o   Local events
  - o   Libraries
  - o   WRAP groups
  - o   Social workers
  - o   Parenting classes/groups
  - o   Promotores

Older Adults

- Training and tech support to download and program the apps will need to be available as one-on-one help or a series of small workshops. This support will need to be available on an ongoing basis, or at least a few times per person, to be most effective for older adults.

- Senior Coastsiders are already are conducting outreach/meal delivery and could be trained to provide outreach, training, and tech support to older adults.

- Venues for outreach:
  - Veterans Hospitals
  - Home care providers
  - Pharmacists
  - Board and Care facilities
  - Faith-based communities
  - Aging adult service workers
  - NAMI
  - Assisted living facilities
  - Senior housing
  - Friendship Centers
  - Senior Centers

- To engage more isolated older adults, it will be important to go to them. Residence managers and case managers can be a good point of contact for isolated people. Doctors, physicians, courses and other health care providers can also be a point of contact. The apps may be helpful for isolated older adults not going to senior centers. Effective methods for reaching out to those more isolated individuals may include:
  - TV ads
  - Offer to come to people's homes to show them how to use the apps
  - Workshops at drop-in centers
  - Daily Journal ads
  - Flyers in places people go to such as grocery stores, pharmacies
  - Primary and mental health care providers
  - Heart and Soul staff trained to present information about the apps
  - Senior centers
  - OASIS for homebound older adults

Consumers

- Consider utilizing County Peer Specialists to support outreach efforts.
- People who use the apps may be able to share information about the apps with their roommates/others in their residential situation as a successful means of outreach.

Parents

- Outreach venues:

- o   Parenting social media groups
- o   Parenting classes and support offered through BHRS

Monolingual Spanish-speaking community

- Community members suggested that the county train the Health Ambassador Program and Health Ambassador Program-Youth on how to use these apps to better reach community members.
- Outreach and engagement should include Promotores and social workers, and other systems in which who should go to schools, events, libraries, WRAP groups, social workers, and community events.

Monolingual Chinese-speaking community

- Star Vista services are currently provided in Chinese. The County should consider linking with existing services.
- Outreach needs to emphasize confidentiality
- Include translators in conversations about the apps to ensure that the concept is accurately translated. [The correct translation for stigma is word that is less strong in connotation than "shame" and is closer to "wrong perception" or "labeling"]
- Outreach partners:
  - o   Senior center
  - o   Chinese Heath Initiative
  - o   Radio and TV
  - o   Churches/faith based communities
  - o   Doctors in Chinese clinics: Northeast Medical Services and Chinese Hospital, both in Daly City
  - o   Ensure sufficient time and translation during outreach process. Provide traditional and simplified language options for outreach and apps. Proficient translation is crucial. Make everything available in both Mandarin and Cantonese.
  - o   Community organizations

Providers

- Apps could increase access by directly connecting people to call center. Need to strengthen crisis line to support demand from apps.
- Health care providers may be able to contribute funding to develop and maintain apps. People could specify their insurance coverage to be able to view options that are covered by their insurance. Explore opportunities to coordinate with other providers beyond Medi-Cal.

Evaluation/Learning Goals from Community

- Does the Tech Suite effectively connect people with mental health services?
- What works best for the priority populations?
- What are clients' experiences with the apps?
- Who uses the apps (e.g. demographics)?

- What lessons are there from Los Angeles and Kern counties?
- Do the apps help clients regulate their medication/wellness?

APPENDIX B: 10-YEAR WET IMPACT & SUSTAINABILITY REPORT

San Mateo County
Mental Health Services Act (MHSA)

Workforce Education and Training (WET)
10-Year Impact and Sustainability Report

Office of Diversity and Equity

San Mateo County Behavioral Health and Recovery Services

February 2018

Table of Contents

Introduction

Background

The Mental Health Services Act (MHSA) was approved by California voters in November 2004 and provided dedicated funding for mental health services by imposing a 1% tax on personal income over $1 million dollars. MHSA emphasizes transformation of the mental health system while improving the quality of life for individuals living with mental illness. It provides funding for treatment, prevention and early intervention, outreach, support services, family involvement, and programs to increase access to services for underserved communities.

Workforce Education and Training (WET) received a total one-time $3,437,600 funding allocation in FY's 2006-07 and 2007-08, with a reversion period (timeframe for expending the allocated funds) of 10 years. With MHSA WET funding ending in 2017-18, BHRS is preparing to sustain the most effective and impactful elements of these investments. Continued investment in WET is critical to supporting BHRS' strategic initiatives and priorities, and for creating a system of care that is responsive to MHSA core values of building community collaboration, cultural humility, consumer and family driven services, a focus on wellness, recovery, and resilience, and an integrated service experience.

This report provides an overview of the impacts of MHSA WET investments in the 10 years of implementation by San Mateo County Behavioral Health and Recovery Services (BHRS), stakeholder priorities, and BHRS' vision for WET as a commitment to building knowledge, skills, and core values.

San Mateo County WET Program

After two years of stakeholder engagement and plan development, the San Mateo County WET Plan was approved and enacted in 2009. Current components of the WET Plan include:

1. **Workforce staffing support –** A WET coordinator, a Community Program Specialist, and an Administrative Assistant provide system wide responsibility for managing implementation, reporting and evaluation of all BHRS training activities.

2. **Training, technical assistance, and capacity building –** Trainings to increase the capacity of providers to respond to behavioral health issues, as well as address public perception on such issues as stigma and suicide in a culturally sensitive manner. Additionally, use of evidence-based and community-defined promising practices has increased as a result of training.

3. **Behavioral health career pathways programs –** Strategies that are necessary to address ongoing vacancies in positions which are difficult to fill.

4. **Financial Incentives –** to create a more culturally competent system**,** this program provides stipends to trainees from local universities who contribute diversity as well as the linguistic and cultural humility of BHRS.

Summary of Recommendations

WET investments are crucial to creating and sustaining a transformed behavioral health care system that is client-centered and provides high quality accessible services. The most impactful elements will be sustained, total of $500,000 per year, through the following three strategy recommendations:

Recommendation 1: A Systemic Approach to Workforce Education and Training

MHSA investments in workforce, education and training have significantly broadened the continuum of topics covered and the transformation of BHRS. Moving forward, a systemic approach to foundational knowledge and BHRS transformation goals (cultural humility, trauma-informed care, standard of care, co-occurring and other integrated care, lived experience integration, self-care, etc.) should be the standard. Trainings initiate dialogue, personal level impacts, and the beginning of culture shifts. Policies, leadership qualities, and intentional linkages to quality improvement goals advance sustainability and genuine system transformation.

- **Sustainability strategy** – a transfer from MHSA CSS will sustain foundational knowledge and training that supports system transformation ($100,000) and the workforce staffing ($260,000) needed to manage, implement, and evaluate WET across the BHRS system of care.

Recommendation 2: Creating Pathways for Individuals with Lived Experience in Behavioral Health Careers and Meaningful Participation

The Lived Experience Academy (LEA) has demonstrated to be a valuable resource for preparing clients/consumers and family members with lived experience to participate in the behavioral health workforce and, providing knowledge and skills in the area of stigma reduction and advocacy, empowering and inspiring participants to share their stories and supporting their recovery, reduced shame, isolation and increased confidence. Creating pathways for individuals with lived experience requires a systemic and integrated approach.

- **Sustainability strategy** – consolidation of the peer and family partners strategies ($60,000) currently funded by MHSA, CSS General Systems Development component.

Recommendation 3: Promotion of Behavioral Health Careers to Recruit, Hire, and Retain Diverse Staff

The WET internships, and specifically the Cultural Competence Stipend Internship Program (CCSIP), are valuable resources for preparing future clinicians to better understand issues related to both promote the mental/behavioral health field and increase diversity of staff to better reflect our client population and retain diverse staff. CCSIP invaluable outcomes included providing a better understanding of marginalized communities, reinstating participants' commitment to working with their community and being able to have a broad impact on the community not just at the clinical level. More has to be done to recruit , hire and retain diverse staff.

- **Sustainability strategy** – a transfer from MHSA CSS ($80,000) to MHSA WET will sustain internship and outreach strategies currently managed by the WET Coordinator.

Overview

In the spring of 2017, San Mateo County Behavioral Health and Recovery Services' Office of Diversity and Equity hired independent consultant Sean Kirkpatrick to assess the impact of WET and identify priorities that would shape the future landscape. Engagement included the following:

- WET Survey for Staff, CBO Partners, Contractors
- Survey for Cultural Competency Stipend Intern Program Participants
- Interviews of Cultural Competency Stipend Intern Program Participants
- Listening Session with the Lived Experience Education Workgroup
- Survey for Lived Experience Academy Participants
- Interviews of Lived Experience Academy Participants
- World Café with the Workforce Development and Education Committee
- LEEW Enhancement report (prepared separately by another contractor)

Materials reviewed in preparation of this report also included training logs, pre/post-tests for trainings, evaluations collected during trainings, reports developed, WET Plans and annual updates, etc.

WET Planning

WET planning has always been built on stakeholder input and feedback. The planning process has targeted a diverse group of San Mateo County community members, clients/consumers of BHRS and their family members, BHRS and contract agency staff (including peer and family workers), and community-based organizations and partners, including Health Equity Initiatives. Online surveys, focus groups, in-person group dialogue and key informant interviews have been deployed to capture the input of over 800 stakeholders.

The foundation for the first WET Plan (FY 2009-10) was based on several planning efforts: 1) the MHSA Community Services and Supports (CSS) planning, which engaged a wide range of stakeholders including members of historically unserved and underserved communities; 2) the Joint Labor/Management Initiative, which was formed to create a framework for addressing both the conditions of employment and the approach to providing staff development; and 3) a planning workgroup, which began developing a vision and set of values and principles to ensure that workforce development, education and training initiatives within BHRS were consistent with the vision and values established through the

CSS planning process. For the second planning phase (FY 2011-13), a Training Survey based on the priorities of the previous plan was added. The original planning workgroup was comprised of BHRS leadership, managers, line staff, consumers, family members, and representatives of community-based organizations. The group identified foundational knowledge, a wide range of competencies that are viewed as central to supporting system transformation and core of the WET Plan.

Currently, the formal governing and advisory bodies ensure that workforce development, education and training initiatives meet the needs of BHRS' clients/consumers, family members and the community.

- **Workforce Development and Education Committee (WDEC)** meets bi-monthly to ensure training and workforce development plan implementation; identify barriers to the training and workforce plans, create strategies to address the barriers, and accountability. The WDEC is facilitated by the WET Coordinator.

- **Lived Experience Education Workgroup (LEEW)** meets monthly to focus on building workforce development, training, and advocacy opportunities within BHRS for clients/consumers and family members, and planning and supporting the Lived Experience Academy Trainings. LEEW is composed of people who have completed the Lived Experience Academy and other people with Lived Experience. The content of the meetings includes discussion of member participation in speaking engagements, BHRS-related committees and commissions, and sharing their Lived Experience stories. Additionally, members discuss announcements, other peer-led organizations and peer-focused conferences.

WET Plan Components

Over the course of WET implementation, the strategies and investments for WET have shifted to meet the evolving training needs of BHRS. A Child Psychiatry Fellowship was initiated in 2007-08 in response to a critical, historically hard-to-fill position within the San Mateo County BHRS system and as part of the It was a partnership of San Mateo County BHRS and Stanford University designed to serve high-risk youth in inpatient, outpatient, and community settings, as well as provide education to a new generation of psychiatrists about recovery- and strength-based service delivery.

Workforce Staffing Support

As each phase of WET implementation brought about increases in scale and need, the WET Team expanded to include a Coordinator, a Community Program Specialist, and an Office Specialist. The WET Coordinator is generally tasked with oversight of the WET Programs and their implementation, the WET Team, and related WET workgroups/committees; evaluation of WET Programs; facilitation of the Workforce Development and Education Committee (WDEC) and the Practice Evaluation Committee; and participation in several BHRS Workgroups. The WET Community Program Specialist implements and facilitates the WET Programs, including BHRS Training Plan trainings; and oversees internship recruitment, the Cultural Competency Stipend Internship Program, the Lived Experience Academy, the Lived Experience Education Workgroup (LEEW), and the Cultural Humility Trainers. Lastly, the WET Office Specialist provides administrative support and documentation for all WET Programs and trainings. The WET Team members are also the administrative staff responsible for administering the Learning Management System for all BHRS trainings. Currently, WET operates under the Office of Diversity and Equity (ODE), and is supervised by the ODE Director. This shift happened three years ago and has enhanced the focus of WET to embed cultural humility, as well as to support the core values of MHSA.

Training, Technical Assistance, and Capacity Building

Training opportunities have greatly increased the capacity of community members and providers to respond to behavioral health issues, as well as address public perception on such issues as stigma and suicide in a culturally sensitive manner. The strategy also supports system transformation by providing training and technical assistance on utilizing evidence-based practices (EBPs) and community-defined treatment practices (CDPs). Sub-categories for training, technical assistance and capacity building are:

1. **Trainings to support wellness and recovery** – San Mateo County BHRS offers trainings to extend and support consumer wellness and recovery, examples include:
   - *Wellness Recovery Action Plan (WRAP)* trainings. WRAP is an evidence-based, self-help approach to achieve and maintain wellness that has been used successfully with mental health consumers and consumers with co-occurring disorders. With a train-the-trainer approach, consumers, family members, contracted providers, and County staff are trained as Master Trainers. The Master Trainers then provide training and support in developing WRAP plans for consumers and staff throughout the system.
   - *WISE Recovery 101 and Peer Support 101* Two separate trainings that have been designed for supervisors and peer workers to support understand and support the participation of Peer Workers in the BHRS provided programs and services.
   - *Trainings for Peer Support Workers/Family Partners* a series of trainings designed to address topics and concerns encountered by Peer Support Workers/Family Partners in managing their roles and responsibilities within BHRS.

2. **Training and technical assistance for and by consumers and family members –** these have included a range of trainings activities, for example:
   - Trainings delivered by and for consumers and family members.
     - *Paving the Way,* a San Mateo model that provides training and supports for consumers and family members joining the BHRS workforce
     - *Hope Awards,* which highlights personal stories while educating consumers, families, staff, and the general public about recovery and stigma; and
     - *Inspired at Work,* a program that provides a framework for consumers and family members to get support for entering and remaining in the workforce.
   - Trainings provided by consumers and family members to reduce stigma.
     - *Stamp Out Stigma,* a community advocacy and educational outreach program in which individuals with mental illness share their personal experiences with the community at large
     - *Breaking the Silence,* a training activity designed to address issues of gender identification in youth and the effects of community violence; and
     - *Consumer-led trainings* by transitional age youth for audiences of all ages.
   - Trainings provided by consumers and family members to increase understanding of mental health issues and substance use/abuse issues, recovery and resilience, and available treatments and supports.
     - *NAMI's Provider Education Training*, an intensive training for providers led by consumers, family members, and experts;
     - *Peer to Peer,* a NAMI-sponsored nine-week course taught by consumers to consumers about mental health, treatments, and recovery; and
     - *Voices of Recovery,* a client and family-driven advocacy and support program for those who have been affected by addiction.

- Trainings for consumers and family members on leadership skill development to support increased involvement of consumers and family members in various committee, commission, and planning roles:
  - *California Mental Health Advocates for Children and Youth Conference*
  - *The Village* educational visits*;* and
  - *NAMI, Heart & Soul,* and other community-based training activities to help perfect the leadership skills of consumers and family members.

3. **Cultural humility trainings –** trainings in the area of cultural humility are designed to reduce health disparities in the community; provide instruction in culturally and linguistically competent services; and to increase access, capacity, and understanding by partnering with community groups and resources. Educational and training activities are made available to consumers, family members, providers, and those working and living in the community. Examples include:
   - *Working Effectively with Interpreters in Behavioral Health Settings*
   - *Culturally Responsive Supervision*, and
   - *Building Bridges to Diversity and Inclusion: Cultural Humility for Non-Clinical Staff.*

   The Health Equity Initiatives work with the WET team to create and support trainings to address special populations and appropriately serve marginalized communities, examples include:
   - *Native American Mental Health: Historical Trauma and Healing Practices*
   - *Working with Filipino Youth,* and
   - *Understanding Issues in the Queer Experience (UNIQUE)*.

4. **Evidence-based practices (EBPs) –** for system transformation are supported through an ongoing series of trainings that increase utilization of EBPs. Such practices aim to engage consumers and family members as partners in treatment, and thus contribute to improved consumer quality of life. The WET Coordinator facilitates the Practice Evaluation Committee which carries out the selection of evidence-based and community-defined practice policy. Examples include:
   - *Functional Family Therapy,* a family-based intervention with at-risk youth in the criminal justice system that focuses on using family and consumer strengths to help youth gain control of their behaviors
   - *Trauma-Focused Cognitive Behavioral Therapy,* a model that integrates cognitive and behavioral interventions with traditional child abuse therapies and focuses on enhancement of interpersonal trust and empowerment; and
   - *Dialectical Behavior Therapy,* a practice focused on developing skills to more effectively deal with distress.

Behavioral Health Career Pathways Programs

The Behavioral Health Career Pathways Programs aim is to recruit, hire, support, and retain diverse staff in behavioral health careers. After the first WET Plan (FY 2009-10) established core program areas, subsequent WET Plans refined strategies. Some program areas were not retained in subsequent plans including the Behavioral Health and Human Resources Forums and the specific Behavioral Health Career Pathways Program with high school students.

1. **Attract prospective candidates to hard-to-fill positions** (including child/adolescent psychiatrists, psychiatric mental health nurses, and *promotores*/navigators) by addressing application barriers and providing incentives. Programs San Mateo County participated in included:
   - *Mental Health Loan Assumption Program (MHLAP)* – 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. Trainees receive up to $10,000 to repay educational loans in exchange for a 12-month service obligation. In fiscal year 2015-16, 25 BHRS awardees received stipends totaling $197,383.
   - *Behavioral Health and Human Resources Forums* – hosted by the Greater Bay Area Mental Health & Education Workforce Collaborative, the purpose of these forums was to influence county behavioral health human resources practices and priorities toward hiring staff who reflect the composition of the community being served. This program was discontinued.
   - *Child Psychiatry Fellowship* – was initiated in 2007-08 and responded to a critical, historically hard-to-fill position within the San Mateo County BHRS system. The Fellowship was a partnership of San Mateo County BHRS and Stanford University designed to serve high-risk youth in inpatient, outpatient, and community settings. This program was discontinued.
2. **Promote the mental/behavioral health field in academic institutions** where potential employees are training in order to attract individuals to the public mental health system in general, and to hard-to-fill positions in particular.
   - *Intern/Trainee Program* – BHRS partners and contracts with graduate school in the Bay Area to provide education, training, and clinical practice for their students at various behavioral health worksites in the County to provide training opportunities for psychology interns, masters-level trainees, alcohol and drug certificate program students, and psychiatric residents each year. Students are welcome to attend any of the five didactic training seminars throughout the county. There are bi-monthly psychiatric grand rounds that are open to all staff and students. Regular in-service training and specialized staff training are also available for students to attend. Additional skills training in wellness and recovery; crisis response, suicide and trauma; cultural humility; integrated care; and co-occurring mental health and substance use disorders were added to the internships.
3. **Promote interest among and provide opportunities for youth/Transition Age Youth (TAY)**
   - *Behavioral Health Career Pathways Program* – Encourages San Mateo County high school students to explore future careers in behavioral health, increases students' understanding of individuals with behavioral health challenges, and reduces stigma. This program was discontinued in FY 15/16.
4. **Create new career pathways and expand existing efforts for consumers and family members** in the workforce to allow for advancement within BHRS and in other parts of the County system.
   - *Lived Experience Education Workgroup/Lived Experience Academy* – Prepares clients/consumers and family members for workforce entry, advocacy roles, participation on committees and commissions, etc.
   - *BHRS New-Hire Orientation* – Starting in 2014-15, BHRS employees receive a 3-session orientation designed in part to help new staff understand how BHRS works and connects to other agencies and departments, to meet and learn from BHRS managers, to explore possibilities for career advancement, and to feel invested in and supported.
5. **Increase diversity of staff to better reflect our client population and retain diverse staff**.
   - *Cultural Competency Stipend Internship Program* – this program shifted to Financial Incentives Program defined below to provide interns with school expense support.

The Financial Incentive Program goal is to **increase the availability of culturally and linguistically competent services to all consumers and family members of BHRS**, and to increase trainees' knowledge and understanding of the values and commitments of recovery- and strengths-based services offered.

1. *Lived Experience Scholarship* – provides up to $500 for clients/consumers or family members to pursue their academic goals toward a clinical, administrative, or management career in behavioral health. Applicants must be current or former BHRS clients/consumers or family members, residents of San Mateo County, and registered for at least six units in a vocational, 2-year college, 4-year college, credential, or graduate program.
2. *Cultural Competency Stipend Internship Program (CCSIP)* – created to support behavioral health graduate students who contribute to the cultural humility/responsiveness of BHRS through linguistic capability, cultural identity and/or experience working with and advocating for special populations represented in San Mateo County. Up to 10 trainees are selected based on their bicultural/bilingual capabilities, with preference given to those who identify or have experience working with special populations. As the program evolved interns were required to interact with and learn from members of the Health Equity Initiatives and other systems-change initiatives. Stipend amounts average $5,000 per participant.

Evolution of WET Priorities

Prior to implementation of the MHSA WET strategy, the landscape was far less robust, with fewer trainings offered annually. Furthermore, topics skewed toward direct clinical training due to norms and an emphasis on medical intervention. For example, 60% of the trainings offered in FY 2002-03 had a clinical focus (e.g. Methadone, Antipsychotics, Risk Management, etc.); in FY 2003-04, 78% had a clinical focus. Cultural humility-focused trainings at this time included Latinos and Mental Health, Cultural Values and End of Life, and a Cultural Competence and Mental Health Summit.

In more recent years, the number and variety of trainings offered have increased significantly. Between 2014 and 2017, BHRS invested $1,308,920 of MHSA funding in WET, providing 95 trainings to over 3,000 people in the same timeframe. In addition to cultural humility trainings spearheaded by the Office of Diversity and Equity, these trainings focused on co-occurring-informed care, trauma-informed care and crisis management and safety, a shift visible in the graph below.

Types of Trainings Offered by Fiscal Year
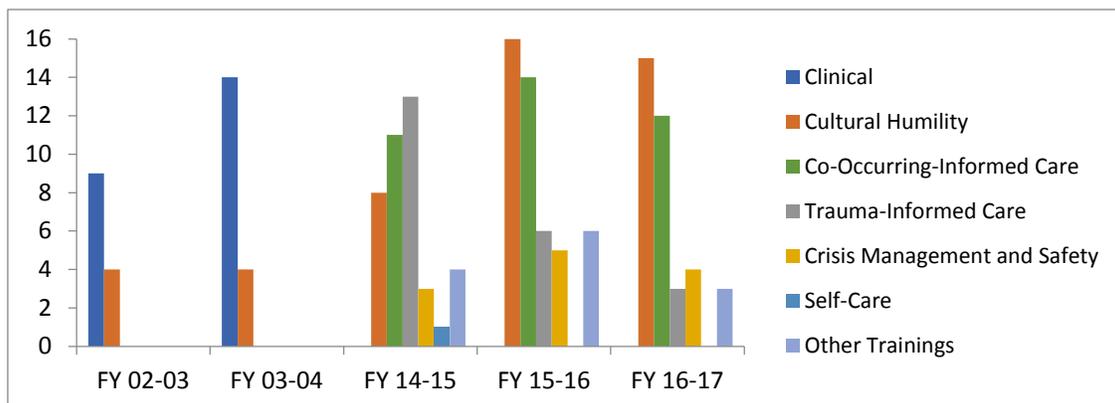
Overall, this increase in diversity of training offerings reflects BHRS' intentionality to invest in training. While it is possible that data collection on training type was lacking prior to the implementation of MHSA, this investment also reflects a response to shifts in training needs, either from the providers or the clients. Additionally, the annual training participant numbers have been relatively stable from year to year; however, there has been an increase in the number of trainings offered. This may signify that more people are being trained across more topics. Throughout the initial planning of WET and iterations of the plan, diverse stakeholders have been engaged to help shape future training topic priorities in four areas (Foundational Knowledge, Special Populations, Clinical Competencies and Skills and Treatment Practices) as described below.

Foundational Knowledge

Foundational Knowledge areas represent the practices and values of San Mateo County behavioral health programs that all employees, regardless of position, should know and understand. Topics for Foundational Knowledge trainings have evolved and expanded in various iterations of WET Plans.

Table 1. Foundational Knowledge Trainings Prioritized

Topic	FY 2009-10	FY 2011-14	FY 2014-17
Cultural competence/humility	X	X	X
Stigma reduction	X	X	X
Self-care	X	X	X
Consumer and family training and support/support and integration of families in treatment	X		X
Customer service	X		
HIPAA and confidentiality	X		
Developing consumer-centered system	X		
Crisis management and safety		X	X
Legal and ethical issues		X	X
Partnering and Collaboration		X	X
Integration of Primary Care and Behavioral Health		X	X
Knowledge of BHRS and Partner Programs		X	X
Spirituality and Behavioral Health		X	X
Managing Assaultive Behavior		X	
Trauma/trauma-informed care			X
Co-occurring-informed care			X
Wellness and Recovery			X
Quality Improvement/Documentation			X
Welcoming and Engagement			X
Inclusion of Indigenous Healing Practices in Tx			X

Special Populations

WET Plans also identified special populations for whom behavioral health staff should receive tailored trainings to effectively treat and serve these special populations. Language used to identify these communities changed over time. The 2014-17 WET Planning stakeholder groups and surveys identified certain cultural groups as special populations, evidence of increased awareness that culture and community-specific trainings help improve quality of services for these groups.

Table 2. Special Populations Identified by Stakeholders

FY 2009-10	FY 2011-14	FY 2014-17
LGBTQQI	LGBTQQI	The LGBTQQI – emphasis on the transgender community
Gender-responsive treatment	Survivors of domestic violence	The Chinese Community
Infants and early childhood	Chinese	The Pacific Islander Community
Developmental disabilities	Filipino	The African-American Community
Abused children	Pacific Islander	The Latino/Hispanic Community
Family law participants	African American	"At-risk" Youth and Transitional Age Youth
Adult survivors of abuse	Latino	Individuals in the Criminal Justice System
PTSD	Co-occurring Disorders	The Aging and Older Adult Population
Geriatric		Individuals with Co-Occurring Mental Health and Substance Use Conditions
Cognitive disorders		Individuals with developmental disabilities – Pervasive Developmental Disabilities
Victims of domestic violence		

The 2014-17 WET Plan identified only 4 cultural communities as special populations (the Chinese Community, Pacific Islander Community, African-American Community and Latino/Hispanic Community). A more recent survey in 2017 identified 10 cultural communities meriting training attention (the African American Community, Arab Community, Asian American Community, Black Community, Chinese Community, Filipino Community, Indigenous Community, Native American Community, Latina/a/x Community [including youth and families], and Pacific Islander Community). Survey respondents additionally indicated need for trainings that address the experiences of marginalized communities, newly immigrated communities, the LGBTQ community (with a focus on transgender people), and spiritually-based communities.

Clinical Competencies and Skills

In addition to Foundational Knowledge, stakeholder groups and surveys identified key areas of clinical competency that should be prioritized for staff training. In various WET Plans, these areas included:

Table 3. Key Areas of Clinical Competency Identified by Stakeholders

FY 2009-10	FY 2011-14	FY 2014-17
Motivational Interviewing	Culturally appropriate responding	Assessing and Treating Suicide Risk/Harm
Integrated treatment of co-occurring disorders	Working with complicated families	Trauma-Informed Care
Cultural humility in clinical assessment	Assessment and Diagnostic skills for substance abuse	Assessment and Diagnosis of MH and SU Conditions
Support of informed consent and choice	Motivational enhancement	Working Effectively with Complicated Families
Wellness Recovery Action Planning	Assessment and Diagnostic skills for mental health	Self-Care
Illness management and recovery	Personality Disorder	Client-Centered Treatment Planning and Documentation
	Relapse Prevention	Crisis Management/Safety
	Assessing Strengths and needs	Working Effectively with Undocumented Families
	Mindfulness Skills	Assessing/Managing Assaultive Behavior
	Client Centered tx planning and documentation	Professional Ethics
		Motivational Enhancement/ Engagement in Treatment
		Relapse Prevention
		Cultural Humility
		Partnering and Collaboration
		Co-occurring Informed Care
		Wellness and Recovery
		Mindfulness Skills
		Group Treatment Skills
		Clinical Supervision
		Integration of family partners/ peers support workers in Tx
		Clinical Case Management
		Integration of Spirituality
		Integration of non-traditional healing practices

Treatment Practices

Stakeholders including consumers and their family members, administrative and managerial staff, and direct services staff identified a number of specific treatment practices to include in the FY 2009-10 WET Plan. Over time, the Specific Treatment Practices became more aligned with State- and Federal-level interventions and requirements, as well as such emerging trends as mindfulness-based interventions.

Table 4. Treatment Practices

FY 2009-10	FY 2011-14	FY 2014-17
Cognitive Behavioral Therapy (CBT)	Trauma Focused CBT	Trauma-Informed Care
Trauma-focused CBT	Advanced CBT	DBT/ DBT Informed Treatment
Family Psycho-Education	Solution focused Treatment	Seeking Safety
Supported Employment	Trauma Recovery and Empowerment Model	CBT for Psychosis
Assertive Community Treatment (ACT)	Seeking Safety	Motivational Interviewing
System of Care and Wraparound	Group Treatment Methods	Brief Family Therapy Models
Dialectical Behavioral Therapy (DBT)	Relapse Prevention	Mindfulness-Based Interventions
Functional Family Therapy (FFT)	DBT	Attachment-Based Therapy Models
Aggression Replacement Therapy (ART)	Brief and Strategic Family Therapy	Wellness Recovery Action Plan
	Family Therapy	Solution Focused Therapy
		Cultural Humility
		Relapse Prevention Therapy
		EMDR
		Brief Psychodynamic Therapy
		Group Treatment
		Somatic Therapy
		NMT
		CBT for Insomnia
		Peer Support/Peer Counseling
		Outcome Informed Services

Fiscal Investments

Workforce Education and Training (WET) received a total $3,437,600 funding allocation in FYs 2006-07 and 2007-08. In FYs 2014-17, BHRS invested $1,308,920 of the total allocation to WET activities. Following is a snapshot of the funding distribution by year and categories based on the WET Plan. There are six categories that reflect the components of the WET Plan, with Training, Technical Assistance and Capacity Building divided into two subcategories, Trainings for System Transformation and Trainings for/by Consumers and Family Members.

Overall Distribution of WET Investments (2014-17)
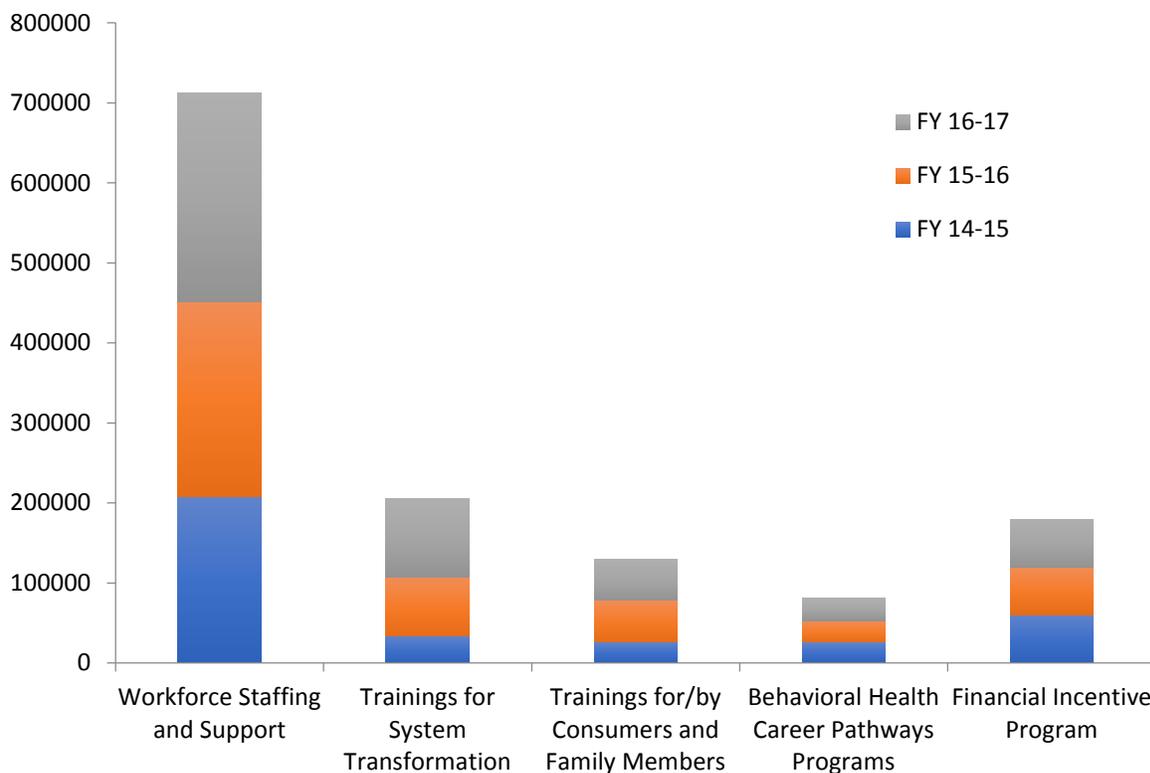
- **Workforce Staffing and Support**, which accounted for over 50% of the total investment ($712,316). Prior to the 2014-17 WET Plan, the WET team had the equivalent of 1.5 full-time staff (referred to as 1.5 FTE), but MHSA funding allowed the team to increase to 2.0 FTE in FY 2014-15 and currently, 3.0 FTE. This additional staffing proved crucial to sustaining the 2014-17 WET Plan, particularly to support trainings, which also received substantial increases in funding.

WET Investments (non-staffing)
FY 2014-17

Legend:
- ■ Trainings for System Transformation
- ■ Trainings for/by Consumers and Family Members
- ■ Behavioral Health Career Pathways Programs

Pie chart values: 34%, 22%, 14%, 30%
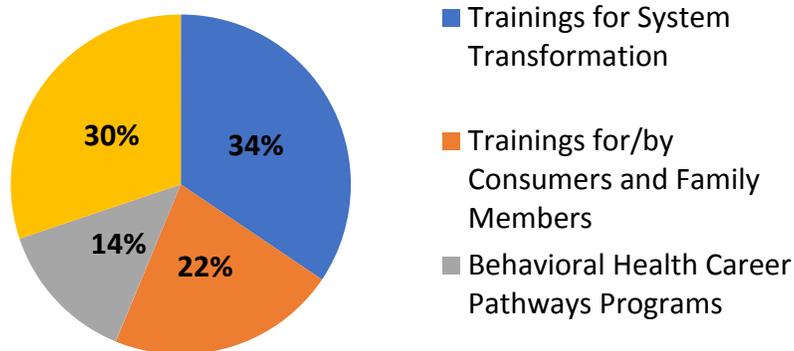
- **Trainings for System Transformation** represented 34% of non-staffing WET investments. From FY 2014-15 to FY 2016-17, funding in this category increased nearly three-fold, from $34,150 to $98,650. With this funding, BHRS was able to offer substantially more trainings designed to reduce health disparities in the community, provide instruction in culturally and linguistically competent services, and increase access, capacity, and understanding of mental health issues; as well as more trainings on evidence-based practices. This funding also enabled BHRS to partner with community groups and offer educational and training activities to consumers, family members, providers, and those working and living in the community.

- **Trainings by and for Consumers and Family Members** nearly doubled between FY 2014-15 and FY 2016-17, from $26,354 to $51,900, and accounted for 22% of total non-staffing investments from 2014-17. These trainings aimed to increase understanding of mental health issues and reduce stigma among consumers, family members, and the general public. Trainings also increased consumers' and family members' knowledge of substance use/abuse issues, recovery and resilience, and available treatments and supports. This funding also enabled consumers and family members to attend leadership trainings to support their increased involvement in various committee, commission, and planning roles. Taken as a whole, these substantial increases in training investments represent BHRS' commitment to reducing health disparities, providing culturally and linguistically competent services, increasing understanding of mental health issues, and empowering consumers and family members.

- **The Behavioral Health Career Pathways Program** investments remained relatively stable and included the Intern/Trainee Program and Behavioral Health Career Pathways Program to encourage San Mateo County high school students to explore future careers in behavioral health. Together, they accounted for 14% of total non-staffing investments from 2014-17. The Intern/Trainee Program increased by only $1,000 per year between FY 2014-17, while funding for the Behavioral Health Career Pathways Program remained at a stable $25,000 annually and was discontinued FY 2016-17.

- **Financial Incentive Program** consisted of the Cultural Competency Stipend Internship Program (CCSIP) and the Lived Experience Scholarship Funds and represented 30% of non-staffing investments. CCSIP funding remained at a consistent $50,000 annually and The Lived Experience scholarship remained at a consistent $10,000 annually between FY 2014-17.

Stakeholder Input

The stakeholder engagement process included the WET Survey for staff, community-based partners, and contractors, and the Workforce Development and Education Committee World Café. The data collected during this process is being used to develop staff training priorities for the next three years of WET Planning (2017-20). As with the previous WET plan, there are four major areas/topics of training: Foundational Knowledge, Special Populations, Clinical Competencies and Skills, and Treatment Practices.

Survey Results - Priority Training Areas

The WET Survey for staff, community-based partners, and contractors was administered to all BHRS and contract agency staff in all positions (i.e. clinical, administrative, managerial, peer positions, etc.). The survey asked respondents about priority areas and training topics; specifically, areas/topics in which they would like their providers to be trained, and in which they would like to receive training.

Overall Training Priorities

All survey respondents were asked to identify BHRS' top training needs as a free response; this allowed us to see whether responses clustered around similar themes without providing options that would bias responses. Given that many respondents have direct contact with clients/consumers, it is unsurprising that the most frequently identified training were related to treatment modalities and clinical interests:

- **Evidence-based practices (EBPs)** – such as Cognitive Behavioral Therapy, Dialectical Behavioral Therapy (DBT), and Eye Movement Desensitization and Reprocessing, Motivational Interviewing.
- **Required trainings** – such as for the Board of Behavioral Sciences (AIDS/HIV training, Law & Ethics training) and Alcohol and Other Drugs contractor required trainings (EBPs, Title 22, CLAS).
- **Other Treatments/interventions** – including psychosocial interventions, peer support integration models, sexual abuse prevention and interventions, and non-verbal modalities such as art therapy and play therapy.
- **Cultural humility** – free responses included trainings on cultural differences, white privilege and systemic oppression, cultural humility/diversity conversations, social equity trainings
- **Career development** – several other responses mentioned topics related to career development, including peer training for certification, culturally informed supervision training, and training on becoming a clinical supervisor.

Foundational Knowledge

Foundational Knowledge areas represent the practices and values that all employees, regardless of position, should know and understand. Staff, community-based partners, and contractors identified the following top training areas, in order of priority:

- Trauma-informed care
- Self-care
- Co-occurring-informed care
- Welcoming and engaging all clients/consumers
- Cultural humility/responsiveness

Clinical Competencies and Skills

Staff who have direct contact with clients/consumers were asked about their priorities with regards to training in clinical competencies. These staff provide direct assessment and treatment-related services, including intake/assessment, counseling, advocacy, and education for consumers and/or family members. The following top clinical areas were identified, in order of priority:

- Trauma-informed care
- Co-occurring-informed care
- Self-care
- Alcohol and other substance use
- Assessing/treating suicide risk/harm
- Assessment and diagnosis of mental health and substance abuse conditions

Clinical staff were also interested in receiving more training in the following priority EBPs:
- Neurosequential Model of Therapeutics (NMT)
- Mindfulness-based interventions
- Attachment-based therapy models
- Motivational Interviewing (MI)
- Eye Movement Desensitization and Reprocessing (EMDR)

Clinical staff were asked about specific mental health conditions/diagnoses for which they would like more training. This question received fewer responses overall, most were interested in:
- Personality disorders (e.g. narcissistic personality disorder, borderline personality disorder, etc.).
- Psychotic disorders
- Co-occurring conditions with mental health, substance use, and physical health issues
- Trauma and trauma-focused care

Administrative Staff Training Priorities

Administrative staff included front office, reception, fiscal/billing, support, contracts, quality management, and information technology staff. Their top five training priorities were:

- Managing crisis phone calls
- Engagement and welcoming
- De-escalation of conflict
- Self-care for administrative staff
- Roles and responsibilities when engaging with consumers/family members

Managers/Supervisors Training Priorities

Managers and supervisors oversee staff performance, as well as programmatic and clinical operations. Their top five training priorities were:

- Creating safety and trust among teams
- How to give and receive feedback in a culturally sensitive/responsive way
- How to facilitate dialogues on racism, sexism, etc.
- Increasing staff motivation
- Documentation for supervisors of interns and trainees

Training Modality and Structure

Hands-on interactive/experiential workshops were the most preferred training modality, followed by in-house expert consultations. Case presentations/consultations, didactic lectures, ongoing seminars, and coaching were also preferred by many respondents. In their free responses, respondents also recommended mentoring, videos for training (separate from Webinars), and in-person "behind the mirror" trainings with real clients as other training modalities to consider.

The most preferred structure and length of trainings were half-day trainings (starting in the morning) and full-day trainings. Half-day trainings (starting in the afternoon), two-hour trainings, and one-hour trainings were preferred half as frequently.

Other recommendations related to modality and structure included offering more trainings in general, offering trainings more than once to provide more opportunities to attend, offering small group trainings, and incorporating more group interaction within trainings. Some of these recommendations clearly complement each other; for example, small group trainings can accommodate more group interaction within each training. An example of how WET has already responded to such recommendations is the "Becoming Visible" training on Sexual Orientation and Gender Identity: this training is being offered twice a month in FY 17-18 in order to reach a broad audience, including BHRS staff, community partners, and contractors.

Workforce Development and Education Committee Priorities

On April 28, 2017, a World Café-style[i] session was facilitated for the Workforce Development and Education Committee (WDEC). Six BHRS staff members and four representatives from community-based partners (Caminar, Daly City Youth Health Center, Edgewood and Your Strength to Heal) participated; all participants are current members of WDEC. The session focused on three topics: Training Priorities, the Impact of WET, and the WDEC's Vision for WET moving forward.

WDEC Identified Training Priorities

Participants identified the following training priority areas: data collection and management using a health equity frame, alcohol and other drugs, certification tracks for individuals with lived experience, trauma-informed systems, self-care, and specific trainings.

- **Data Collection and Management Using a Health Equity Frame –** the group recommended that there be trainings on performing community assessments and data collection to inform equitable quality services. These trainings should use CLAS requirements as a core principle for providers, and not only for prevention staff. One participant also recommended using process evaluations to assess the efficacy of training implementation.

- **Alcohol and Other Drugs –** several training priorities in the area of alcohol and other drugs (AOD) were identified, including substance use, co-occurring-informed care, and including more people with substance use lived experience on training panels. One participant observed that AOD treatment is different from mental health treatment, and that more training specific to AOD would improve this understanding.

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[i] http://www.theworldcafe.com/key-concepts-resources/world-cafe-method/

- **Certification Tracks for Individuals with Lived Experience –** several participants indicated that there is a need for certification tracks, especially for peer support workers. Certification tracks would allow individuals with lived experience to find new career paths within clinical/support fields without needing to complete a graduate school track. An example of such a program was the AOD Training Academy held in FY 2017-18.

- **Trauma-Informed Systems –** the group felt that BHRS needs to move beyond trauma-informed care to deeper trainings that support the development of a trauma-informed system. Participants noted that this effort should be staged across three to five years and monitored at each step so that the transformation to a trauma-informed system is carried through. Related trainings should also include the importance of culturally-informed care. Training administrators would also be needed to evaluate the utility of trauma-informed principles in their work. A Bay Area initiative, Trauma Transformed, focused on developing trauma-informed systems was mentioned as a potential resource[ii].

- **Self-Care –** continued attention to self-care should be a priority, as the group felt that it was "not happening" with consistency and clarity of purpose. One recommendation was to use trainings as settings for self-care and processing, with the goal of creating a culture where staff build more self-care into their daily work.

- **Specific Training Topics –** in addition to the training areas described, participants identified the following specific trainings and training topics as priorities:
  - Acuity and risk increase
  - Cult abuse
  - Culturally appropriate trainings, especially on suicide
  - Harm reduction
  - Human trafficking
  - Practical skills, especially for people in direct service
  - How to use community resources and free support services
  - Suicide among specific population (e.g. Dr. Joyce Chu's suicide among Chinese adolescents)
  - Recovery oriented clinical services
  - CBT
  - CBT for Psychosis
  - Child Management techniques
  - Collaborative Problem-Solving for Clinicians and Social Workers
  - DBT
  - EMDR
  - Motivational Interviewing
  - NMT
  - Positive Parenting Program
  - Psychoeducational
  - Substance use prevention
  - Relapse Prevention
  - Crisis/suicide/assault intervention (i.e. Crisis Intervention Training)
  - Tobacco Cessation
  - Clients' stories

[ii] http://traumatransformed.org/

WET Impact

Both survey respondents and the WDEC where asked about how WET has shaped the culture of BHRS, as well as how trainings have impacted them individually. Overall, stakeholder input was positive and majority of stakeholders acknowledged how WET trainings are able to shape BHRS' culture and enhance services by providing opportunities for all to learn and practice cultural humility, igniting much needed system transformations, allowing for new insight and awareness, promoting dialogue, increasing understanding, and ultimately better serving clients.

There were specific programs/trainings that were mentioned as being particularly impactful including the Lived Experience Academy, Neurosequential Model of Therapeutics (NMT), Seeking Safety, the Health Ambassador Program, Mental Health First Aid, Health Equity Initiatives, anti-stigma work, and the internship program. The following themes capture the comments from the perspective of survey respondents and WDEC participants:

Improving Cultural Humility

The most commonly mentioned accomplishments of WET in shaping the culture of BHRS were related to improving cultural humility, multiculturalism, and cultural sensitivity. Many respondents also felt that they had been personally impacted by cultural humility-related trainings, with one writing that such trainings gave them "greater awareness and better practice methods on how to work with specific populations." Leanna Lewis' trainings and consultations on cultural humility were mentioned specifically, but culturally informed trainings in general have also made a difference.

Increasing Focus on Trauma-Informed Care

WET trainings have had an impact on increasing focus on trauma-informed care. Participants observed that cultural humility and trauma are the "big platforms" for BHRS/ODE's WET investments. It was noted that people continue to ask for more trainings, it is a constant request. It was also noted that because trainings are left to individual choice versus being a requirement for all, it may not be sufficient to laying the groundwork for trauma-informed systems change.

Cultural Humility and Trauma Informed

"Cultural Humility gave me a helpful frame for addressing a microaggression I experienced, which was empowering."

[trainings on cultural humility] "open the door for difficult and important conversations amongst staff."

"become very sensitive to the impact trauma has on myself and others. I am aware that there is so much I don't know and need to learn as I interact with others."

Creating a Culture of Learning

BHRS' 20-hour training requirement was identified as having an impact on the institutional culture of learning and growing. Several respondents felt that having more trainings available was helpful to their work. Other clinicians stated that trainings related to licensing and opportunities to earn CEUs were valuable.

Improving the Standard of Care

The impact of WET on cultural humility was even more poignant in relation to how trainings affected providers. Exposure to cultural humility-related trainings permeates into providers' work and interactions with clients/consumers. Additionally, several respondents felt that trainings helped enhance providers' clinical skills.

Valuing Lived Experience

The Lived Experience Academy (LEA) and Lived Experience Education Workgroup (LEEW) were especially important for increasing peer support and training. The establishment of LEEW was cited by many respondents as crucial to welcoming staff with lived experience into BHRS, impacting BHRS' culture. Other respondents felt that incorporating lived experience into trainings increased their level of support for the work of lived experience staff, as well as enhanced connections among different staff.

Building Capacity for Co-occurring Care

While systems for co-occurring AOD and mental health capability have developed, participants felt that resources were still needed. There are greater interactions and integration of services between substance abuse providers and mental health treatment providers, and more interaction with other systems such as health and criminal justice, towards an Organized Delivery System. Additionally, these efforts have helped to identify change agents from all agencies, giving people within the system a place for networking, cross-training and cross-pollination, resulting in a significant shift in the work and moving the work out of prior silos.

Increasing Awareness of the Importance of Self-Care

Participants noted the importance of self-care and trainings related to it yet, awareness of the importance of self-care is not sufficient to creating a system that supports it across all staff levels. It was noted that lots of workers burn out, and they have no ability or mechanism to refresh within their current work environment. Additionally, there are still legal obstacles and limitations in place because of the union. There is still very little preventive care for this workforce, and employees have to fight for their self-care needs to be honored.

Culture of Learning

"I have appreciated being exposed to dialogue that I can bring back and apply directly."

"Hearing a perspective of the people I work with in words that resonate with me so that I can listen to people better."

"[Trainings have] encourage[d] ongoing learning to better serve clients at BHRS."

"Learning empowers me to keep fighting the good fight!"

Standard of Care

[trainings] *"have allowed providers of treatment to explore new possibilities and promote insight and awareness."*

"Ongoing education is so important for a clinician. It really raises our standard of care."

Lived Experience

"incorporating lived experience at trainings has help[ed] me and others put a face to the training...very important...please keep this up."

Focusing on Client Centered Services

Participants acknowledged that WET investments have helped impact the focus on client outcomes. All decisions (clinical and non-clinical) should be made through the lens of how they will benefit clients and families. "Client-centered" is more than clinical, and involved continuous quality improvement, not just quality assurance. Efforts should be made such that all decisions should derive from client- and family-centered perspective, and that we are present for them and coming from a place of love vs. judgment.

Challenges

Need to Focus on Systemic Changes

WDEC participants noted that they feel that there needs to be more conversation about how to perpetuate systemic changes fostered by trainings so that they result in systems transformation. These transformations need to be seen in policies and qualities of leadership. There is a need to create ways of measuring the impacts of workforce education and training that are aligned with the goals of systems change. This was also mentioned by survey respondents on a number of occasions as they discussed trauma informed care and self-care for example and the feeling that there is still not a system that can support full implementation.

Systemic Transformation

"The goal should be a systemic transformation that includes everyone, from janitor to judge."

Additional Comments

A small number of survey respondents were "not sure" or felt that they had not been impacted by trainings. One respondent noted that the WET investments have tended to privilege mental health over AOD, noting how this "shapes what staff perceive as priorities; because most training are focused on mental health, it is perceived as a priority over substance use."

Vision for WET Moving Forward

Cultural Humility

Stakeholders were also asked about what areas of training should receive ongoing investments. Cultural humility (multiculturalism, social equity, power/privilege, etc.) and culturally informed trainings received the most responses, with one respondent writing, "Cultural Humility is an entry point, but we need to dig deeper!" At least one respondent also noted that the Health Equity Initiatives have an important role to play as trainers and providers of key information and perspectives, stating that they would like to see ongoing investment in trainings from such teams as the Native American Initiative, Latino Collaborative, and PRIDE Initiative.

Trauma-Informed System and Self-Care

Trainings on trauma-informed care and NMT received the second-highest number of responses followed by Self-Care. Specifically, continuing to invest in building a *trauma-informed system* – moving beyond trauma-informed care – built on social determinants of health as a foundation with the vision of building a permanent culture within BHRS' network of providers and organizations. Participants connect this vision to a system that supports *self-care* as well. Specifically, there needs to be a greater focus on self-care to prevent burnout in the workforce and continued investment in WRAP trainings.

Youth Career Path Development

Another vision is connected to workforce development through a focus on *youth career path development* in behavioral health fields. One participant pointed to youth training being done in the Filipino community as an example. Participants also would like to see greater youth representation in regional meetings.

Lived Experience-Focused Trainings

WDEC participants see a continued investment in *lived experience-focused training*, with a goal of honoring lived experience people by making trainings more inclusive and welcoming. WDEC would also like to see more lived experience people in trainings as a goal moving forward. *Certification courses* were mentioned as a vision.

Alcohol and Other Drugs (AOD)

Several participants would also like to emphasize AOD moving forward. Recommendations include addressing *the needs of AOD treatment providers* who often face barriers to training due to the nature of their work (such as evening hours, financial constraints, long commutes, etc.) that limit their ability to participate in, and benefit from, training opportunities. There is a wish for AOD providers and interns to collaborate more. Lastly, there is a vision is to create and support a culture that recognizes that "sobriety does not equal wellness," and that being sober is just the beginning of the journey to recovery.

Specific Trainings

The group would like to see *guiding principles for all trainings/programs* developed by BHRS/ODE, and that these be a focus of future trainings. Other program ideas include:
- Service learning projects
- Training focused on long-term recovery such as Voices of Recovery
- Human trafficking training
- Family treatment models
- Training to SOGI standards (it was noted that San Francisco Department of Public Health makes training on gender orientation mandatory, and that this should be considered).
- Trainings from the Bay Area Regional Health Inequities Initiative[iii] (County of San Mateo Public Health, Policy and Planning Department is a member of the initiative)
- Grant writing and organizational development

[iii] http://www.barhii.org

Other Comments

- **System Change –** Focusing the work of the WET Coordinator on system change priorities
- **Decentralized Training System** – Developing policies and structures for training that can be developed in house
- **System Orientation for Contractors** – using BHRS College for contractors to learn about BHRS. Related to this, the group suggested that there be a survey to identify who can offer specific trainings and experiences within BHRS in order to maximize internal resources as well as acknowledge strengths that are untapped within the system.
- **Improved Communications of Trainings** – there was a request for improved communications so that training opportunities are seen earlier, and for a more integrated communication system that is connected to calendaring.
- **Intern Training Manual** –that can be used system-wide towards improving clarity of goals, tracking of outcomes, and continuity in order to level the field of practice. Should include an interview process for interns.
- **Crisis Intervention Team (CIT) Shared Curriculum** –develop a strategy for sharing curriculum across the system with providers.
- **Online Training** – it was observed that the system is not meeting its goals for providing webinars, while also noting that face-to-face training is a preference that might be impacting this outcome.

Lived Experience Education Workgroup and Lived Experience Academy

In addition to the surveys and dialogues conducted with staff and providers as described above, it was important to delve deeper into WET funded programs.

Overview

The **Lived Experience Education Workgroup (LEEW)** engages clients, consumers, and family members and prepares them for workforce entry, advocacy roles, participation in public committees/commissions, and other empowering activities. In addition to those with lived experience, BHRS and contractor staff also participate in the LEEW, which oversees the **Lived Experience Academy (LEA)**. Graduates of LEA train to share their stories as a tool for self-empowerment, stigma reduction, and public education about behavioral health issues through the LEA Speaker's Bureau. Speakers are compensated at a rate of $35 per hour to speak at BHRS trainings and events throughout San Mateo County.

As of Spring 2017, there were approximately 40 LEEW members, with 20 active members. The Enhancement of Lived Experience Workgroup Report, submitted to ODE/BHRS in March 2017, found that this is less than what is needed for clients/consumers with lived experience to be fully represented throughout the system of care. Specifically, additional consumers and family members would enhance the work of the Community Service Areas (CSAs) and Health Equity Initiatives (HEIs), as well as increase participation in competitive employment. In 2016, LEEW members participated in the Mental Health and Substance Abuse Recovery Commission; BHRS Quality Improvement/Quality Management; Workforce Development Meetings; Housing, Operations & Planning meetings; CSA committees; and various ODE HEIs.

Participating in LEA had positive and far-reaching impacts on BHRS consumers. As one Listening Session participant described it:

"Empowering. Non-shameful. A supportive journey. I felt that I was not just a consumer, but part of the team. My mentally ill children have a different experience of me now. We all have our individual stories. This helped me with my children, moving them from street drugs to taking their meds, and they are now open to seeing the psychiatrist."

Methods

"I've gone from a really good life to nothing to starting to build my life back up again...If not for LEA and other classes offered by BHRS, I would not be where I am today."

- LEA participant

In the Spring 2017, three methods of data collection were used in this evaluation conducted:

- **LEA Survey** – current and former LEA participants were surveyed about their perceived outcomes and level of agreement to a series of statements.
- **LEEW Listening Session** – current and former LEA participants were invited to attend the Listening Session held on April 4, 2017. The focus of was LEA's impact on community involvement and personal and professional development.
- **LEA Interviews** – former LEA participants were interviewed for a deeper perspective of LEA's impacts.

Results

Lived Experience Academy Survey

A total of 14 current and former LEA participants responded to the WET Survey. Almost all respondents felt that LEA met its goal of preparing graduates for workforce entry, providing them with knowledge and skills necessary to work in behavioral health. Almost all survey respondents also felt empowered to share their stories as a result of their participation in LEA.

Legend: ■ Strongly Agree ■ Agree ■ Neutral ■ Disagreed

"Lived Experience Academy prepared me to w... reduce stigma of behavioral health and red... topics, issues and services in the commu... — Strongly Agree: 8, Agree: 6

"I have had opportunities to use the skills, value... perspectives fostered through the Lived Exper... Academy in my work and/or advocacy... participating in the prog... — Strongly Agree: 6, Agree: 5

"I would recommend the Lived Experience Aca... to people I know who are interested in learning... about peer roles and career paths in beha... health and reco... — Strongly Agree: 10, Agree: 3, Disagreed (yellow)

"Because of my participation in the Lived Exper... Academy, I am better prepared to be a part... behavioral health workf... — Strongly Agree: 8, Agree: 5

"The trainings I received as a participant in the... Experience Academy matched my goals for grow... knowledge and skills in the area of behavioral... and recovery stigma reduc... — Strongly Agree: 5, Agree: 8

"Because of my participation in the Lived Exper... Academy, I feel more empowered to share my... as a client/consumer/family men... — Strongly Agree: 9, Agree: 4

"I felt inspired to see the growth and empower... of other Lived Experience Academy peers in ter... crafting their sto... — Strongly Agree: 7, Agree: 4

Survey respondents identified two main areas of impact on their current work and/or professional development: (1) improved ability to participate in the behavioral health workforce, and (2) increased comfort and confidence in sharing their own story.

Open-ended responses to the survey indicated that participation in LEA helped trainees process their feelings and support others, "Initially, LEA helped me process my own feelings about the experience, and I went on to become increasingly effective at supporting other family members in learning effective advocacy skills." Another participant wrote, "I am advocating more for people who are either not aware of the opportunities for them to speak up or unable to because of the severity of their condition."

Furthermore, survey responses highlighted the value of LEA's close partnership with ODE, as respondents expressed confidence in the positive impacts of ODE's work. Respondents also indicated that ODE is a key player in equity and diversity in San Mateo County.
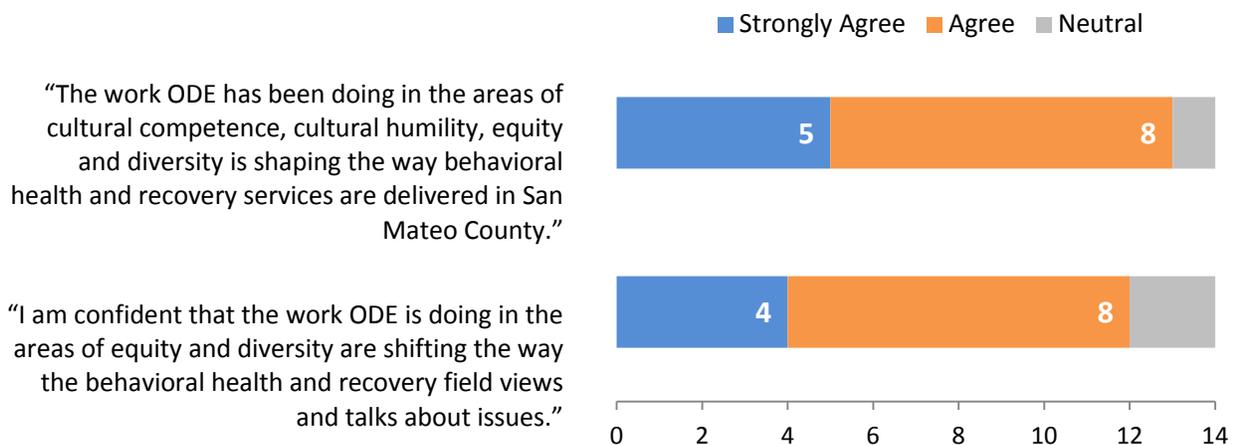
In their open-ended responses, survey respondents also identified at least two areas of improvement for LEA: (1) increasing the number of speaking opportunities, and (2) having ongoing, additional training, with more cohorts of LEA annually. Some examples of responses include the following:

> "I wish there were more opportunities for me to be able to use the new capabilities I achieved through the Lived Experience Academy."

> "I had a great experience going through the LEA…I wish there were more opportunities for speaking."

> "There should be more training so people can have more tools in the box."

> "Keep supporting this important group, INCREASE number of academies each year. Use your contract agencies to leverage your capacity to teach this."

Taken as a whole, these survey responses indicate that LEA is a valuable resource for preparing clients/consumers and family members with lived experience to participate in the behavioral health workforce. Not only does LEA arm graduates with knowledge and skills in the area of stigma reduction and advocacy, it empowers and inspires participants to share their stories and support others. Additional training opportunities and speaking engagements would help increase the presence and inclusion of individuals with lived experience in the behavioral health workforce.

Lived Experience Education Workgroup Listening Session

A total of 16 LEEW members participated in the Listening Session, including ODE/BHRS staff and LEA participants who are currently employed within BHRS or with partner CBO's. The Listening Session focused on LEA's impact on personal and professional development, as well as community involvement. Among the strongest outcomes of LEA identified by the Listening Session participants were **empowerment**, increased **confidence** and **reduced shame**, and **reduced isolation**.

> *"My story is empowering, I can now sit comfortably with diverse clients, they tell me that I am of service. There is a life after hospitalization. LEA helped me with my story, which I share."*
>
> *"My life has changed dramatically, now I see myself, how I allow others to see me, more confident than I ever thought I could be. I am free because of LEA."*
>
> *"I am no longer ashamed about my condition."*

With specific regards to motivational interviewing training, participants noted, "[it] bolstered my self-confidence," and, "The program teaches us to fight against self-stigma."

Community-building aspects of LEA were also noted, with Listening Session participants speaking specifically to how LEA helped **reduced feelings of isolation**:

> *"I was isolated from my family. The LEA Speakers Bureau helped me to talk to my family and get through to them about what triggers me and what helps."*
>
> *"We all shine because of the program. It is like family – non-judgmental, reduces loneliness, very therapeutic."*
>
> *"I felt lots of self-guilt, family and peer guilt. I am part of my community, part of something, because of LEA."*
>
> *"I'm homeless but I don't feel homeless."*

Greater confidence

"My life has changed dramatically, now I see myself, how I allow others to see me, more confident than I ever thought I could be. I am free because of LEA."

Reduced Isolation

"I felt lots of self-guilt, family and peer guilt. I am part of my community, part of something, because of LEA."

Listening Session participants also shared that LEA was intimately connected to their **healing**, with one participant saying that they, "Found it very healing and liberating…telling your story lifts you." Another noted the **transformative** nature of the process, saying, "To be able to look in the mirror and say 'I forgive myself' has been transformed into acceptance, 'I accept myself.'" In the realm of professional development, Listening Session participants noted increased **empathy** and improved **communication**.

Empathy

"I've been part of the County system for the past 20 years. Through LEA, I saw that I was more like clients than I had acknowledged."

Communication Skills

"The experience of going through LEA has helped my communications skills, I am amazed at myself that I could share without crying."

"I have so many stories. Which to tell? The tools we learned in LEA were useful for helping me organize my thoughts."

Lived Experience Academy Interviews

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

- LEA participant

Three former LEA participants were interviewed. The interviewees represented participation across the timeline of LEA program implementation, with participants from the 2012, 2013, and 2015 cohorts. They represented ethnic/racial diversity, with one African American, one Latino/a, and one Asian (Chinese) American participant. Two were male and one was female.

All three have sustained their involvement with LEEW: two have participated in facilitating the most recent LEA training, and two have additionally trained as presenters for BHRS. All three are also involved in the work of related efforts (e.g. participation in HEIs, specific committees, and other mental health consumer-led organizations such as NAMI and California Clubhouse).

The interviewees identified three key areas in which LEA made a discernable impact: at the **individual/personal level, the community level, and the systemic level.** The interviewees also expressed some disappointments, which revolved mainly around changes to the program.

- **Individual/Personal Level** – all three interviewees identified specific areas for skills and awareness that they gained through participation in the LEA, and similar to the Listening Session offered examples including increased **confidence** and a sense of **empowerment**, while feeling reduced shame and stigma.

  "LEA helped shape my participation and contribution, boosted my confidence and how I carry myself."

  "LEA helped take away the shame, and gave me confidence to share my story."

  "A lot of weight was lifted off of me once I could share my story. I was really ashamed of many things."

  "For many years, I felt so much shame, which prevented me from doing so many things. I felt weird and that I didn't belong. I used to pray that God would send me something awful so I can finally appreciate what I have. Shame, self-hate, guilt about mom, dad, little brother's experience of my illness."

  "A big challenge for us is stigma, most importantly self-stigma. When we feel that there is something wrong with us, it is difficult for us. When we tell our stories, it helps us to shed our self-stigma. It helps normalize things for us."

Empowerment

"I had never shared my story with anyone before… It felt really empowering, I wanted to share my story with a larger audience."

"I was nervous when I first spoke about my story, I was only comfortable in meetings where I knew everyone. To talk to others, doctors, classrooms, nursing school students, etc., was difficult for me. I've spoken through NAMI and other orgs. The training really helped me learn to speak more confidently."

The interviewees also echoed that LEA helped with their **recovery**:

"To have this training to help tell our stories, it has helped me with my recovery process also."

"The more we feel that we have support from others, the more it helps with our recovery process.

Beyond personal gains and healing, the interviewees also spoke of the importance of sharing their stories. They recognized the **value** of speaking with confidence about their experience in supporting and educating others and a sense of **validation** that allowed participants to reach beyond themselves, be part of the wider community, and help others:

"To be able to go through the training was exhilarating for me, being able to present to different groups, hear feedback, being able to provide support and advice for people. Hearing the feedback and responses was something I had not expected. People were genuinely interested in learning more, and this helped dispel some of the internalized shame I felt. I was more able to talk about my story with family, friends and acquaintances. It really boosted by confidence and self-esteem. This is my story and I am an expert on my story."

"I feel valued that I can help other people."

Confidence

"I was more able to talk about my story with family, friends and acquaintances. It really boosted by confidence and self-esteem. This is my story and I am an expert on my story."

Recovery

It's when we feel it is ok internally to have a mental health issue and that we are not going to be treated as a leper of some sort, we begin to be more of an advocate.

Validation

"The more we are validated for our feelings, the more comfortable we are in speaking out for our needs. We have a better ability to attend BHRS committee meeting to give our input about what is missing or overlooked or could be more helpful for us."

Similar to the Listening Session participants, interviewees also noted an increased sense of community through the LEA and reduced isolation:

> "LEA has the feeling of community that other trainings I have been through don't – community, genuine compassion and love."

> "I am definitely excited about the prospects of bringing my consumer perspective to this work in the future. It really feels like a family and community."

- **Community Level** – the interviewees expressed an eagerness to **participate** in participation in public committees/commissions, and other empowering activities:

> "If it wasn't for lived experience and advocacy trainings…I have been able to do so much more than before. I have participated in the Spirituality Initiative, Youth and Children's Services Committee (my son has mental health issues so I am a consumer and a family member), the Chinese Health Initiative…I attended the symposiums on Spirituality."

Furthermore, the importance of sharing their stories, as well as the boost in confidence to do so, was best expressed by the interviewees' newfound ability to advocate for themselves and others. **Advocacy** and an eagerness to give voice to others were brought up several times:

> "[LEA] helped me learn how to advocate for others with tact."

> "[LEA] helped me advocate for myself when my rent was being raised with the Housing Authority and my landlord."

> "As I took advantage of more opportunities, I had more capacity to help."

> "The way I see it, we who have mental health issues do not speak out for ourselves (the majority of us), so those of us who can have a responsibility to speak out for those who cannot."

Areas of advocacy need included decriminalization of the mentally ill, disability benefits, regulations that limit income for those receiving the benefit, and loss of life insurance policy due to it being seen as an "asset." This respondent further noted that the income limits and benefit amounts are not realistic given the cost of living in the Bay Area.

- **Systemic Level** – the interviewees identified three areas of systemic impact due to the investment made in the LEA. These impacts fall broadly into the following areas: *Lived Experience Voices, Workforce Diversity,* and *Movement-Building & Advocacy Opportunities.*

Advocacy

"My goal is always to give a voice to others who are silenced or feel that they have to hide due to stigma. I hope my voice can help give voice to others."

"I not only advocate for myself, but try to advocate for others to benefit their situation."

All three interviewees shared how their LEA training made it possible for them to present their stories in an array of settings, and how their voices made an impact on the way behavioral health professionals viewed people with lived experience:

> *"I was able to do presentations last year for the psychology interns coming into the hospital, 10-12 students working on their doctorates, through the Spirituality Initiative."*

> *"Since the course, I have spoken to middle and high school age children, to MFT trainees, pharmacology students, etc. It helps them understand what we go through, what are the challenges, and also how to work with us better. I have also spoken with people who run the 24-hour suicide prevention hotline, their feedback is that it helps them understand our mindset so they can do their job better."*

The interviewees also spoke to how LEA training made a difference in their own professional development, allowing them to enter and be successful in the behavioral health workforce.

> *"I work with CA Clubhouse, Heart and Soul, Stamping Out Stigma, the Peer Association we just started. … None of the things, awards, recognition, etc., plus my own desire to share my story, none of that would have happened without LEA."*

Significantly, the interviewees also discussed how LEA training and empowerment could build toward a collective movement. One interviewee shared a vision of shared advocacy paving the way to make bigger and more meaningful impacts.

> *"I have overcome a lot in the past 8 years, but I am at the point of wanting to have a bigger impact. People with insurance and/or money, they are living on the island of themselves. NAMI and CA Clubhouse are on their own islands. How do we get them to come together to coalesce and speak with a shared voice to make meaningful legislative changes? State, federal, local Board of Supervisors."*

Lived Experience Voices

"Before the advocacy group training, they didn't have consumers attending these meetings to give them direct feedback. It is tremendously helpful to them to hear from us."

Movement Building

"By training people with lived experience to share their stories, it builds a grassroots movement to help voice our concerns in a public arena."

Challenges

LEA interviewees shared some of their disappointments in the recent direction of LEA and LEEW. Many of these disappointments were related to changes in **program structure**, while others were related to the limited **opportunities available** for LEA graduates:

> *"I don't think the program is the same. Only one of their [recent] 8 graduates came to LEEW meeting. The curriculum has changed, no longer using the 7 elements of public speaking training. There are only 5 sessions now. They didn't use the seasoned facilitators from previous classes [this last round]. I have some dissatisfaction with LEEW group and how it is being held. They are doing only one LEA per year now, and we only have stuff to do during MH Awareness Month and Recovery Month/Suicide Prevention Initiative events."*

"The class size has been cut in half - only one group, and only 5 classes, and smaller group going through the LEA. We had 12-15 per group go through the whole thing in the past, with 25 people going through each year, now only 6-7 in the past year. There should be LEA in Spring and Fall, and Advocacy training in the summer."

"We used to have a lot more opportunities to speak, more happens in May which is mental health awareness month and in September which is suicide prevention month, but other months there are fewer opportunities. After the sessions and graduating, we were part of a Speakers Bureau, but not sure if I am still on the list. I wonder whether it is really active and actively managed by anyone. We used to have more opportunities to speak, was very active at one point."

"I want more speaking engagements. There are opportunities through Heart and Soul and NAMI, [and] LEA participants need to be connected."

"I would do more year-round advocacy, not enough opportunities for LEA participants currently."

"If the right opportunities come up, I would be interested. I have volunteered a lot - I've looked at RFPs, offered IT background to gather data, looking at data when it is related, they haven't taken me up on it. Even if they don't have funds, they could create volunteer opportunities for us that help with our sense of self-worth and recovery. I don't see people open to having volunteers in BHRS. I know of a handful of LEA participants who are working with BHRS as family partners or peer supports, there are a few of us, but few and far between."

Interviewees also expressed dissatisfaction with the **stipend levels**, a concern echoed in the WET Survey and Listening Session. While LEA Speakers Bureau participants previously received a stipend of $35/hour for speaking engagements, more recent LEA participants have been paid only $25. In a separate report,[iv] LEEW members also shared that the process of getting merited stipends appeared inconsistent. For some LEEW members, lack of clarity on whether ODE or the Office of Consumer and Family Affairs is responsible for distributing stipends led to significant delays in receiving stipends. In addition, LEEW members raised questions about whether LEEW members who are employed by BHRS or community-based contractors are eligible to receive stipends. From these accounts, it seems that changes in stipends – both amount and policy – have not been **clearly communicated**.

Perhaps one of the most revealing ways in which former LEA participants expressed their appreciation for the skills and community gained from their participation was in their desire for BHRS to support high-quality programming for people with lived experience, which stems from their belief that LEA helped them. Their hope is for programs like LEA to be available in order to help others.

"My vision is that BHRS starts taking care of this because it helps people, not just to do it."

"I just want it to be the same high quality it was in the past. Nothing bad to say about LEA in and of itself, it has helped a lot of people. Don't kill it, take care of it. We want it to be around for other people to enjoy and benefit from. It has helped a lot of people in different ways."

[iv] Enhancement of Lived Experience Workgroup Report by Ellie Dwyer, March 2017

Recommendations for LEEW and LEA

The following recommendations for LEEW and LEA are based on the results of the WET Survey and stakeholder feedback from the LEEW Listening Session and LEA Former Participant Interviews.

More trainings for leaders with lived experience

LEEW members would like to see more investments in training for leaders with lived experience, including more LEA cohorts, with more sessions. Refresher trainings were deemed useful, with particular interest in advocacy training (Advocacy Academy).

More opportunities to use skills learned from LEA

Noting that "sharing your story takes practice," LEEW members voiced interest in having more speaking engagements. Because of the empowerment, confidence, and value LEA graduates experience through sharing their stories, having such opportunities on a regular basis would greatly benefit LEEW members. Hearing the voices of people with lived experience would help clients and clinical trainees better understand the population they serve as well.

Integrate LEA into all consumers' recovery

Many Listening Session participants and interviewees said that LEA was integral to their recovery. They suggested that, for consumers who are ready, being able to go through a program that builds skills and confidence in sharing their stories should be an opportunity available to all. One former LEA participant stated, "If I had the ability, I would use my magic wand to make those who are at a level of readiness and recovery to take the LEA. It would be a formal part of peoples' recovery."

Cultural Competency Stipend Internship

Overview

The goal of the **Cultural Competency Stipend Internship (CCSIP)** is to provide more culturally responsive services to clients and the community. Up to 20 stipends are awarded annually to interns who are providing mental health and alcohol and other drug services within the Older Adult, Adult, and Youth systems of care, or interns who are providing coordination and logistical support in the Office of Diversity and Equity (ODE). Stipends are awarded based upon the trainees' ability to add to the cultural competence of services BHRS provides. Recipients of the stipend are required to participate in a Health Equity Initiative (HEI) project/program 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 our services and educating our staff as negotiated between the trainee/intern and the HEI co-chair.

Participating in CCSIP was a valuable experience. As one respondent wrote:

"This was a wonderful experience and I am so thankful for the opportunity. I would like to return to the Latino Collaborative once I return to the Bay Area after internship next year."

Highest priority is given to applicants who are bilingual and/or bicultural and whose cultural background and experience is similar to the clients he or she will serve or to an identified underserved population in the community for whom we would like to have more outreach. It is also a priority to award stipends to students who have personal or previous experience serving marginalized populations including:

- Gay/lesbian/bisexual/transgender/queer/intersex/two-spirit or gender-nonconforming clients
- Individuals or family members of individuals with lived experience
- Individuals with physical disabilities
- Individuals with lived experience as inmates in correctional settings

In FY 2015-16 CCSIP participants conducted projects in support of the Spirituality Initiative, the Filipino Mental Health Initiative, the Latino Collaborative, the Native American Initiative, the African American Community Initiative, the PRIDE Initiative, the Arab Community Workgroup, the Diversity and Equity Council, and the Chinese Health Initiative. Their projects included:

Surveys and Assessments:

- Two county-wide surveys that assessed clinician comfort in addressing spirituality in treatment in order to determine the impact of spirituality training and advocacy efforts on clinician practices. The surveys also sought to understand client perspectives on spirituality in treatment.
- An assessment of why African American males receive longer and harsher sentencing than European American males who have committed similar crimes through an examination of the role of psychological assessments in the sentencing process.
- Focus groups with African American/Black consumers and clients of BHRS to better understand how African Americans feel about and perceive access to care, welcoming at clinics and service points of entry, information provided and its relevance, treatment options and opportunities, experiential perceptions regarding Cultural Humility, and thoughts about what could be done better to improve their treatment experiences and outcomes.

Example of past CCSIP Projects:

A survey-based assessment of clinician comfort in addressing spirituality in treatment

Workshop on mental health and socio-emotional issues for a Filipino Barkada student group

Monthly newsletter with mental health information for the Latino Community

- Creation and facilitation of a workshop on mental health and socio-emotional issues at Westmoor High School for the Filipino *Barkada* student group.
- A presentation on mental health issues and services at the Moonridge facility in Half Moon Bay, which offers affordable housing through Mid-Peninsula to agriculture workers.
- A presentation to San Mateo County providers and the community on Native American mental health and strategies for working with the Native American community to improve health outcomes in this population. This project was part of a larger workshop that integrated various aspects of Native American healing practices, as well as experiential activities involving drumming.
- A presentation at the Mills High School Wellness Panel on childhood development and parent-child-teen communication in Mandarin Chinese.
- A three-day PhotoVoice workshop for older adult (age 60 and older) clients of BHRS.

Outreach Efforts:

- Creation of a subscription-based monthly newsletter to increase access to mental health information for the Latinos.
- Development of an up-to-date and sustainable social media presence and Website for the PRIDE Initiative that provides LGBTQQI2S individuals in San Mateo County with information about events, groups, and services for the community
- Direct outreach from the PRIDE Initiative to other HEIs in order to facilitate a conversation about the issues faced by the LGBTQ subpopulations of their respective communities.
- An outreach event and presentation to Arab communities in San Mateo County on behavioral health and recovery resources, services and issues.
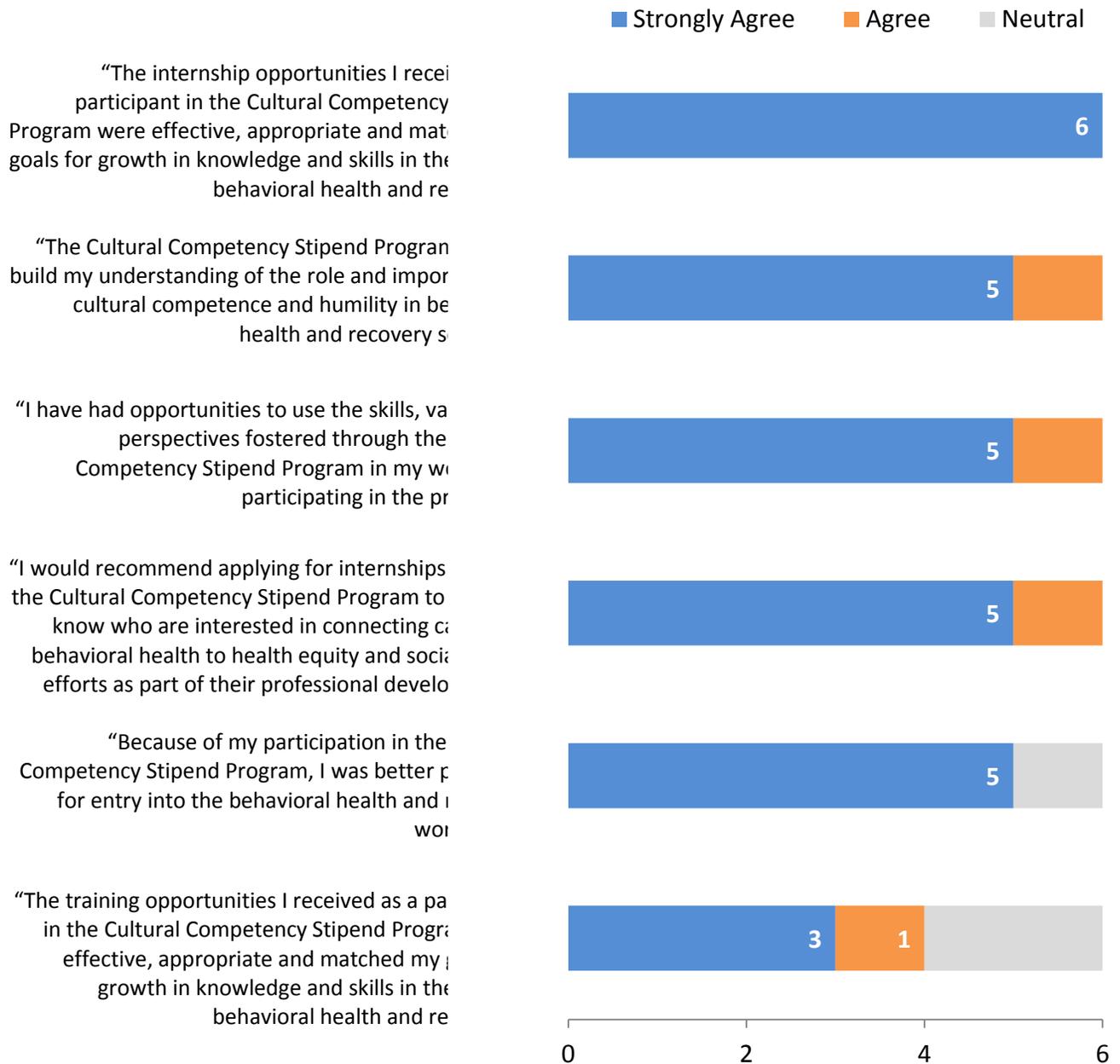
Methods

Two methods of data collection were used for the CCSIP evaluation:

- **CCSIP Survey –** current and former CCSIP participants were surveyed about their experiences in CCSIP, and level of agreement on a series of statements.
- **CCSIP Interviews** – former participants were interviewed for a deeper perspective of impacts.

Results

WET Survey for Cultural Competency Stipend Internship Program Participants

A total of six current and former CCSIP participants responded to the WET Survey. All respondents strongly agreed that CCSIP matched their goals for growth in knowledge and skills in the area of behavioral health and recovery, and all agreed that CCSIP helped build their understanding of the role and importance of cultural competence and humility in behavioral health and recovery settings.

Legend: ■ Strongly Agree ■ Agree ■ Neutral

"The internship opportunities I recei[ved as a] participant in the Cultural Competency [Stipend] Program were effective, appropriate and mat[ched my] goals for growth in knowledge and skills in the [area of] behavioral health and re[covery]" — Strongly Agree: 6

"The Cultural Competency Stipend Progra[m helped] build my understanding of the role and impor[tance of] cultural competence and humility in be[havioral] health and recovery s[ettings]" — Strongly Agree: 5, Agree

"I have had opportunities to use the skills, va[lues and] perspectives fostered through the [Cultural] Competency Stipend Program in my wo[rk since] participating in the pr[ogram]" — Strongly Agree: 5, Agree

"I would recommend applying for internships [through] the Cultural Competency Stipend Program to [people I] know who are interested in connecting ca[reers in] behavioral health to health equity and socia[l justice] efforts as part of their professional develo[pment]" — Strongly Agree: 5, Agree

"Because of my participation in the [Cultural] Competency Stipend Program, I was better p[repared] for entry into the behavioral health and r[ecovery] wor[kforce]" — Strongly Agree: 5, Neutral

"The training opportunities I received as a pa[rticipant] in the Cultural Competency Stipend Progra[m were] effective, appropriate and matched my [goals for] growth in knowledge and skills in the [area of] behavioral health and re[covery]" — Strongly Agree: 3, Agree: 1, Neutral

In their open-ended responses, survey respondents also spoke of how CCSIP increased their awareness of diversity-related issues, including privilege and power differentials:

> *"I have become very involved in the various events that various initiates have offered after seeing the tremendous amount of work that goes into hosting an event. These events have truly developed my awareness and understanding of other cultures, which has allowed me to be more mindful and culturally sensitive when providing treatment to someone of a different race/ethnicity/ spiritual community."*

> *"[I am] more aware of diversity related concerns and needs assessment."*

> *"I am thinking about issues of privilege and power in the therapy room in deeper ways."*

> *"I have realized how fortunate I am to have attended a Master's program that places such a strong emphasis on cultural humility. Much of the information presented through the initiative was not new to me, but I was glad to be involved in raising awareness in the county."*

> *"It has allowed me to gain a deeper understanding of the Latino community and the services that the entire county (outside of just BHRS) has for this population. It has also allowed me to see where the areas of strength/deficit are when providing mental health services to this community, therefore giving me an idea of how I may be able to improve this system when I complete graduate school."*

Thus, the main areas of impact on CCSIP trainees' work were (1) **increased knowledge and skills** in behavioral health and recovery, including the roles of cultural competence, cultural humility, health equity, and social justice; and (2) **deeper understanding and awareness of diversity**, including how specific communities view mental health services.

Furthermore, survey responses highlighted the value of housing CCSIP within ODE, as respondents expressed **confidence in the positive impacts of ODE's work**. Respondents also indicated that ODE is a key player in equity and diversity in San Mateo County.
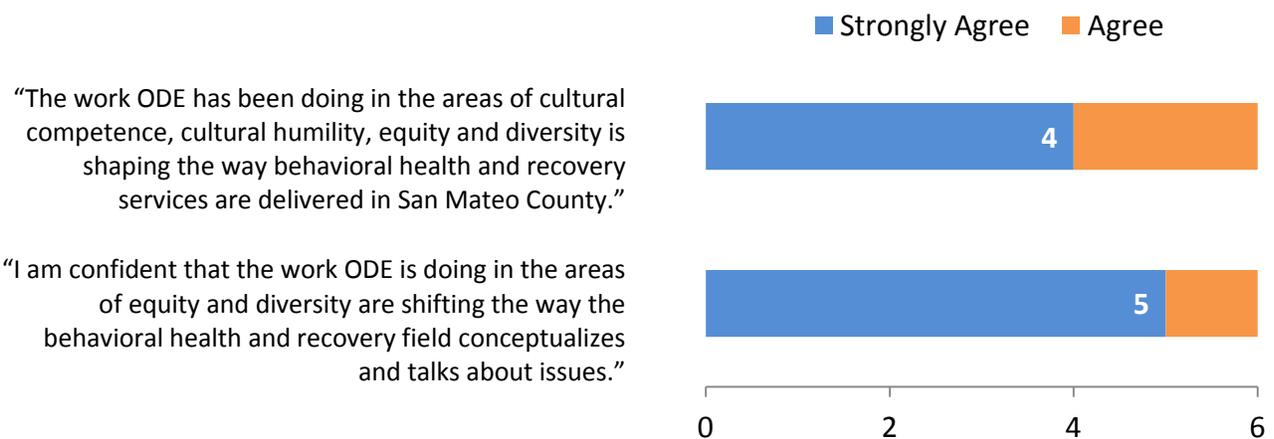
In their open-ended responses, survey respondents spoke about the challenges of participating in CCSIP, which were primarily logistical in nature.

1. The HEI schedule and the schedule for the regular intern program should be aligned. For at least one intern, the regularly scheduled meeting of the assigned HEI coincided with the intern seminar, leading to the intern to nearly drop out of CCSIP. Moreover, they "did not receive any support or assistance from CCSIP regarding this issue."
2. The time constraints for the internship project were not realistic. While interns are expected to devote 10 hours per week to CCSIP, much more work occurred toward the end of the year, when data had to be compiled and final papers written. One intern who wrote about this challenge suggested two possible solutions: 1. It was very challenging to get approval for their project, and had the project been approved sooner, they would have had more time to implement it. 2. CCSIP interns can work together to make the project more manageable.

Taken as a whole, the survey responses indicate that CCSIP is a valuable resource for preparing future clinicians to better understand issues related to diversity, marginalized communities, privilege, and power. Its emphasis on cultural humility and cultural competence helped foster skills, values, and perspectives that participants found useful. Some logistical coordination would improve the interns' ability to contribute to their assigned HEI's during an already busy and stressful intern year. Nonetheless, feedback from CCSIP participants was overwhelmingly positive.

Cultural Competency Stipend Internship Program Former Participant Interviews

Three former CCSIP participants were interviewed. Two interviewees participated in the 2015-16 cohort, and one participated in 2013-14. They represented ethnic/racial diversity, with one African American, one Asian (Chinese), and one Middle Eastern (Egyptian) participant. All three were female. Two interviewees worked on projects that supported specific HEIs (African American Community Initiative and Chinese Health Initiative), while the third supported the work of the Arab Community Workgroup.

All three have sustained some level of involvement with BHRS and/or the County. One continued supporting the African American Community Initiative past their intern year. Another was hired as the Chinese community outreach worker for ODE to host events, connect clients and consumers to services, and participate in the Chinese Health Initiative's work around stigma reduction, mental health awareness, and help-seeking in the Chinese community. The third is currently a provider in the BHRS system of care, and is a member of the Bay Area Muslim Therapists group. As part of her CCSIP project, she gave a presentation to the Arab community; after her intern year, she reached out to high schools in Daly City with a plan of doing presentations and support groups in the next year. While the former participants who were interviewed may thus be somewhat self-selecting, they and the internship supervisor felt that their experiences were representative of the average intern's participation in CCSIP.

The interviewees identified two key areas of impact: at the *individual/personal level* and the *community level*. The interviewees also gave feedback on the program, particularly around the level of support they received, and made recommendations.

- **Individual/Personal Level** – broadly, the interviewees felt that they gained a better understanding of **working with marginalized communities**, new **connections** and networks, and **professional development** and growth as therapists as a result of their participation in CCSIP. Some specific examples they offered included:

  "All those connections I made with the County through the internship have helped my work with clients now. Exposure to classes and workshops and digital storytelling, the network I have now."

  "I will be going back to get my PsyD, my CCSIP experience will be helpful in my career later. I want to work with Chinese families as a therapist, there is a large population in the Bay Area, might intern at RAMS at some point."

Understanding of Marginalized Communities

"I appreciated working in the community…I now understand the challenges of working with monolingual Chinese speakers better."

Another significant impact of participation in CCSIP was the opportunity to **serve communities** with which the interviewees identified:

Commitment to Serving Own Community

"Without CCSIP, I would not have had as strong a feeling about wanting to work with my community."

"I think the internship solidified my want and need to work in the Arab community, address stigma, identify resources. Being able to present on mental health was amazing, a lot of people shared their fears, experiences of being discriminated against, fears of seeking services. Being able to offer a space to do that was very impactful. It has given me more of a drive to work with this population… without CCSIP, I would not have had as strong a feeling about wanting to work with my community. The experience helped open the door to work with the Arab population."

"When I was an undergraduate, I was in a different state, so this was a great opportunity for me to work in my community for the first time, the other state was not diverse. Great to meet other people with similar interests."

"It really helped me personally to be more motivated to help my own community. I would not have stepped into community mental health if I had not participated in the CCSIP program."

- **Community Level** – for the interviewees, working within the County system was a powerful way to make a **broad impact**; the County brought greater visibility and legitimization of their work:

  "I think the opportunity to have an impact, to be involved in health equity initiatives or work groups, doing PhotoVoice or presentations in a specific community, was incredible. Doing it on a County-wide level is special. Having support and funding from the County, food provided by BHRS, etc. … Because it was through the County, this holds more meaning. A lot of the attendees of our presentation were recent immigrants, they didn't know the structure or the meaning, but having the County behind the work is really important. More access, resources, partnership."

  "I think the thing I appreciate the most is that San Mateo County has this kind of opportunity. I was exposed to lots of different ways to interact with the community through ODE, also being able to do the mental health work at the same time. I feel that San Mateo County is the leader in having these conversations about equity and diversity."

  Another interviewee noted the work still to be done:

  "I would like to think that the work we did made some progress. Having honest and open conversations about mental health is a success. I hope for more. I hope the community is able to access more resources. There are more amplified needs now due to the current context.

Making Broad Community Impact

"…having the County behind the work is really important. More access, resources, partnership."

"I feel that San Mateo County is the leader in having these conversations about equity and diversity within the County."

Challenges

When asked about what they found challenging about participating in CCSIP, the majority of the interviewees' comments revolved around the support they received. While one interviewee found CCSIP support to be "just right," others would have preferred more **guidance**. Many of the former participants' comments indicated that the trainees would have liked more **clarity on expectations**, especially with regard to splitting their time between clinical hours and completing their CCSIP projects. They struggled with balancing the **expectations of their various supervisors**, who had differing levels of support for interns' projects (one comment suggested that some supervisors did not take CCSIP seriously). Some comments indicated that there was room for ODE to work more closely with clinical supervisors in order to better integrate CCSIP and clinical training. For example, one interviewee was able to limit her clinical caseload in order to accommodate the CCSIP project, but this appears to be a rare exception.

Additional comments indicated that CCSIP participants would have benefitted from **basic skills training** such as project coordination, community outreach, and time management. The interviewees expressed a need for general help, but beyond additional training, they were not specific about what kind of help was needed. One interviewee had knowledge of a coordinator who was later hired to "help interns get the support that they need", and she seemed to view this support from ODE positively.

The interviewees found the CCSIP **time allotted overwhelming**, yet insufficient. Many interns were required to devote as many as 20-24 hours on clinical training on top of school commitments and other responsibilities, so the additional hours for the CCSIP project were often difficult to incorporate into

their usual work day. At the same time, the interns were very enthusiastic about the cultural competence work, and wanted to be actively involved with ODE's work as well as the HEIs. For example, the intern who worked with the African American Community Initiative (AACI) worked on three different projects during her intern year, and found that untenable. Reflecting on her year with CCSIP, she stated that she "I could have easily spent all 20 hours with the African American Community Initiative."

When the interviewees were asked about the **stipend amount** ($5000), their responses were mixed. While they felt that it was helpful, especially in terms of not having to take out as much in loans, the amount "could have been more," and ran out quickly for most. Suggestions included having fewer interns, each of whom would receive a larger stipend; splitting extra funding among CCSIP participants; and splitting the stipend into two separate checks. Some interviewees thought that the offered amount was less than what other organizations were offering, while others felt that it was more. The fact that the County covered mileage was helpful.

In addition to sharing the views expressed above, the intern who worked with the Arab Community Workgroup had some specific concerns about the **continuity** of the Workgroup. While her work with the Arab Community Workgroup was impactful, she expressed disappointment that it did not continue, nor did it lead to the establishment of a formal HEI. She has attempted to reconnect and help with this effort; but it is not realistically possible for her to carry her CCSIP work forward outside of her current role without some form of compensation. She also expressed a desire for opportunities to provide feedback and stay connected with the County. Her comments indicated that she would have liked to see some plan for sustainability, as well as some formal network for staying involved.

These final thoughts reflect how uniquely devoted CCSIP participants are to serving their communities. By rooting their work in cultural competence and cultural humility, CCSIP interns help the program meet its goal of providing more culturally responsive services to clients and the community. As this last interviewee stated:

> *"many choose to be part of CCSIP for personal and professional reasons, [to be] part of the community."*

Recommendations for CCSIP

The following recommendations for CCSIP are based on the results of the Survey and Interviews.

Basic skills training

Only two-thirds of the survey participants felt that CCSIP training opportunities were effective and appropriate, and matched their goals for growth in knowledge and skills. As we are unable to follow up with the one-third of respondents who did not agree, we use the responses of the former participant Interviews to inform us on what was missing. These responses indicate that CCSIP interns could benefit from training on such basic skills as project coordination, community outreach, and time management. While this additional training may seem excessive at first, the responses indicate that some upfront investment in these ancillary skills may help set CCSIP participants up for success during the rest of their intern year. These trainings could be provided or coordinated by ODE, a strategy that could also help CCSIP participants feel more supported by and connected to ODE's work. Another suggestion could be to let the interns choose a number of skills workshops, and get feedback at the end of the year on which trainings were most useful during their internship.

Better coordination between CCSIP and clinical supervision

The former participant interviews indicated that major challenges throughout the year were understanding the expectations of various supervisors and, often, lack of support from clinical supervisors. The interviewees also noted that there was room for ODE to work more closely with clinical supervisors in order to clarify expectations and time commitments with regard to CCSIP and clinical training. Better coordination between the two programs might strengthen clinical support for trainees' participation in CCSIP, and help legitimize the CCSIP projects in the eyes of the clinical staff. It could, in some cases, also help CCSIP participants limit their clinical caseload in order to balance the time with their CCSIP projects.

Sustainability of CCSIP projects

One former participant interviewee noted that once an intern's year is over, their relationship with the County essentially ceases, and their project might not continue. While this is not necessarily a widely held view, it makes sense to invest in the sustainability of the CCSIP projects. One way that ODE does this is by ensuring that the CCSIP interns' work supports the work of the HEI's, which have more consistency in terms of membership and participation from year to year. ODE could also encourage or require interns to incorporate a sustainability plan or component into their project proposals. Another way might be to actively encourage new interns to continue the work of previous projects; however, that could be challenging because much of the interns' work hinges on the relationships they build with County staff and community members.

Sustainability Recommendations

WET investments are crucial to creating and sustaining a transformed behavioral health care system that is client-centered and provides high quality accessible services. The most impactful elements will be sustained through the following three strategy recommendations: 1) A Systemic Approach to Workforce Education and Training; 2) Creating Pathways for Individuals with Lived Experience in Behavioral Health Careers and Meaningful Participation; and the 3) Promotion of Behavioral Health Careers to Recruit, Hire, and Retain Diverse Staff.

WET sustainability ($500,000 per year) was prioritized through the planning process for the FY 2017-2020 Three Year Program Plan as vetted by the MHSA Steering Committee, presented to the Mental Health and Substance Abuse Recovery Commission and opening of a 30-day public comment period and public hearing process.

Table 5. WET Sustainability - Recommended Components and Cost

WET Recommended Components	Sustainability Amount
Workforce Staffing and Support	$260,000
Trainings for System Transformation	$100,000
Trainings for/by Consumers and Family Members including LEA, LEW and LE stipends	$60,000
Behavioral Health Career Programs including MHLAP, Internship, BHRS Career Orientation, CCSIP, and MCOD recruitment/ hiring/ retention strategies	$80,000
TOTAL	$500,000

In 2008, counties received guidance[v] regarding the continuation and funding of WET approved projects through other MHSA components. The two relevant options for BHRS are transferring MHSA Community Services and Support (CSS) funding (not to exceed 20% of the average amount of MHSA funds allocated for the previous five years) and consolidating programs across other MHSA components.

Recommendation 1: A Systemic Approach to Workforce Education and Training

MHSA investments in workforce, education and training have significantly broadened the continuum of topics covered and the transformation of BHRS as demonstrated by stakeholder perceived key benefits of WET including; Improving Cultural Humility, Increasing Focus on Trauma-informed Care, Creating a Culture of Learning, Improved Standard of Care, Valuing Lived Experience, Building Capacity for Co-occurring Service, Increased Awareness on Importance of Self-Care and Client-Centered Services. Additionally, expansion to include those with lived experience, community partners, contract providers, and interns, which were not supported with much intentionality prior to MHSA WET.

Moving forward, a systemic approach to foundational knowledge and BHRS transformation goals (cultural humility, trauma-informed care, standard of care, co-occurring and other integrated care, lived experience integration, self-care, etc.) should be the standard. Trainings initiate dialogue, personal level impacts, and the beginning of culture shifts. Policies, leadership qualities, and intentional linkages to quality improvement goals advance sustainability and genuine system transformation. Additionally,

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[v] Department of Health Care Services Information Notice #08-16, published April 4, 2008

measuring the impacts of workforce education and training in alignment with systems change goals, will ensure meaningful activities and appropriate investments.

An example of a systemic approach to transformation is BHRS investments to cultural humility. Championing cultural humility was held as a primary responsibility of the state-mandated Ethnic Services Manager and a cultural competence committee (the Diversity and Equity Council) within the Office of Diversity and Equity (ODE). With MHSA WET investments, resources were made available to develop a training infrastructure for cultural humility priorities. ODE worked with the Quality Improvement Committee to develop policies that reinforced the importance of cultural humility as a standard of quality care; staff with direct client contact are required to participate in the Working Effectively with Interpreters training. Additionally, ODE's Health Equity Initiatives have brought valuable perspectives, insights and liaisons into the BHRS system. HEIs provide critical community voices to the shaping of BHRS' vision and programming rooted in the communities. Most recently, BHRS Leadership' commitment to Multi-Cultural Organizational Development (MCOD) engaged BHRS supervisors and managers in monthly dialogues needed to help BHRS realize the potential of cultural humility and inclusion through strategies aimed at personal, interpersonal, and organization levels; setting goals to address implicit bias, power and privilege and around recruitment and hiring, leadership development and training (including making Cultural Humility a required training of all staff), and engaging in challenging topics about race and culture.

Sustainability strategy

A transfer from MHSA CSS will sustain foundational knowledge and other training that supports system transformation ($100,000) and the workforce staffing ($260,000) needed to manage, implement, and evaluate WET across the BHRS system of care.

Recommendation 2: Creating Pathways for Individuals with Lived Experience in Behavioral Health Careers and Meaningful Participation

The Lived Experience Academy (LEA) has demonstrated to be a valuable resource for preparing clients/consumers and family members with lived experience to participate in the behavioral health workforce. And, the LEA has not only does LEA provided graduates with knowledge and skills in the area of stigma reduction and advocacy, it empowers and inspires participants to share their stories and supporting their recovery, reduced shame, isolation and increased confidence.

Creating pathways for individuals with lived experience requires a systemic and integrated approach. Moving forward, Training By/For Consumers and Family Members will include the Lived Experience Academy (LEA) and Speakers' Bureau ($15,000), Lived Experience Stipends ($10,000) and other trainings such as Recovery and Peer Support 101, Inspired at Work trainings for BHRS Peer Support Workers/Family Partners, Wellness Recovery Action Plans, etc. ($35,000).

Currently, Peer Support Workers and Family Partners employed throughout the BHRS Youth and Adult Systems are funded through MHSA CSS and supported by the Office of Consumer and Family Affairs (OCFA), a team of diverse consumers and family members with lived experience. It makes sense for OCFA to oversee this strategy with support from WET staff to help coordinate the system-wide trainings. An additional consideration would be for OCFA to contract the Lived Experience Academy, Speakers' Bureau and Stipends to a collaboration of consumer and family member agencies, linking this strategy to

other similar efforts in the community and create a more integrated system. Furthermore, this would provide participants access to the full array of resources held by partner organizations, while at the same time giving an opportunity for leadership development to clients and family members receiving supports and services at or through their specific organization.

Sustainability strategy

Consolidation of the peer and family partners strategies currently funded by MHSA, which also includes the California Clubhouse among other programs will not only sustain but better integrate this programmatic strategy. The recommendation ($60,000) will be funded through CSS General Systems Development component of MHSA.

Recommendation 3: Promotion of Behavioral Health Careers to Recruit, Hire, and Retain Diverse Staff

The WET internships, and specifically the Cultural Competence Stipend Internship Program (CCSIP), are valuable resources for preparing future clinicians to better understand issues related to both promote the mental/behavioral health field and increase diversity of staff to better reflect our client population and retain diverse staff. CCSIP invaluable outcomes included providing a better understanding of marginalized communities, reinstating participants' commitment to working with their community and being able to have a broad impact on the community not just at the clinical level.

The WET team will continue promoting/monitoring the Mental Health Loan Assumption Program (awards are provided by the State) supporting and strengthening the internship programs ($55,000) including the CCSIP stipends and specifically paying attention to the challenges in terms of greater support, communication and basic skills training identified by former participants.

More has to be done to recruit , hire and retain diverse staff. The recent MCOD goals include strategies aimed at recruitment, hiring and retaining diverse staff. Currently there is a committee, led by the Director of Adult System of Care and made up of diverse staff looking at specific strategies. A review of the original WET approved plan indicates funding was set aside ($25,000) for development of targeted materials, outreach and recruitment efforts at schools and cultural/ethnic specific organizations (Historically Black Organizations, etc.), mentoring and developing specific training "promotion readiness" for staff, among other strategies.

Sustainability strategy

A transfer from MHSA CSS ($80,000) to MHSA WET will sustain internship and outreach strategies currently managed by the WET Coordinator.

Conclusion

This report provides a documentation of the perceived impact that WET funded trainings and programs have had on staff, community-based partners, and contractors over the past 10 years. The interviews with former participants of two programs, LEA and the CSIP allowed for a deeper look into longer-term impacts these programs have had on clients/consumers, family members and behavioral health graduate students.

Throughout the 10 years WET priorities evolved, programs were discontinued, priority efforts (specifically, cultural humility, trauma-informed care, co-occurring care and lived experience integration) were refined. While most of these priorities require a more integrated and systemic approach for meaningful transformation, there is undoubtedly positive impacts, culture shifts and appreciation by stakeholders across the system including staff, partner agencies and clients/consumers and family members. This report has shed light on some areas of further development and improvement and it is expected that strategies will continue to evolve. Given this and the fact that WET funding is now directly tied to service components of MHSA, it will be crucial that the community program planning process incorporate workforce training and development assessment and prioritization where needed.

The Behavioral Health and Recovery Services, Office of Diversity and Equity, Workforce Education and Training look forward to another 10 years of meaningful trainings, programs and most importantly system transformation to better serve the San Mateo County community and especially clients/consumers and family members.

Lived Experience Academy Participants

- *"It made me more confident to present to people who have no idea what it is like to have a serious mental illness, to be able to see me. That is very empowering."*

- *I have emerged a more compassionate person, the experience has paved the road for what I want to do, what I am passionate about. I want to be a MFT*

Behavioral Health System of Care Staff

- *"[trainings] helped me see my clients in a new light and really, really show respect to them and support them."*